Perceived social status among people with psychiatric disabilities attending work-oriented and meeting place-oriented day centers

Tjörnstrand, Carina; Argentzell, Elisabeth; Eklund, Mona

Published in:
Work: A Journal of Prevention, Assessment & Rehabilitation

DOI:
10.3233/WOR-162388

2016

Document Version:
Peer reviewed version (aka post-print)

Perceived social status among people with psychiatric disabilities attending work-oriented and meeting place-oriented day centers

Abstract

BACKGROUND: Day centers have been criticized for giving attendees a lower social status because they only offer activities that are often work-like although not financially of benefit to attendees.

OBJECTIVES: To explore day center attendees' perceived social status and to identify associations among the attendees with the center's orientation with activity, well-being, and psychiatric symptoms.

METHOD: Day center attendees in meeting place-oriented (n=39) and work-oriented (n=54) day centers in Sweden were interviewed addressing the targeted factors using both self-rated and interview-based instruments.

RESULT: Attendees rated themselves close to the middle on the social status measure. No difference between groups based on day center orientation was found. Their self-perceived positioning on social status was positively related to the worker role, occupational engagement, self-rated health, self-esteem, self-mastery, and depressive symptoms. Logistic regression models showed better self-rated health was the only predictor of belonging to the group with a higher level of social status when dichotomized according to the median. Self-rated health was

the strongest indicator for scoring above the 75th percentile on perceived status, followed by self-esteem, which was also a significant indicator.

CONCLUSION: These findings yielded new knowledge concerning perceived social status in the target group and the importance of health and self-esteem.

Key words: health, occupational engagement, occupational therapy, community mental health, social capital

Introduction

Perceived social status has been found to be negatively affected by a low level of social and economic capital (1). It has also been found to be associated with poor health outcomes (2). These findings indicate that there could be a link between people's perceived social status and their opportunities for work and other productive activities, their health, and their general wellness. People with psychiatric disabilities are at great risk for being affected by factors in their social, economic, and physical environments (3). People with psychiatric disabilities have the highest unemployment rates among all illness groups. They thus have an unfavorable situation with respect to opportunities for building social and economic capital (4) and attaining or maintaining a high level of social status.

Day centers for individuals with psychiatric disabilities are a well-established alternative for work on the open market in Sweden. They are run by the municipalities. They aim to promote social participation with meaningful productive, recreational, and educational activities. There are mainly two types of day centers in Sweden: work-oriented and meeting place-oriented centers (5). Work-oriented day centers offer productive occupations such as café/food catering, maintenance work, the manufacture of wood and clay products, or working with textiles. Meeting place-oriented day centers focus on providing opportunities for meaningful leisure occupations and represent a place where people can socialize, relax, and try out a variety of hobbies (6). The day centers cannot increase the attendees' economic capital because they do not provide opportunities for earning money. The centers have been criticized for being degrading due to a lack of support for becoming employed (7). Research indicates that when attendees are highly engaged in productive activities at the day centers, they tend to perceive themselves as having a job in spite of not receiving any remuneration (8, 9).

A debate is ongoing in Sweden and other countries about whether or not being a day center attendee has a stigmatizing and institutionalizing effect (7, 10), and infers a possibly lower social status for day center attendees. Meeting place-oriented day centers with a focus on leisure activities have been particularly criticized and some have closed or changed to become work-oriented (11). To our knowledge, previous research has not investigated perceived social status and possible correlates among day center attendees. Since meeting place-oriented day centers do not offer productivity, the attendees could be assumed to encounter fewer experiences pertaining to factors that have been seen as inherent in employment and important for mental health, for examples, time structure, collective purpose, status, and productive activity, (12, 13); and therefore, attending a day center, particularly one that is meeting place-oriented, might generate the perception of a low social status. On the other hand, day centers engender positive experiences for the target group (9, 14, 15), which could be of importance for perceived social status. They can open up a social world for people who otherwise may lead a passive life in the home environment (16-18) with time spent in a day center found to be associated with occupational engagement (19). Occupational engagement is defined here as the degree to which an individual is able to be part of a broader social context and is engaged in personally meaningful activities that can create routines and a balanced everyday life (20). Day center attendees have been shown to have more social contacts (21) than non-attendees, indicating that day centers might promote social status through enhancing attendees' social capital. Choosing to attend a day center has been profiled as a means of promoting recovery and gaining access to engagement in meaningful activities, social integration, active citizenship (5), and an experience of belonging (9). These factors are inherent in the definition of social capital (2), which in turn has been found important for a person's perception of social status (1). How the

availability of social integration is related to perceived social status in day centers is thus worth investigating.

