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## OCCUPATIONAL INCLUSION: PERSPECTIVE OF PEOPLE WITH SCHIZOPHRENIA <sup>1</sup>

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**ABSTRACT.** The study investigated people with schizophrenia along their family members and activity / work colleagues to understand the factors that difficult or contribute to the occupational inclusion of subjects with this mental health disorder. We used a qualitative methodology through narrative interviews, seeking to know the perception of these subjects on the topic of interest. Individual interviews with 20 subjects were conducted. These were recorded and later transcribed for content analysis. Three themes emerged from the speeches. In the category adherence to the treatment, the participants speak of the importance of the diagnosis and clinical / drug treatment for maintaining a healthy functioning. On stigma and exclusion category, the subjects point to the difficulties of participating in the social life after the diagnosis; prejudice and functional difficulties are related to this finding; as well as feelings of worthlessness and low self-esteem. In the category occupation and meaning of life, the participants point to the rescue of the desire to enjoy life and to develop as a person since the possibility of participating of meaningful activities; the subjects reflect on the impact of the occupational activity in the family and in the community relationships, in addition to emphasizing the improvement in standard of functionality and performance after the inclusion experience. It is concluded that efforts should be made to expand the occupational inclusion opportunities for people with schizophrenia and other severe and long term mental health disorder.

**Keywords:** Occupational inclusion; schizophrenia; stigma.

## OCUPACIONAL: PERSPECTIVA DE PESSOAS COM ESQUIZOFRENIA

**RESUMO.** O estudo investigou sujeitos com esquizofrenia, familiares e colegas de atividade/trabalho na busca do entendimento dos fatores que dificultam ou contribuem para a inclusão ocupacional de pessoas com este transtorno mental. Utilizou-se a metodologia qualitativa, por meio de entrevistas narrativas, na busca de conhecer a percepção destes sujeitos sobre a temática de interesse. Foram feitas entrevistas individuais com 20 sujeitos. Estas foram gravadas e, posteriormente, transcritas para análise de conteúdo. Três temáticas emergiram dos discursos. Na categoria aderência ao tratamento, os participantes falam da importância do diagnóstico e do tratamento clínico/medicamentoso para a manutenção de um funcionamento saudável. Na categoria estigma e exclusão, os sujeitos apontam para as dificuldades de participar da vida social após o diagnóstico; o preconceito e as dificuldades funcionais são relacionados a este achado; assim como sentimentos de inutilidade e baixa autoestima. Na categoria ocupação e sentido da vida, os participantes apontam para o resgate do desejo de desfrutar a vida e se realizar como pessoa a partir da possibilidade de exercer atividades significativas; os sujeitos refletem sobre o impacto da atividade ocupacional nos relacionamentos familiares e comunitários, além de enfatizarem a melhora no padrão de funcionamento e desempenho após a experiência de inclusão. Conclui-se que devem ser feitos esforços no sentido de ampliar as oportunidades de inclusão ocupacional para pessoas com esquizofrenia e outros transtornos mentais graves e de longa evolução.

