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COLLECTIVE IDENTITY FORMATION IN THE MENTAL HEALTH CLUBHOUSE COMMUNITY

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ABSTRACT

Contemporary community-based mental health programs are predominantly individually focused. Those programs provide few opportunities to develop collective identity among service users. Yet several lines of identity research have demonstrated that strong and positive collective identity may buffer the ill effects of stigma and discrimination on individuals from stigmatized populations. This article reviews that research and through it analyzes the Fountain House model mental health clubhouse and the international clubhouse movement. The collective, mutual aid, and social movement activities within and between clubhouses are considered in light of their contribution to collective identity formation. The article concludes with an appeal to go beyond the typical services research that is focused upon incremental improvements to interventions, and to include research on basic social and psychological processes, such as identity, to inform the way mental health services are designed.

INTRODUCTION

Serious mental illnesses include the diagnoses of schizophrenia, bipolar disorder, schizoaffective disorder, and major depression. Many who have been diagnosed with these conditions become asymptomatic in the short-term and manage any

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return of symptoms with medication, treatment, and support, or never again experience symptoms. Many others struggle with symptom management throughout their lives. When the symptoms of these conditions become disruptive to everyday life, those affected are considered to have psychiatric disabilities. Many believe that principally focusing on the medical aspects of psychiatric disabilities is counterproductive (Mandiberg, 2012), and prefer to use terms such as mental health condition to shift the focus. Medical interventions help some and not others control the overt symptoms (e.g., hearing voices, paranoia, thought disorders) that accompany mental health conditions. However medical interventions are largely unsuccessful in moderating the loss of motivation and interest in the world that often are associated with psychiatric disability. As a result, a number of social support and psychosocial services have been developed to assist people to regain the skills and interest in leading community lives.

Contemporary mental health services for people with serious mental health conditions and psychiatric disabilities have an overwhelming bias toward individual processes of illness, dysfunction, disability, and their amelioration. This focus on the individual has shaped which mental health interventions have been created and supported. It has also influenced whether the collective processes of interventions are even recognized and leveraged for the advantage of service users (Mandiberg, 1999). For example, despite many interventions being delivered collectively, service users are inevitably encouraged to have goals that do not include other service users for housing, socialization, and work.

This individual focus has left those mental health intervention models that adopt collective, community, and group approaches marginalized within mental health services, resulting in difficulty competing for contract and research funding. Successful collective program models such as the Fairweather Lodge, affirmative business, intentional communities, and the mental health clubhouse are all considered non-mainstream despite their embrace by the service users and research evidence of their effectiveness (Borzaga, 1996; Cook, Leff, Blyler, Gold, Goldberg, Mueser, et al., 2005; Fairweather, 1969, 1980; Macias, Rodican, Hargreaves, Jones, Barreira, & Wang, 2006; Mosher & Menn, 1978; Mosher, Menn, & Matthews, 1975; Schonebaum, Boyd, & Dudek, 2006). Fairweather Lodge encourages the mutual support of its members through living and working together in their recovery process (Fairweather, 1980; Trepp, 2000); some affirmative businesses provide work and jobs to employees collectively (e.g., in social cooperatives), making individual abilities less important than the collective ability to accomplish work (Warner & Mandiberg, 2006); the mutual support of small groups in intentional communities redounds to individuals (Mosher, 1999); the mental health clubhouses leverage the mutual support and social relations created by working together in work-focused task groups to achieve collective and individual outcomes (Doyle, Lanoil, & Dudek, 2013). In recognizing the potential of the collective, these models achieve

both collective and individual benefits. This is in contrast to individually-focused models that often do not benefit the collective, or do so inadvertently (Mandiberg, 1999).

This study looks at the most successful of the collective models as assessed by the number of instances of replication and its broad influence on community-based mental health; the mental health clubhouse innovated by Fountain House beginning in the late 1940s. There are currently over 300 clubhouses in 37 countries, making it the most replicated collective mental health model. The dissemination of the mental health clubhouse model is promoted by the International Center for Clubhouse Development (ICCD), a training, technical assistance, and certifying organization for mental health clubhouses and potential clubhouses around the world (http://www.iccd.org/). This study will look at the collective processes of individual clubhouses and the larger community of clubhouses as facilitated by the ICCD and how these processes forge collective identity among clubhouse participants, referred to in the clubhouse community as members. The article will draw on research and theories on collective identity and the self to look at processes of identity formation, especially collective identity formation. The article will consider the effects of psychiatric symptoms and disability on identity, including the effects of exclusion, stigma, and self-stigma; how participation in the clubhouse affects identity; and how the strong collective identity engendered by clubhouse participation may buffer the negative effects of stigma and exclusion, and in that way promote recovery.