A person's perceived position in the social class hierarchy influences the way that person acts and his or her view on possible social and economic opportunities (1). It has been maintained that social status is an indicator of power structures in a specific society. Examples of these are having a job and completing a certain level of education. Perceived position in the social class hierarchy may enhance social participation, bring a sense of belonging, and enable members of the society to cooperate with others, all of which are factors that influence how people perceive their social status (22). The question we examined is if day centers, particularly work-oriented ones, can in the same way as work and education endorse and promote social capital and influence social status. The fact that work in day centers is non-profitable and attendees have been shown to have a lower education level compared to non-attendees (23) may instead affect attendees perceived social status negatively. As mentioned above, day centers provide activity-based interventions and bring a feeling of togetherness, but have been criticized for not promoting a worker role (24). It would thus be interesting and important to investigate whether factors pertaining to attendees' views of having a worker role, their previous education, and other socioeconomic factors are associated with their perceived social status.

Social participation is important in terms of where people perceive themselves to be on a social scale and another facet concerns what this perceived position means for a person's autonomy (25). Autonomy implies a certain amount of control, in terms of what and how much one feels one is able to do, which in turn is important for the person's perceived social status. Kraus et al. (1) further maintained that perceiving to be at the upper end of a social status continuum increases feelings of control, implying that control and status may mutually reinforce each

other. Engagement in day center activities has been shown to be associated with a degree of control over one's life situation (19, 20). So, if day center attendees experience low social status then they may feel less in control, and possibly be less engaged in occupations.

Self-esteem is another factor that has been maintained as being influenced by day center activities (14, 19) and can be of relevance for perceived social status. The review by Kraus et al. (1) addressing social status showed self-esteem and respect and admiration from others can form a positive shield against the negative health effects of belonging to a low social class in society. Whether self-esteem is of relevance for social status in the day center context is not known.

In terms of people with mental illness, it appears to be warranted to investigate whether psychiatric symptoms are of importance for perceived social status; psychiatric symtoms need to be further explored in relation to social status. Depressive symptoms have not been shown to be involved in the process of status attainment, neither as a cause nor a consequence (26). In other aspects, perceived social status and its correlates among day center attendees are currently unexplored. The aim of this study was to investigate social status in the day center context and its associations with day center orientation, time spent in the day center, occupational engagement, social integration, the worker role, socio-demographic variables, self-variables in terms of self-control and self-esteem, and health-related factors. This research can generate greater knowledge about factors that can be addressed to promote day center attendees' social status and thus counteract possible feelings of discrimination and stigma.

Method

This cross-sectional study was approved by the Regional Ethical Review Board (Reg. No. 303/2006). The research was performed in meeting place-oriented and work-oriented day centers in the southern part of Sweden.

Participants and study context

Participants were recruited in four municipalities, which included a total of seven day centers, located in both urban and rural areas. The staff consists of a mix of health professionals, such as occupational therapists, social workers, and/or skilled craftsmen. The managers for these centers were approached and all agreed to participate. The research team held a meeting at each center where participants were informed about the project. Both oral and written information was given to the attendees, highlighting the principles of voluntariness and confidential treatment of data. From a sample of 194 who had been contacted for participation in the study, written informed consent was obtained from 93 attendees. Fifty-four of these attendees attended work-oriented day centers and 39 attended meeting-place oriented day centers; and 59% were men and 41% were women. The participants' socio-demographic characteristics are presented in Table I.

Table I in about here

Procedure

The data was collected by three research assistants, occupational therapists with previous experience working with the target group, and all three received specific training with the instruments. The interviews took about 60 minutes each and were performed in a separate

room at the day center. Some participants needed help from the research assistants in terms of explanations of items, and breaks were offered when needed. In cases where the participants needed assistance with reading the questions, the research assistants were careful not to influence the responses.