**Palavras-chave:** inclusão ocupacional; esquizofrenia; estigma.

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## INCLUSIÓN OCUPACIONAL: PERSPECTIVA DE PERSONAS CON ESQUIZOFRENIA

**RESUMEN.** El estudio ha investigado personas con esquizofrenia, familiares y compañeros de actividad/trabajo para comprender los factores que dificultan o contribuyen para la inserción ocupacional de sujetos con este trastorno mental. Se utilizó la metodología cualitativa, a través de entrevistas narrativas, con el objetivo de conocer la percepción de estos sujetos sobre la temática de interés. Las entrevistas individuales se llevaron a cabo con 20 sujetos. Estas fueron grabadas y posteriormente transcritas para análisis de contenido. Tres temáticas emergieron de los discursos. En la categoría adherencia al tratamiento, los participantes hablan de la importancia del diagnóstico y del tratamiento clínico/medicamentoso para el mantenimiento de un funcionamiento saludable. En la categoría estigma y exclusión, los sujetos apuntan para las dificultades de participar de la vida social tras el diagnóstico; prejuicios y problemas funcionales están relacionados con este hallazgo, así como los sentimientos de inutilidad y baja autoestima. En la categoría ocupación y sentido de la vida, los participantes señalan el rescate del deseo de disfrutar de la vida y realizarse como persona a partir de la posibilidad de ejercer actividades significativas; los sujetos reflexionan sobre el impacto de la actividad ocupacional en las relaciones familiares y sociales, y hacen hincapié en la mejora del nivel de su funcionamiento y desempeño después de la experiencia de inclusión. Se concluye que deben ser hechos esfuerzos para ampliar las oportunidades de inclusión ocupacional para personas con esquizofrenia y otros trastornos mentales graves y de larga evolución.

**Palabras clave:** Inclusión ocupacional; esquizofrenia; estigma.

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During the last century we could note as the development of therapies, including pharmacological, contributed to minimize symptoms and stabilization of mental disorders of long evolution (such as schizophrenia), transforming the lives of the patients who are no longer institutionalized in mental hospitals (Amaddeo, Barbui, & Tansella, 2012). The science development, however, was not accompanied by an increase of social resources that enable these subjects to participate satisfactorily in the community life. For social resources, it is understood up here the whole range of alternative rehabilitation resources that allow the subject to expand his autonomy capacity. As an example, we can mention the therapeutic and income generation workshops, the community centers, the social economy projects and the labor inclusion (Rodrigues, Marinho & Amorim, 2010; Silva & Lussi, 2010; Filizola et al., 2011). For this reason, the institutionalization has been occurring in the twenty-first century, but now it is domestic.

Everyday experience with the patients' families reveals how this situation (the domestic institutionalization) is designed as the underlying element to the disease, becoming naturally absorbed and thus trivialized. After a period of denial and anger related to the disease, there is complacency, in a subtly perverse dynamic, in which the subject is practically, sentenced to an inactive and emptied of meaning life.

From the family microcosm for the life in community we can see that the negative perception of the capabilities and mental disorders carrier possibilities spreads exponentially. The ignorance justifies the exclusion, sustained in a secular imaginary which links the mental illness to the disorganization and violence. Who would dare to employ a person with schizophrenia? The term, itself, is impregnated in prejudice and it confirms the need for rejection. Employers protect themselves, from thoughtless way, against an imaginary threat, creating obstacles to these subjects to access to the labor market. Although not all of them are able to perform work activities, a large portion could work and contribute socially.

It is quite likely that the lack of information is one of the factors that sustain this preconceived imagery and stigma perpetuator. Some studies, for example, suggest that there is a lack in the quantity and quality of information provided by the doctors to the families and patients about the disease, including questions about the treatment and the social management (McCabe et al., 2002; Van Meer, 2003). The communication between the professionals and the users of the health services is often hampered by the lack of capacitation of the former, resulting in the transmission of information sometimes incomprehensible.

The use of certain terms and diagnoses by the media worsens this scenario, as they tend to reinforce the stereotypes and to encourage a negative view of the mental illness (Duckworth et al.,

2003). With rare exceptions, the term schizophrenia, for example, is used by the media as an offense associated to the disorder and especially to the aggression (e.g. "one behaved like a schizophrenic person ... the company goes through a schizophrenic crisis ..."). This type of comment, of course, tends to feed the aforementioned preconceived social imaginary and to reinforce the patients' low self-esteem pattern, by stimulating the development of attitudes and self-stigmatizing behavior. Such attitudes mean that, in addition to its surroundings, the patient sees himself in a distorted, contradicted and negative way, which can keep him in a position of resigned passivity, not allowing himself to enjoy the social and the employment opportunities.

In Brazil, there are no population-based studies on occupation and employment rates among patients with severe mental illness. Presumably, however, they are quite low, as in other contexts (Boardman & Rinaldi, 2013).