METHODS

Both authors have various experiences with the clubhouse model. One author worked in a clubhouse for 13 years in the United States, managed a clubhouse in London for 3 years, and served on the training faculty of the ICCD. The other author referred clients to Fountain House in the 1970s, converted 3-day treatment programs to clubhouses in the 1980s when he managed a mental health system, and researched the dissemination of the clubhouse model internationally. This study is based on the authors' collective experiences with clubhouses and on the formal research of one of the authors. The formal research is based upon data from various research studies utilizing ethnographic, participant observation, semi-structured interviews, and case study methodologies (Mandiberg, 2000). The semi-structured interviews were convenience and snowball samples of individual clubhouse members, staff, administrators, and board members; ICCD staff; and funders of clubhouses. All interviews, participant observation, and ethnographic field work occurred in clubhouses around the world, at training sessions of ICCD groups, and clubhouse conferences/seminars. The case study material includes extensive review of documents from various individual clubhouses and the ICCD.

IDENTITY PROCESSES IN SERIOUS MENTAL HEALTH CONDITIONS

Many of those affected by serious mental health conditions first develop symptoms in their late teens and early 20s, coinciding with high school, post-secondary education, and early work life. After the onset of symptoms many people cannot do what they formerly could in their family, school, work, and social lives. Individuals often interrupt education, job training, and work because of the intrusive and disruptive effects of symptoms. The lives of individuals affected by these serious mental health conditions come to be dominated by the symptoms, their treatment, and the various program supports created for them. In many countries supports may be financial, medical, and those needed for daily living, including housing. Each of these supports entail applications, eligibility reviews, waiting lists, and often follow-up reviews. Many who receive these supports live in fear that they will lose them, reinforcing the centrality of the mental health condition in their lives.

The disruption to the lives, hopes, dreams, and abilities of those affected has a devastating effect on their individual identities. When severe symptoms are experienced, personal identity becomes destabilized, social roles are altered, and group affiliations change. Estroff (1989) calls mental illness an "I am illness," similar to some others that have the totalizing effect of defining the person. However, formerly held identities of people never go away in the process of mental health conditions and their recovery (Estroff, 1989). Several researchers have noted that individuals strive toward "rediscovery and reconstruction of an enduring sense of the self" (Davidson & Strauss, 1992) as reflected in personal narratives and goals (Erwin, 2008; Estroff, 1989; Ridgway, 2001).

Most identity theories acknowledge that all individuals have multiple identities that they draw upon and that may become salient in one or another context (Sedikides & Brewer, 2001; Stryker & Burke, 2000). Salience can be thought of as the strength or relevance of an identity in a given situation. The new identities that emerge from experiencing a mental health condition and its treatment may be ambiguous for the individual and for others with whom the individual interacts. This led mental health service users to develop the concept of recovery as a process of reclaiming their lives, reflected in the phrase "I am in recovery" (Davidson & Roe, 2007). Many mental health professionals and academics (Corrigan, Giffort, Rashid, Leary, & Okeke, 1999; Drake, 2000; Jacobson & Greenley, 2001), government bodies (United States Deptartment of Health and Human Services, 2003), and family members (http://www.nami.org/Template.cfm?Section=About_Recovery) have also embraced that notion. "I am in recovery" has become an important aspect of the identity of many who have survived mental health conditions and their treatment. Some mental health professionals see recovery as an outcome, however, reflected in the phrase "I have or have not recovered." This view of recovery

is unlikely to contribute to a positive identity formation for those who have not achieved that outcome.

All of the identity categories connected to mental health conditions carry potential stigma burdens. Stigma includes the beliefs, attitudes, and actions of others toward individuals and groups with discredited statuses and conditions (Corrigan, 2000; Goffman, 1963; Link & Phelan, 2001). It also includes self-stigma, or the internalization of the stigma attitudes and actions of others in the self-concept of the individual (Corrigan, Watson, & Barr, 2006). Recovery as an element of identity and the enactment of it in the recovery social movement may be seen as a potential way to overcome the pernicious effects of stigma.