Instruments

Socio-demographic factors. Questions were part of a background questionnaire designed for the study and concerned: gender, age, educational level, and civil status. Additional questions asked about amount of hours spent at the day center and self-reported diagnosis.

The MacArthur Scale of Subjective Social Status. An instrument in the shape of a social ladder, called The MacArthur Scale of Subjective Social Status developed by the McArthur Network on SES & Health (27), was used to assess perceived social status. There are two versions of the ladder and the one used in this study was the society ladder which has shown good test-retest stability (28). The participants were asked to imagine that a ladder with ten steps represented the social status and hierarchy of people in society. At the top of the ladder (10) are the people who are "best off" – those who have the most money, highest education, and the most respected and best paid jobs. At the bottom of the ladder (0) are the ones who are disadvantaged, poor, and have no jobs. The participants were asked to imagine that the higher up they perceived themselves to be on the ladder, the closer they would be to the people who were at the very top. The lower down they felt to be on the ladder, the closer they would be to people who were at the bottom. The participants marked the step where they perceived themselves to be on this ladder.

The Swedish version of the Pearlin Mastery Scale (Mastery-S) is a self-report scale with good construct validity in terms of unidimensionality (29). The instrument has been translated from

the scale described by Pearlin et al. (30) and indicates the perceived control of a person's life situation. The scale has seven items that reflect the degree to which people believe they can influence important factors in life. A four-step response scale is used, from "strongly disagree" (=1) to "strongly agree" (=4), where a higher score indicates greater self-mastery.

The Rosenberg Self-Esteem Scale (RSES) contains ten items (31). The present study employed the response alternatives yes and no, as recommended by Oliver, Huxley, Priebe and Kaiser (32). The final score indicates the balance between positive and negative self-esteem; and a higher rating reflects better self-esteem. Predictive validity of the scale has been established and the RSES has shown to be valid across many cultures and languages (33). The scale has demonstrated good properties in terms of test-retest reliability and internal consistency (34).

The SF-36 is a short-form health survey used in clinical practice and research. The first item in this survey was used to estimate subjective health and has been proposed to be a reliable one-item estimate of self-rated health (35). The wording is "In general, how would you say that your health is?". A lower rating indicates better health and the response options range from "excellent" (=1) to "poor" (=5).

The Profiles of Occupational Engagement in people with Severe Mental Illness – Productive occupations (POES-P) (36) evaluates, by self-report, an individual's productive, work-related engagement. The POES-P, which is structured in two parts, is developed from the instrument Profiles of Occupational Engagement in people with Severe Mental Illness (POES) (37). The first part is a time-use diary and the second part is a checklist. The time-use diary requests information from the latest visit to the day center and gives a report on the activities performed. It asks with whom and where the activity was performed and about experiences (feelings and thoughts) when engaged in the activity. The respondent then rates his or her occupational

engagement according to statements such as “I think what I do is meaningful for me”, “I think I am able to manage the tasks I perform”, and “I think I take the initiative for what I do”. The response scale ranges from 1 (not at all) to 5 (always) and a higher rating indicates a higher level of occupational engagement. The POES-P has shown satisfactory properties in terms of internal consistency, and discriminant and convergent validity (36).

Interview Schedule for Social Interaction – Self-Rating (ISSI-SR). Social integration was measured by the Swedish version of the instrument Interview Schedule for Social Interaction (ISSI) (38). It has four subscales, and the Availability of Social Integration (AVSI), was used in this study and has been found valid and reliable for people with severe mental illness (39). AVSI yields a maximum score of 6 and target one aspect of social capital, namely to measure the quantity of a person’s social contacts.

Brief Psychiatric Rating Scale (BPRS) (40) was used to assess severity of psychiatric symptoms. A professional made the assessment based on an interview and observation. Each item represents a type of symptom, such as hallucinations, and is rated on a scale from 1 (no symptoms) to 7 (extremely severe symptoms). The 18-item version was used for the analysis in the present study and the items were grouped into sub-scales of positive, negative and depressive symptoms, and general psychopathology. BPRS has been shown to possess good inter-observer and intra-observer reliability (40). For this study, a structured interview was used which has been found to reduce variability in the ratings and enhance reliability of the BPRS (41). The interviewers were trained for BPRS interviewing and rating performed directly after the questionnaire session.