A recent study in China found that people with schizophrenia have greater opportunities to use their productive skills and get work in the rural areas than in the urban areas (Yang et al., 2013). Inherent characteristics of rural culture, as the least competitive labor, would favor the inclusion in this environment. In addition, and more importantly, perhaps the mental illness eventually passes unnoticed in the rural areas.

The abovementioned study finds resonance in the subsidized researches by the World Health Organization which show that in the developing countries people affected by schizophrenia and related disorders have a considerably better prognosis, with higher recovery rates, than people with the same disease in the developed countries (Jablensky et al., 1992). Such research suggests that the difference in the prognosis may be related to the general attitude of the population towards individuals with schizophrenia, perhaps more tolerant, in the developing countries.

Another survey, conducted in Germany, points out that people with mental disorders have more difficulty than those with physical illnesses and disabilities to be included in the labor market (Richter et al., 2006). Subjects with schizophrenia and alcohol dependence are most affected by this reality. This finding is complex and may be linked to both a more negative perception of mental disorders and to the lack of culture and inclusion laws addressed to this population.

Concerned about this problem, the authors of this article conducted a study that investigated the universe of the patients with schizophrenia who perform significant occupational activities. The study aimed to assess the perception of these people, as well as their caregivers or business activity / work colleagues on the factors that influenced their occupational inclusion.

## Method

Qualitative, descriptive and observational study using the narrative interview technique to approach and know the history of life and the daily life of the individuals with schizophrenia who perform occupational activities were our instruments.

### Subject

The study was conducted with subjects with schizophrenia, severe mental disorder and long evolution that commit, from a significant and persistent mode, the social functioning (DSM-V, 2014). All participants were over the age of eighteen, without legal impediments (interdiction, for example) and without cognitive impairment that affected their decision-making capacity. It was also essential that these subjects were available to talk openly about their daily lives.

As an inclusive key criterion, these subjects should be linked to the occupational inclusion experiences. We contacted two institutions that carried out activities compatible with this criterion: the first, an association of people with mental disorders that promotes the socialization and the rehabilitation activities; the second, a workshop that houses a labor inclusion project for people with mental disorders.

Additionally, caregivers / family members and professionals involved in the daily life of these subjects, over the age of eighteen, were also invited to participate in order to understand comprehensively the issue investigated.

Twenty people were interviewed; among them nine with schizophrenia, seven families' patients and four were professional / co-workers. These subjects were included in the study after being properly informed about these studies aims, and all of them agreed to participate by signing the Free and Informed Term of Consent, according to the Resolution 466/12 of the Conselho Nacional de Saúde (National Health Council), which deals with research involving humans' beings. The study was approved by the Comitê de Ética em Pesquisa do Centro Universitário Metodista IPA (Research Ethics Committee of the IPA Methodist University).

### **Procedures**

After the initial contact, the interviews were scheduled, and they were performed in the place of business or work of the participating subjects, who chose the given space and with privacy policy. All interviews were recorded, transcribed and then analyzed for content analysis.

In the narrative interviews with the schizophrenic carriers, three basic ideas were addressed: 1) Who I am, as I am, how I feel: The person was asked to talk about himself, as noted, as he deals with his feelings, etc.; 2) How I deal with the prejudice: the subjects were asked about the impact of the disease on their daily life, the difficulties of living with the disease, the social stigma, etc.; 3) How I could include myself: the subject is encouraged to talk about his occupational inclusion experience and its effect in the relationships, in the affections and in the social functioning. Caregivers/family members were asked about the impact of the inclusion experience in the subject daily life and in the social relations. The professionals were asked about the inclusion experience on the job location/occupation and the consequences of that experience for everyone involved.

We tried to analyze the contents in their semantic and pragmatic levels (Bauer & Gaskell, 2008). The semantic analysis aims to investigate the meaning of the speech in order to identify the most important elements of the informant's narrative, his feelings and the considerations regarding the issues investigated while the pragmatic analysis is concerned with the environment and the way the information is transmitted. Three themes emerged from the discourse, setting up the analytical categories of the study: treatment adherence, stigma and exclusion, work and life meaning.