Some stigma research looks at the psychological burden of carrying easily recognizable versus concealable stigmas (Corrigan & Holtzman, 2001; Pachankis, 2007; Quinn, 2006). The consequences of carrying stigma associated with a recognizable condition or status includes discrimination, social exclusion, and significant psychological burden, including stereotype and identity threats (Steele, Spencer, & Aronson, 2002). Vigilance to detect the kind of identity-based devaluation cues that one hopes not to find exacts a "psychic cost" from individuals subject to discrimination and exclusion (Spencer, Steele, & Quinn, 1999), with under-performance a possible result (Steele & Aronson, 1995). This under-performance effect was also found for concealable mental health conditions (Quinn, Kahng, & Crocker, 2004), suggesting that those with stigmatized identities may perform below their ability in tasks when the stigmatized identity is made salient. Fear that a concealable stigmatized status will be revealed, such as many mental health conditions, makes that status salient and so creates a significant psychological burden (Merin & Pachankis, 2011; Pachankis, 2007).

However, Mossakowski (2003) investigated whether collective ethnic identity buffers the stresses of discrimination and results in improved mental health for individuals from a stigmatized ethnic group. She found that the strength of ethnic identity is associated with fewer symptoms of depression. That is, the stronger the ethnic identification through such activities as participation in ethnic community activities and a strong sense of ethnic pride, the better the individual was able to cope with experiences of discrimination that often lead to depression. Strong ethnic identity reduces the effects of ethnic-based discrimination on individual mental health. This coincides with other research that consistently demonstrates that African Americans have a strong sense of ethnic pride despite experiencing overt racism and discrimination because of their racial membership (Phinney, Cantu, & Kurtz, 1997; Umaña-Taylor, 2011). Together, this research indicates that strong in-group collective identity appears to buffer the negative effects of discrimination and stigma by the out-group majority. Could this also be the case for people with mental health conditions?

SELF, IDENTITY, AND THEIR RELATIONSHIP TO RECOVERY

The two related concepts of identity and self are used broadly throughout academic literature and, from these, other oft-used concepts and distinctions are derived such as self-esteem and self-efficacy. The research literature on self and identity indicates that some forms of identity contribute positively to processes of recovery, including buffering the effects of stigma and discrimination, while others may be less useful or counterproductive. Researchers of the *self* often draw a distinction between the individual self, the relational self, and the collective self (Markus & Kitayama, 1991; Sedikides & Brewer, 2001; Trafimow, Triandis, & Goto, 1991). The individual self is the unique set of traits that individuals have as they compare and differentiate themselves from others (Sedikides & Gaertner, 2001). The relational self is based upon direct relationships with significant others, including role relationships that are familial (e.g., parent-child), romantic (e.g., spouse), institutional (e.g., therapist-client), and small group-based (e.g., task groups) (Aron & McLaughlin-Volpe, 2001; Brewer & Gardner, 1996; Sedikides & Brewer, 2001; Smith, Coats, & Murphy, 2001). The collective self is based upon the group or groups to which the individual belongs in contrast to other groups (Tajfel & Turner, 1986). The distinction between the individual self and the collective self is one of individuation versus inclusiveness; the relational self is role-based as distinct from a more general collective identity.

Individual self and identity is influenced by the reactions of others (Cooley, 1902; Mead, 1934; Stryker & Burke, 2000). When others do not confirm an identity that is salient to the individual (e.g., good at sports), the salience of that identity is reduced. Thus, although the individual with a mental health condition may form a competent identity, a disconfirming reaction by others in the broad community may reduce the salience of that identity (Stryker & Burke, 2000). For example, with the assistance of a supported employment program an individual with a mental health condition may get a job and adjust to the workplace, resulting in a positive sense of self at the individual level and, with the mental health staff, at the relational level. If co-workers do not accept the individual as a colleague, however, that positive sense of self will be disconfirmed and its salience will be reduced. In that way the positive identity of the individual as a competent worker will diminish over time.

Additionally, identity that is confirmed in some interpersonal relationships (e.g., with mental health staff) and not with others (e.g., the broad community) may result in the avoidance of disconfirming relationships and the seeking of confirming relationships. In other words, it may lead to less involvement in the broad community and more dependency-related impersonal relationships with mental health staff and/or with others in the mental health service user community. Additional dependency on mental health staff has negative outcomes for the individual and for the cost of mental health services. On the other hand, increased

interdependencies with others in the mental health user community have positive outcomes for the individual and public expenditures (Mandiberg & Warner, in press).

In the collective self, the identity of the self is the group's identity; for example I am a New Yorker (Abrams & Hogg, 2001; Tajfel & Turner, 1986; Turner, 1985). Collective identity may also be based upon a condition, status, or socially defined demographic; for example, I am a cancer survivor. An individual may have several independent collective identities, such as I am a New Yorker and a cancer survivor, or merged collective identities, such as I am a New York cancer survivor. Collective identities may be reinforced by symbolic, participative, and narrative processes. For example, participation in the movement of cancer survivors or in fund and awareness raising cancer walks may make that collective identity especially important to participating individuals.