## **Discussion of Results**

The individual stories, with its obvious characteristics, revealed significant similarities: the initial resistance to assume as having a mental disorder; the need for adherence to the drug treatment for the stabilization of the disease; the stigma and the prejudice that lead to loss the emotional bonds and social and occupational opportunities; the idleness linked to a life emptied of meaning; the overcoming by including in significant social and occupational activities. Then we will describe these findings.

### **Treatment adherence**

When we ask them to describe their history, we find subjects eager for the opportunity to be heard. The interview that puts the focus on personal life is, somewhat, analogous to an analytic session. The subject is the main actor and the spotlight. It is a novelty, perhaps, for people who are generally used to being coadjuvants. The need for listening denouncing the human desire for uniqueness. Through speech, we can access the submerged desires in the subject unconscious; desires eventually unknown even by him. Freud (1912/1996) a point out that to talk and listen to himself the subject constructs the paths to his liberation and acceptance.

N., mother of a schizophrenia carrier, reports that the elaboration of their conflicts is through the exercise of the speech: "*I talk, and I talk a lot ... we are not ashamed of our son ... many of my*

*problems I can solve talking ... I go to parties, family gatherings, and M. (Son of N., the schizophrenic carrier) goes along, always ..."*

N. is 68 years old, 25 of which are devoted largely to the cause of her child. She is a partner/founder of an association of people relatives with mental disorders in her city, where she operates on a voluntary basis daily. Everything she learned she tries to teach other mothers who have similar difficulties and seek the association for support. Her speech is imbued with enthusiasm, showing a lot of knowledge about her child's disease and needs. Her son, M., also attends the association daily, where he performs various occupational and recreational activities promoted by it. It is clear during the interviews that there is a strong positive influence in their lives due to their participation in that family association.

Research indicates that to participate in associations and/or family organizations is a protective factor related to resilience in patients and chronic disease caregivers such as HIV/AIDS (Carvalho et al., 2007), the degenerative diseases (Nascimento et al., 2011) and the dementias (Silva, Steps & Barreto, 2012). The associations offer to the subjects a unique area of comprehensive listening, necessary to cope with the often hostile reality imposed by the disease.

The life of the subjects we interviewed changed dramatically with the onset of the disease. Studies and career were interrupted. In addition, it was necessary to transit through the *via crucis* from the health system, to finally find a successful treatment, which for each took a considerable time. On the other hand, the successful treatment does not mean a cure of the condition, as it was desired, but an acceptance that it could be controlled by the adherence to the treatment. At first, they denied the disease. None of them wanted to be the patient of a mental disease which for many is still perceived as madness. Family and friends moved away. The feeling of loneliness and misunderstanding was part of their daily routine.

The participant N. reports strongly negative memory of the first internment of her child. She could not visit or even see him during a week, because the visits were prohibited. She was very afraid. And the son, M., moreover, because he was locked in a place perceived as hostile, plagued by the disease and without understanding why he could not see his parents. What had he done wrong? The explanation offered by the treating physician never really seemed acceptable to them: his family disturbed his mental health. So the best treatment at that moment was momentarily to move away the family until the child was out of the outbreak. For N., it did not make any sense. Today, she can understand that the treatments are never the ideal ones, especially when referring to hospitalization.

As for M., which currently is 42 years old, the hardest part was facing the reality of a future without prospects. He worked in a transport company before the first psychotic episode, at 29 years old. He was a young man with a promising career. The disease brought an early retirement as an alternative for his livelihood. He was very depressed and useless. What he would do with his life was a permanent question in his mind. He thought very often about suicide as a way to escape from this reality. During the first years as a disease carrier, he isolated himself, realizing his impotence and a person with no other alternatives. It took seven years from the first internment to the stabilization of his disease. Seven "long" years, according to M.. A necessary time, so that the family could finally understand what it was "it all", what that disease was, and mostly that it was possible to move forward. It was possible and even to be happy as a schizophrenic patient. *"We have to accept and move on, doing the best, without guilt of being so, understanding that it is a disease, taking the drugs ... The cure, to my knowledge, does not exist yet."* as M. stated.

However, the optimistic narrative of M. is an exception, possibly linked to his personal history, marked by great family support and search for the best treatment options. Subjects with these characteristics more easily find room for inclusion when compared with those who fight against the diagnosis and face resistance of all kinds, especially the familiar prejudice, which is a major barrier to the treatment adherence (Wam Kasim et al., 2014).

L., now 39 years old and also a frequenter of the aforementioned association, reports as important the contact with some welcoming doctors and psychologists, and according to her perception, interested in her welfare, who explained to her about the disease and, especially, about the importance of taking the drugs. At first, she refused to use them. She was afraid of using the drugs. Only after her second hospitalization, she realized that the drugs could interrupt the disease cycle, leaving her less

confusing. During this period, she returned to study at the faculty of philosophy, which she had interrupted, and she managed to complete the course. But that was not enough to give her back the pattern of previous functioning. The schizophrenia brought her a big difficulty in the social relationships. Her life was very limited to the domestic space. And in this space, she felt little welcomed and understood. As she reports,

*When I had my first outbreak, I did not want to take the drugs, because I thought that it would turn me into a crazy person. My brother calls me crazy until now ... I can even understand that he thinks so, as he studied little ... I think this has relation with the past, when the people with schizophrenia went to the mental hospitals. It remained as a very great prejudice. Then, my psychologist explained me about the treatment ... Then, I understood. (L., portadora de esquizofrenia).*

The above statements are echoed in the scientific literature. Studies indicate that the treatment adherence is very tied to the capacity of understanding its importance (Mohamed et al., 2009, Silva et al., 2012). The limited capacity of insight and the denial of the disease often complicate the prognosis of subjects with schizophrenia (Johnson et al., 2012). On the other hand, the treatment adherence appears to be linked to the patient education/information and to the relationship with the professional that meets him (Välimäki et al., 2012). Adherent patients also, have fewer symptoms and more likely to maintain the social relationships and the occupational activities. The adherence, in this sense, is a success labor predictor (Wan Kasim et al., 2014).

### **Stigma and exclusion**

The prejudice is one of the most impacting factors for the social inclusion of people with schizophrenia. As a rule, there is a helplessness linked to the diagnosis, which means, for example, that this subject opinion is of little importance (for family, for the health services and for himself) or that the general perception of his competence to have a relationship with anybody and to work is negative (Daumerie et al., 2012). This determines, including, attitudes of self-stigma and avoidance. Üçok et al. (2012) show that these people often anticipate the discrimination situations when they are looking for a job or an affective relationship, although that discrimination could not occur, in fact.

T., a psychiatrist aged 55 years old, who works with people with severe mental disorders for over thirty years, emphasizes the overall difficulty of the society to deal with the mental disorder in a less prejudicial way. According to her, the prejudice is so deep that it is present even among those who should contribute socially to a greater acceptance and understanding of the disease, as is the case of the psychiatrists.

*I work in an NGO that includes people with schizophrenia in the labor market. These people, to participate, need to be in treatment and have a professional referring. Sometimes, we get patients that come with doctor's referral, but do not know what they have really ... The fellow never talked to them about it. (T., psiquiatra)*

The prejudice tends to vary according to the culture in which the subject is inserted. More competitive contexts tend to be less tolerant generating more embarrassing situations for the subjects with any disorder that affects the functioning. (Jablensky et al., 1992). Less negative conceptions, on the other hand, seems to be associated with the fact that the subject is female, then she has more education and she has had work experience previous the diagnosis (Stuber et al., 2014).

Historically, the image associated with people with severe mental illnesses such as schizophrenia and other psychotic disorders was on the disorganized, delusional and potentially violent subject. In the Western world until the middle of the last century, many of these individuals spent much of their existence excluded from the social life, interned in sanatoriums (Foucault, 1964/2005). The psychiatric reform processes, leveraged by changes in the paradigm of how to care and the emergence of the psychotropic drugs led to a significant change in this framework: people with severe mental illness are no longer institutionalized.