Taylor and Whittier (1999) point out that collective identity in social movements is created in the process of social movement participation. This everyday work of movement participation, or micromobilization, builds and reinforces collective identity (Hunt & Benford, 2004). Taylor and Whittier define collective identity as "the shared definition of a group that derives from members' common interests, experiences, and solidarity." They suggest that three factors be used as analytic tools for understanding collective identity in social movements: *boundaries*, meaning the social, psychological, and physical formations that delineate groups that challenge through movements from groups that constitute established orders; *consciousness*, or the shared "interpretive frameworks" that arise through the processes of the social movement; and *negotiation*, the redefining of identity through interaction (Margolis, 1985). Margolis discusses how the meaning of "woman" in the 1960s-1970s became redefined through the private and then public enactments of what it meant to be a woman. Parallels can be seen with the private and public enactment of recovery.

Although typically the individual must accept the collective identity for it to be considered a self-identity (Tajfel & Turner, 1986; Triandis & Trafimow, 2001), when the identity is imposed and stigmatized, as in mental health conditions, it may only be "accepted" ambivalently. Ogbu (2004) has investigated identity issues of involuntary social minorities (e.g., African-American descendants of slaves, Native Americans, and low caste members). Ogbu finds that the individual and collective attempts of involuntary minorities to solve their status problems lead them to develop identities and actions that are specifically in opposition to the dominant group. Oppositional collective identity may be expressed through culture, language, artistic expression, and goals. Perhaps the most familiar expression of this in the U.S. context is often cited example of some African-American youth rejecting academic achievement because it is associated with the dominant white majority (Ogbu, 2003). Oppositional collective identity among survivors of mental health conditions and their treatment may result in similar norms that reject the goals of the dominant community.

On the other hand, those wanting acceptance by the majority face a "burden of acting white" (Ogbu, 2004) that requires bicultural skills or what Du Bois called "double consciousness" (Du Bois, 1903). For those with mental health conditions this may mean masking or suppressing some behaviors associated with mental health conditions while interacting with the majority, but expressing them when with their peers. This double set of behaviors may exact an emotional toll on the individual, again leading to favoring interacting predominately with peers rather than with the majority community.

THE MENTAL HEALTH CLUBHOUSE

The Fountain House mental health clubhouse model had its origins in a mutual aid group of individuals who had been institutionalized at Rockland State Psychiatric Hospital in New York who were living in New York City after their discharge. The group, We Are Not Alone (WANA), began meeting informally in various locations in Manhattan in 1944. In 1948, a group of wealthy supporters purchased a building for them to meet in on the west side of midtown Manhattan. Over several years what began as a loosely structured place to gather became a distinct mental health model. What has emerged is a model centered on what the clubhouse community calls the *work ordered day*.

Work is the focus of regular daytime activity for many in the world, leading to social interaction, social support, and productive self-efficacy. Yet many of those with mental health conditions do not have access to meaningful work-focused activity, resulting in social impoverishment. The clubhouse model centers social interaction and the resulting social support on work-based activities aimed at supporting the activities of the clubhouse. Members affiliate with a work unit within the clubhouse, which becomes the basis of their social supports and a source of relational identity. Typical work units include the administrative unit that maintains the records of the clubhouse and other administrative responsibilities; the culinary unit that plans for, shops for, and prepares lunch for members; the maintenance unit that maintains the physical setting of the clubhouse; and the education unit that arranges education and training opportunities for members. Work is a productive activity. Clubhouse members are not paid for the work they do to maintain their own activities, making the work similar to the activities that occur in any mutual aid group. Being paid for work is employment. For those wanting an employment experience, clubhouses have created *transitional employment* opportunities that give members a time-limited experience with competitive employment. Transitional employment typically lasts between 6 and 9 months. The member working on the job has the support and back-up, if necessary, of clubhouse members and staff who also know how to perform the work. Those in transitional employment placements may be able to go to several sequentially, or return to the work ordered day of the clubhouse. Clubhouses also have *supported employment* opportunities developed through

relationships with local employers—permanent competitive jobs where the employee is supported by members and staff members.