Initially, especially in those countries that have been the pioneers in the reform processes, there were great expectations about the impact that would have the deinstitutionalization on these subjects' lives. It was believed that the institution had stolen the autonomy of the patients and thus, the deinstitutionalization would give it back. In isolation, this measure soon proved ineffective as a means of social reinsertion (Turner, 2004, Botha et al., 2010). The subjects were not automatically reassuming the control of their lives and being reintegrated into community life. Many of them, instead, became institutionalized at home, maintaining a restrictive pattern of life, characterized by poor social relationships and the occupational experience almost absent.

In Brazil, the patients who were born after this period, although they have been benefited from the provision of less rough medications from the point of view of side effects, inherited a limited social and health system, whose rehabilitation resources and social inclusion are scarce. That is, a system that has failed to account to meet needs that exceeded the limits of what we may call as the usual clinical practice: to provide drugs and quick consults.

Our study found that the answer to the needs of the health system in our country, with respect to the rehabilitation and to the inclusion issues, seems to be coming from independent initiatives: associations, non-governmental organizations, non-formal centers of support and coexistence, solidarity economy initiatives. The subjects that we interviewed participate directly or indirectly in structures such as these, where they perform occupational and professional activities and they also receive support.

J., a 63 year-old musician, mother of a patient with schizophrenia, regularly attends the association of people relatives with mental disorders yet previously mentioned, where she has taught a music workshop. Her daughter also attends the association. The benefits, she said, are immense. In addition to his daughter develops occupational and recreational activities, she relates to people who have similar problems: *"Living with other people with the same disease helps to reduce the loneliness, it fills the gap ... The activities are also very important as they improve the esteem, and they favor the creativity ..."* (J., musician, mother of a patient with schizophrenia).

## Occupation and life meaning

Keeping occupationally active is a major challenge for people with schizophrenia. Long periods of idleness after the onset of the disease and the cognitive deterioration that often accompanies make difficult the employability of the individuals. Most commonly, those who manage to stay active outside the family perform rehabilitation activities, for example, therapeutic or income generation workshops. Although these are relevant and necessary strategies, eventually they are perceived as a bit challenging for some of the users (Wagner et al., 2011).

Another feature that has been steadily gaining strength in our country, and that is already extremely recognized in other countries, is the type of protected work, a free translation of the authors to supported employment, a term used by the international literature, and designating quite different experiences of inclusion through work (Mueser & McGurk, 2014). It is designed for individuals with a disability or disabilities who require support to perform the activity for which they were hired. In general, the subject receives training and ongoing support to accomplish the task, although this is not always necessary, since many individuals become quite independent and competitive with the passage of the time (Kinoshita et al, 2013). This occupation mode also implies in the systematic education and training of the contracting company about the inclusion process.

Some participants of this study are part of a labor inclusion program for people with mental disorders developed in the city of Porto Alegre/Brazil, which falls under the protected working mode. F., 31, has been participating in this program for four years. He reports how hard it was to live with the functional losses that appeared in his life after the onset of the disease. He was often feeling useless and incapable. He states that he had difficulties with the management of the disease, especially to the treatment adherence. This was fundamental for F. in order to reach stability and then to resume his occupational life. The return occurred with the entry into the mentioned program: *"I'm working through this program ... It was hard, in the beginning ... It takes a lot of persistence and not gives up at the first obstacle."* (F., a schizophrenic carrier).

In this program, the subjects are included in the companies through the Quotas Law no. 8213 for people with disabilities (1991), who are understood as having a psychosocial disability. The recognition that behavioral and cognitive dysfunctions present in certain mental diseases is configured in a psychosocial disability framework is recent, and that has been included in the list of deficiencies by the Convention on the Rights of Persons with Disabilities (CRPD), adopted at the General Assembly of the United Nations Organization (UNO) on 13/12/06 (Sasaki, 2010). It is a new nomenclature and therefore subject to obstacles and "des" bureaucratic understandings. A breakthrough, anyway, if we thought that until recently the lack of a proper nomenclature meant that these individuals could not benefit from this law.

*Before the Convention and the discussion on the issue of psychosocial disability, we could only include in the Quota Law those people who had mental retardation (intellectual) along with mental illness. It was very unfair ... we sometimes heard about cases of mental retardation misdiagnosis only to include the subject with schizophrenia. (T., psychiatrist).*

H., F. co-worker, described how the experience of living with him is enriching. H. is 27 years old and has been working for two in a storage area of a large supermarket in the city of Porto Alegre/Brazil. He had never experienced with a "special" person, according to his words. He had prejudices that he lost from this coexistence. He cried when reporting that initially he had few expectations about the working capacity of F. He believed that the activity in the sector where they work became more organized with his coming.

The coming history of F. in this supermarket is symbolic: as part of the labor inclusion program, after six months of job training, F. was allocated as a packer. He was anxious and did his job with dedication. However, one of his personal characteristics makes his adaptation difficult. F. is a so perfectionist person, he likes everything organized, separated by size, color, etc. He took a long time packing, organizing the customer purchases in bags. In the everyday run of an urban supermarket, his behavior was seen as an obstacle to the smooth running of the service. Complaints began to emerge, which produced him a great suffering. He thought about quitting. He was dissuaded by a manager of another sector of the company, Mr. P., who knew what his problem was and had the idea to bring F. to collaborate with his team. In this new sector, F. would work with the stock, which demanded greatly organization. The manager in question realized that the feature that almost led F. to be fired (perfectionism and over-organization) would be useful in the new job, including contributing to that, some time later, his sector was awarded as the most organized of the company. Sir P. believes that the dedication and performance of both F. and other individuals included in the company very often go beyond the expectations. *"The care he dispenses at work, the desire to do everything right, perfect, he also teaches us a lot ... It makes you to want to be better."* (P., stock manager of a supermarket).

The above statements help to understand how the work activity is crucial in building self-esteem. In addition, it is clear that the impact of an inclusion program goes beyond the subject included, covering his surroundings, producing changes in the social values that may only be truly perceived in the long run. This story also leads us to reflect on the importance of the work in the rescue of the citizenship. The subject included becomes a subject of value: he contributes socially, familiarly, and he is recognized: *"When I'm working, I forget everything, the illness, the problems, I am a person able to do what I do, and that's enough."* (F., a schizophrenic patient).

Mueser & McGurk (2014) conducted a systematic review of the literature and found eighteen randomized studies showing that the protected work is more efficient in expanding skills and competencies in individuals with severe mental disorders than those traditional rehabilitation strategies. Another systematic review of the literature found that the protected work was superior not only to the usual rehabilitation modalities but also to any other type of work. Among other favorable findings, the subjects adept at this kind of work have more stability in competitive jobs (Kinoshita et al, 2013).

The lack of opportunities of occupying, on the other hand, condemned the subjects to a dramatic process of social exclusion. This process begins from the diagnosis, very commonly understood as a disability label. The domestic reclusion, in this context, becomes gradually understood by the family and by the subject as an inexorable fate. There are no possible alternatives or space for creativity. Nor



there is space for reflections and questions. What is on is the rule, and the rule is the true. And the truth in this case is that the subject should really be incapable. How to oppose to that preconception and to enlarge the inclusion area becomes an individual and collective challenge.

The term labor inclusion relates to the right of having equal opportunities, so that any individual has a chance to participate in the labor market (Mello & Wagner, 2011). In practical terms, it means that even if having a deficiency, the subject may exercise an employment activity, as it is provided the access conditions to allow him to exercise this activity successfully. An accessible environment reduces the disadvantage of the person with disabilities in relation to others. If there are no barriers, the person will not be deficient in relation to any activity, although there may be a functional limitation.

The interviewee T., a psychiatrist who works with labor inclusion, emphasizes that often the family difficult the process of inclusion because they fear for her son's safety, keeping an overprotective attitude in order to save him from any suffering. This same attitude is eventually adopted by work colleagues in an almost natural way.