The focus of the clubhouse on the work ordered day and the social relationships that accrue from it makes the mental health clubhouse model distinctly different from most other mental health service models. Many mental health programs have employment as an ancillary service, or as an ultimate goal of services. While these programs may see the value of work for the individual, they are not centered on it as a process. There are other distinctive differences in the clubhouse model as well. The origins of the clubhouse model in mutual aid lead clubhouses to intentionally limit staff and define staff roles and skills as primarily facilitating and sharing work more than doing, to avoid staff members from usurping member-level and unit-level initiative; clubhouses do not have staff-only spaces, such as staff offices; and there are no staff-only trainings or meetings. Most mental health services are focused at the individual level, ignoring or downplaying any collective benefits (Mandiberg, 1999). The clubhouse begins at the collective level, however, with benefits then accruing to individuals.

Most formal mental health models principally rely on staff to support service users. Staff have the formal training, expertise, and in some instances the legitimizing degrees, certification, and licenses to provide funded services. At the other end of the support spectrum are self-help and mutual aid support models. Following Borkman (1999), self-help refers to individual action to help oneself, such as from following recommendations in a self-help book. In mutual aid, individuals come together to assist each other on an individual or collective basis (Borkman, 1999). Although there may be some competition between professional and mutual support efforts (Stewart, Banks, Crossman, Poel, Lavoie, Borkman, et al., 1994), in other instances there is cooperation (Borkman, 1990). Professional programs may refer service users to mutual aid support groups, such as Alcoholics Anonymous, and mutual aid groups may bring in professionals as advisors and experts. In these instances of cooperation, the professional and the mutual aid remain distinct, although there can be some blurring. There are also instances of hybridization of the professional and mutual aid. For example, there is a current trend to employ Peer Specialists in funded mental health services. Peer specialists are individuals with experience as mental health service users who are employed by formal mental health programs as members of support and treatment teams (Gates, Mandiberg, & Akabas, 2010). The mental health clubhouse represents a different type of hybrid, perhaps reflecting its mutual aid origins. The clubhouse relies principally upon the collective support of the unit and its activities to benefit individual members. Staff members are participants in the activities of the units, but their roles and responsibilities parallel those of members. When unit activities need organizing, staff may facilitate the unit to problem-solve together. The staff member tries not to co-opt unit decision making and problem-solving processes, however. In that way staff members function more like community organizers rather than typical clinical staff with expert

knowledge. In fact, professional training, and consequently specialist knowledge, is not a requirement in most clubhouses for staff positions.

There are activities in clubhouses that go beyond the work ordered day; however, they occur in evenings and weekends. These include leisure activities, educational opportunities, visiting other members in need of support, holiday and accomplishment celebrations, opportunities to pursue various individual interests, and the chance to just relax in an unconditionally accepting environment. These activities promote a broader sense of fellowship and mutual responsibility beyond the unit affiliations. Perhaps more than that, they reinforce a strong attachment to the broader clubhouse membership and to the clubhouse itself. Although in the world outside of the clubhouse members may face stigma, stereotyping, and exclusion, the clubhouse belongs to them. This ownership of space is significant (Pierce, Kostova, & Dirks, 2001). In the broader community, people with mental health conditions are visitors, where any mistake can reveal that status and some mistakes can result in removal, incarceration, and even greater stigma. In owned space, the fear of discovery and the potential for mistake is removed.

Participation in a clubhouse also promotes friendship and mutual aid relationships that transcend the clubhouse. In many individual mental health models, where broad community integration is the common goal, friendship and mutually supportive relationships are either actively discouraged or passively not encouraged. The clubhouse encourages that friendship and mutual support relationships that are formed inside the clubhouse be extended beyond it.

COLLECTIVE IDENTITY WORK IN THE CLUBHOUSE AND THE CLUBHOUSE COMMUNITY

Internal Clubhouse Processes and Collective Identity

People come to clubhouses with identities formed by their interactions with family, friends, service providers, and institutions, and their assumptions about mental health conditions. Their dyadic relationships have come to be dominated by roles associated with those assumptions. Their sense of collective identity may also be related to their membership in this stigmatized group. At the individual, dyadic (relational), and collective levels, having a mental health condition most likely is a salient identity, although other identities undoubtedly exist as well.

Although people come to the clubhouse because of their mental health conditions, the work ordered day and the collective and mutual support processes of the clubhouse dominate social interaction and relationships. All are working for the benefit of the clubhouse and there is no discordant voice to undercut the development of a new clubhouse-related identity. The mental health clubhouse is specifically designed to promote collective mutual support in work ordered

day units, and broader mutual support through the fellowship of the clubhouse itself. These activities lead to collective identity as members of the clubhouse community. New members are given the opportunity to find their own place within the clubhouse. It is common for new members to try out several kinds of work before they find tasks in which they feel most comfortable. The low staff numbers in relation to the workload of the program leads members to build mutually supportive relationships with each other and with the unit as a whole, rather than dyadic relationships with staff. Similar to community organizers, staff members promote unit-based support, problem solving, and leadership development among members rather than assuming those functions themselves.