C., 34, reports that in the first days of work she was very afraid. She had been hired to work as a typist, but "*she was shaking so much*" that she could not do her job properly. A colleague, realizing her difficulty, began to assume "*temporarily and without anyone knowing, except them*" tasks that could fit her. C. was relieved by the presence of the colleague, who, in a sense, substituted her own mother (who, at great expense, had been dissuaded from being with her daughter at work). Over time, however, this dynamic has surfaced: her colleague felt overloaded, while C. had increasingly feared. From the occupational therapist intervention responsible for C. selection and inclusion in the company, the problem was solved. C. received greater attention and support to carry out her work and her colleagues were informed about the importance of not adopting paternalistic attitudes. A year later, C. was completely at ease in her work as a typist, assuming including other functions for which she felt unable previously.

Cases of F. and C. exemplify the need for a different look at the circumstances and on the individual history of the subject included in the labor market. If this is not taken into account, the entire investment may be lost. Companies that propose to include need to develop a comprehensive perspective, rather than overprotective or rigid/inflexible, so as not to underestimate the potential of the subject. It is a great challenge, which refers to the need to overcome old models and contracts of employment, based on competence as a static value, without taking into account the real possibility of individual building of these skills from the opportunity.

No doubt, the work universe undergoes fundamental changes in its conception and organization associated to the inclusion process of people with various disabilities. There is an urgent need to raise awareness and training from the companies and employees for the reception of these people (Simonelli & Camarotto, 2011). This qualification takes place formally through training, but also on an informal basis, in the daily life. It's living that we can see the other as he really is, not as we imagine that he was. The imagination is usually permeated by historical prejudices that hinder the inclusion.

## Final Thoughts

The need to be active as a work power is inherent to the human species, as part of those peculiar and distinctive features associated with the creative process and the personal development. We seek the occupation as a form of unburdened the existence weight, which does not always make sense. The exercises which fulfill the need to give meaning to the existence are to work, to create, to plan, to take care. When, for some reason, we are deprived of the opportunity to meet this need, we find ourselves threatened, including in our dignity.

People with schizophrenia often experience this condition of existential indignity. Unable to manage their own life autonomously and especially without occupational opportunities compatible with their psychosocial disabilities, these individuals are threatened to live a lonely and empty existence. The lack of personal projects and especially of an occupational perspective ends exposing the patient

to a number of risks, such as the substance abuse and the treatment dropout, which worsen the disease progression (Cheng et al., 2014).

In "Eichmann in Jerusalem: a report on the banality of evil" Hannah Arendt (1963/2001) discusses a human inclination - almost universal – for the thoughtlessness, pointing to the interdependence between unconsciousness and evil. We are led, from Hannah considerations, on this particular case - the trial of a Nazi war criminal - to reflect on the human vulnerability to the justified destructive act. We conjecture, in this sense, that the process of exclusion suffered by the person with schizophrenia corresponds to a certain destructive social colluding, thoughtless, of course, because it is not understood in this way. One that stigmatizes and excludes bases one's attitude in the historic fear of violence and disorganization. Fully justified, then, the carrier social exclusion, since he can be a threat. It does not matter in this process, how helpless the subject actually is.

The thoughtlessness, to Hannah Arendt, is the evil disguised, cleared by the excuse of ignorance. In the field of the mental health, the thoughtlessness follows condemning innocent subjects to death in life. It is important that professionals involved in the care of people with severe mental disorders such as schizophrenia abandon the traditional position of accommodated passivity attitudes and take to question the choices - also passive - of patients and caregivers. You can magnify the social and labor participation of the carriers, as a collective project.

People with schizophrenia who we have interviewed are proof of that event. Although they experienced feelings of worthlessness and hopelessness in the initial process of the disease, they have moved forward and have transcended the disability label, transforming their lives into an experience that is worth. This was only possible thanks to the treatment adherence and to the efforts of a social and professional network involved in the construction of inclusion strategies.

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