The work performed by the units is intentionally collaborative. Unit meetings to plan the work of the day encourage discussion of the tasks that need to be accomplished and who is interested in working together on them. Interest in working on the task is more important than training in or knowledge about it, with the expectation that training and knowledge are properties of the group, not the individual. Although some individuals may be more knowledgeable or skilled than others, there is the expectation that less skilled individuals can learn what they need to know and that the work of the group will overcome any individual shortcomings. People who work, plan, and accomplish tasks together form a sense of ownership and collective identity (Hinsz, Tindale, & Vollrath, 1997).

Moreover, many of the unit tasks build and reinforce pride in the collective endeavor of the clubhouse which results in a strong identification with it. For example, one of the most common tasks of a clubhouse unit is to provide tours of the clubhouse to prospective members, colleagues from other clubhouses, mental health professionals, and other visitors. In the process of the tour, the member leading it explains clubhouse philosophy, the work of the units, how the clubhouse differs from other mental health programs, personal stories of how the clubhouse has helped people in their recovery, and other information that imparts pride in the collective effort. Clubhouses typically display a "Clubhouse Bill of Rights" posted prominently on the walls comprising four guarantees: "a place to come, meaningful work, meaningful relationships and a place to return." Tours stop at the poster and with great pride the tour leaders explains each right, often in contradistinction to other mental health services they may have received. In fact, on a typical tour the discussion often turns to how the clubhouse differs from other mental health services, reinforcing in-group identity (Turner, 1999).

Another unit-based activity that encourages identification with the clubhouse is a newsletter that typically is produced by every clubhouse monthly. Newsletters share news about the clubhouse and the community in which it is embedded, information on other clubhouses around the world, and events that members might find interesting. Most importantly, perhaps, the newsletter recounts individual stories of resistance to society's marginalization of members and reinforces pride in the collective accomplishments of the clubhouse. The newsletters are often sent to sister clubhouses around the world and to clubhouse supporters.

Although the activities of the units and the work ordered day create and reinforce collective identity, there are other structural factors and activities in the clubhouse that are not focused on the units. Perhaps most importantly, the ethic in the clubhouse is that it and all of its activities belong to the members. Ownership is a powerful incentive to identity (Pierce, Kostova, & Dirks, 2001). Members serve on staff hiring committees, are involved in strategic planning, and in many clubhouses serve on the boards of directors. They are involved in fundraising, public relations activities, and public campaigns supported by clubhouses, such as anti-stigma efforts. When a member is absent from the clubhouse or is hospitalized, members always participate in outreach efforts. Additionally, the sense of member ownership and the ethic of joint staff and member responsibility for the work of the clubhouse mean that the commitment to no staff-only space and no staff-only trainings and conferences is much more than symbolic. That ownership is reinforced by the lifetime membership that clubhouse members enjoy. That is, members know they will always be welcomed unconditionally.

The Clubhouse Movement: Identity Work between Clubhouses and Clubhouse Members

An international community of clubhouses and clubhouse members has emerged from an intentional dissemination effort facilitated by Fountain House and the International Center for Clubhouse Development (ICCD). From a social movement perspective, many of the ICCD activities can be seen as micro-mobilization efforts. Fountain House received a 5-year National Institute of Mental Health training grant in 1976 to train others in the clubhouse model. From that grant, Fountain House developed a 3-week training curriculum for members and staff that is consistent with the overall focus on promoting mutual support. Instead of more traditional manualized and classroom-based training, the clubhouse training is based upon direct experience in an existing well-functioning clubhouse. Often, several different existing clubhouses and groups planning new clubhouses are brought together in the 3-week training sessions. This serves to promote interpersonal relationships among the various clubhouses in training and their training mentors, reinforcing a collective trans-clubhouse identity.

The first replication from clubhouse training occurred in 1976 in Washington, DC. By 1980, 334 trainees had participated in 37 3-week training groups, resulting in 77 programs that were using Fountain House methods (Anderson, 1998; Flannery & Glickman, 1996; Propst, 1992). In the following year, there was enough international interest in the Fountain House clubhouse model to have an international conference, hosted by a clubhouse in Pakistan. The clubhouse community had its 16th conference, called international seminars, in Sweden in 2011. At the fifth international seminar in St. Louis in 1989, the clubhouse community adopted a set of standards from a list submitted by clubhouses

around the world. There are currently 36 standards that are used normatively and for clubhouse certification. The standards get reviewed consensually by ICCD clubhouses internationally every 2 years (http://www.iccd.org/).

In 1987, Fountain House received a Robert Wood Johnson Foundation grant to create the National Clubhouse Expansion Project, which in 1994 became the International Center for Clubhouse Development (ICCD). The ICCD coordinates clubhouse model dissemination, maintains standards for clubhouse programs, certifies clubhouses adhering to those standards, operates clubhouse training, and provides technical assistance to current and potential clubhouses. There are currently over 300 ICCD clubhouses in 34 countries around the world (http://www.iccd.org/). The ICCD promotes a high level of cohesiveness among the clubhouses, members, and staff members internationally through its structure and its activities. There are 10 Training Bases around the world and all ICCD certified clubhouses must attend training at a training base. Consistent with the clubhouse standards and norms experienced members, staff members, and board members attend clubhouse training together and return to their clubhouses to share what they have learned. Committees and working groups of the ICCD also always include both members and staff members from clubhouses around the world. For example, there is a Faculty for Clubhouse Development that advises and certifies clubhouses. The faculty is comprised of current members and staff members from international clubhouses with extensive knowledge and training concerning the clubhouse approach (http://www.iccd.org/faculty.html). Faculty activities always include members and staff members without any distinction between them. Clubhouses located in states, provinces, and countries sometimes also interact together as clubhouse coalitions. There are currently 17 coalitions (http://www.iccd.org/coalitions.html).

The outcome of this highly articulated and participatory organization is a broadly-based social movement and a unique transnational community with a strong collective identity. That community and social movement has its own culture and has developed shared stories and myths, rituals and practices, artifacts, and cultural representations. For example, between 1996 and 1999 one of the authors conducted research at 30 clubhouses around the world (Mandiberg, 2000), and subsequently visited ten other clubhouses, each time receiving a tour. At all 40 tours some version of the same story about the origins of the original clubhouse, Fountain House, was told. It recounts a heroic story of a group of people who knew each other as patients in a state hospital in New York who, when they were discharged to New York City, met together on the steps of the main branch of the New York Public Library and formed a self-help group called We Are Not Alone, or WANA. The story is sometimes embellished with other heroic details such as the meetings occurred in the dead of winter, one of the founders was from Russian nobility, and they were refused entry to the library. Some of the story is true, including that the group has mutual aid origins, group members knew each other from the hospital, and one of the principals was descended

from Russian nobility. Other parts of the story are untrue, however, including the ubiquitous detail about the steps of the New York Public Library! Like many heroic myths, it serves the function of maintaining continuity, cohesion, and identity (Bruner, 1990). In this case it also helps to shift collective identity from a painful and stigmatizing experience of psychiatric hospitalization, mental health symptoms, and social exclusion (Engel, 1993) to heroic strength and resilience. Stories of struggle often serve this function for stigmatized groups in building strong and positive in-group identity (Davis, 2002).

The founding myth is not the only example of how a cohesive community and collective identity is formed and maintained. Every 2 years the international community of clubhouses comes together in a large meeting called the international seminar. At this event, member and staff member representatives from clubhouses renew friendships, get updated on events within the clubhouse community, exchange new ideas and practices, and celebrate the clubhouse community, culture, and social movement. International seminars have been held around the world. In off-years, sometimes regional seminars are held (e.g., a European clubhouse seminar). These regional seminars have the same function and often replicate international seminar practices. For example, inevitably there is the opportunity for each participating clubhouse to hang its banner or flag in a great hall. It helps to strengthen pride in individual clubhouses but also pride in the collective whole and its diversity. Clubhouse members are proud to know that their collective identity is international and commands respect from the wider community. In addition to members and clubhouse staff, presenters at seminar sessions, workshops, and plenaries might include transitional employers who work with a clubhouse and board members from the community in which a clubhouse is located. In that way, clubhouse movement events both recapitulate the same sense of ownership that is evident in individual clubhouses and reaffirm the positive identity of the clubhouse and its members in the perception of its supporters in the broader community. There is typically an open microphone period where clubhouse members share experiences, feelings, and their connection to the clubhouse community.

DISCUSSION: UNDERSTANDING COLLECTIVE IDENTITY AND CLUBHOUSE PARTICIPATION

Several different lines of research indicate that strong identification with a group that has robust positive intragroup identity, although they are viewed as stigmatized by those outside of the group, can act as a buffer for individuals against the negative effects of discrimination, social exclusion, and stigma (Mossakowski, 2003; Ogbu, 2004; Steele et al., 2002; Taylor & Whittier, 1999). Our review of the structural and interpersonal efforts of clubhouses, clubhouse members, and inter-clubhouse processes demonstrate that much of the activities of clubhouses create positive intragroup identity even though members may

confront stigma in their interactions with the external community. The collective clubhouse identity may provide a significant buffering or coping support in light of the largely unsuccessful efforts to reduce the stigma of mental illness in the broad community (Mandiberg & Warner, in press). This is in contrast to normative community-based mental health programs that do no internally-focused identity work, leaving their service users to rely on their own personal sense of self as they confront stigma.

Service users of these more individually-focused programs may have collective identity buffers they are able to draw upon to counter the negative effects of mental illness stigma. Candidates include, for example, positive intragroup racial and ethnic identity; other mental health-related social movements such as the recovery, peer, and survivor movements; being members of religious congregations; and participation and inclusion in various civil society and sports activities such as clubs or sports teams.

Individual clubhouses and the international movement of clubhouses create community and owned space in addition to social movement participation and identity opportunities. The clubhouse movement in combination with clubhouse community-building and clubhouse identified space helps to achieve the three factors that Taylor and Whittier (1999) find are critical to the formation of collective identity. The *boundaries* that are created around those embracing clubhouse collective identities are not only symbolic, metaphorical, and political, but physical as well. Members are free to move back-and-forth between the broad community and the clubhouse community, sure of their unconditional acceptance in the latter. The clubhouse community and movement have developed robust common "interpretive frameworks" or *consciousness* in their shared experiences and the collective understanding of them. Additionally, clubhouse members mutually experience what it means to live a productive and meaningful life within the clubhouse community, which they then enact in the broader community as well. This *negotiation* of identity creates opportunities for what Margolis (1985) called "redefinition negotiation."

CONCLUSION/FINAL THOUGHTS

The design of mental health services has largely drawn from medical and rehabilitative sources. This path dependent line of development has led to innovations within a fairly narrow set of assumptions. In contrast, this article draws from the literature outside of medicine and rehabilitation in the disciplines of sociology, social psychology, anthropology, and the study of social movements as they relate to identity, especially collective identity. The identity literature highlights some fundamental potential problems in the design of traditional services.

For example, individually-focused services build dyadic relationships and identity at the expense of collective relationships and identity. Users of mental

health services often build close and dependent relationships with their principal service providers. This is true whether the service provider comes from a mental health profession such as social work or counseling, or from a peer provider. The "we" created is the service user and service provider rather than the collective. Dyadic identity has not been demonstrated to have the same stigma and discrimination buffering advantage as collective identity. Moreover, principal strong dyadic relationships (i.e., "strong ties") result in fewer social and community opportunities for people with mental health conditions than less strong but more numerous and broader relationships (i.e., "weak ties") (Granovetter, 1973). For example, people with mental health conditions who are dependent on the staff of supported employment or supported housing programs for their opportunities, a strong tie dyadic relationship, will have fewer opportunities to learn of job and housing opportunities than people with the broader contacts that result from collective relationships.

Additionally, when traditional mental health programs place people with mental health conditions in the broad community in housing, work, and socialization, they face burdens of stereotype threat, identity threat, and the mental health equivalent of "acting white" (i.e., "acting normal"). Collective identity has the potential to buffer these burdens as long as the in-group collective identity is positive, despite it being stigmatized by out-groups. Social movements historically, and especially new social movements more recently, often provide the vehicle for developing these strong in-group collective identities of otherwise stigmatized statuses. Mental health services can make use of the advantages of collective identity development through social movement processes by integrating those processes into the design of the services and/or by allying the program with existing social movements. The clubhouse does both. It creates a strong sense of a clubhouse social movement at the same time that it allies itself with the burgeoning recovery movement among the users of mental health services.

The field of mental health needs to look outside of its narrow focus to benefit from research in other disciplines. For example, Mandiberg (2010) drew on the research on the assimilation patterns and processes of refugees and immigrants to gain insights on how the assimilation of people with mental health conditions might achieve improved outcomes. At the same time, the mental health field needs to confirm that what is true in the research literature for other populations is also true for those with mental health conditions. This suggests the need for basic research in social sciences in addition to the more common services research. For example, are identity processes similar for people with various mental health conditions to those for the general population? That would allow confirmation of the observation that those in mental health social movements, such as clubhouse and recovery, have better outcomes and begin to answer if people who are in such movements already have improved conditions or their conditions improve as a result of movement participation.

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