The Worker Role Self-assessment (WRS). To assess how the participants perceived their possibilities of having a future worker role, the WRS (42) was used. The participant responds to

14 statements about their worker role, e.g., “I think that work will be part of my life in the future”, “I get strong support from the rehabilitation and healthcare staff for returning to work”. The WRS has shown satisfactory internal consistency, test-retest reliability (42) and construct validity (43).

Data analysis

The software used was the SPSS Statistics 18.0. Since the instruments employed ordinal scales and the data was non-normally distributed, nonparametric tests were used. The Mann-Whitney U test was used to analyze if perceptions of social status differed between groups based on day center orientations, gender, educational level and civil status. Spearman correlations were used to calculate associations between potential correlates forming continuous variables and perceived social status.

The statistically significant variables showing associations with perceived social status at $p<0.05$ according to these initial analyses were then entered in two forward stepwise (conditional) logistic regression models with either of two dichotomizations of perceived social status as the dependent variables. In Model 1 social status was dichotomized at the median and in Model 2 the cut was made at the 75^{th} percentile. The decision to try two alternatives for dichotomizing the variable was based on the wish to determine which factors distinguished the group with the highest level of self-perceived status and to see if these differed from the variables that were important for scoring above the median level.

Results

The mean social status rating was lower (3.72) for those who attended meeting place-oriented day centers than for those who attended work-oriented centers (4.51); the difference was, however, not significant (p=.087). Similarly, there were no differences between these groups in terms of gender (mean=4.36 for men and 3.61 for women; p=.075), civil status (mean=45.8 for married and 44.8 for singles; p=.874) and educational level (mean=40.6 for low education and 46.9 for high education; p=.177).

Bivariate correlations showed that social status had the strongest association with health, followed by self-esteem, depressive symptoms, and self-mastery. The result indicated social status was related to the worker role and occupational engagement (see Table II).

Table II in about here

The logistic regression analysis included the factors of health, self-esteem, self-mastery, depressive symptoms, the worker role, occupational engagement, and general psychopathology as independent factors. The Hosmer-Lemeshow test supported both Model 1 and Model 2, as indicated by non-significant p-values of 0.932 and 0.989.

Model 1 (see Table III), which had the median as the cut-off for forming a high and a low group of social status, explained 29.8 % (Nagelkerke R Square) of the variance in social status and correctly classified 72.4 % of the cases. Perceived health, with an odds ratio of 0.35, was the only predictor variable and the model was statistically significant χ^2(df 1 n=93) = 21.9, p<0.001. The odds ratio indicated an almost tripled chance of belonging to the high group on perceived social status for each scale step on perceived health.

Model 2, where the cut-off between a high and a low social status group was set at the 75th percentile, correctly classified 79.3 % of the cases and explained 44 % of the variance in social status. The two variables health and self-esteem remained in Model 2, $\chi 2$ (df 2 n=93) = 28.8, $p<0.001$. The strongest predictor was again perceived health with an odds ratio of 0.353. The second predictor had an odds ratio of 6.39, indicating that for each scale step towards higher self-esteem respondents were more than six times more likely to belong to the group scoring above the 75th percentile on perceived social status.

Table III in about here

Discussion

The result of the regression analysis shows self-rated health was the most important factor for the day center attendees' perceived social status, which concurs with the findings in studies on social status in other populations (2, 44). Self-esteem was the second most important factor in the regression analysis in this study and together with health constitutes a necessity for reaching the highest steps on the perceived social ladder. A relationship between self-esteem and social status has been considered obvious, but has also been maintained to be stronger among adults than among adolescents (45). Age may matter in terms of whether a person's self-esteem brings societal social status, and generates the type of results found in the present study. The relationship has been said to be dependent on the context, in that self-esteem and social status have a stronger relationship when a person is satisfied being in a context he/she currently belongs (1, 46). The participants in this study did not rate their social status at a

particularly low level with a mean rating of 4.05 and SD 2.2 on a scale from zero to ten. This indicates that the day center attendees generally felt they were close to the middle of the social scale in society, which corresponds with theories concerning social status: being among others in the same situation and social class generates a higher social status and can be important for self-esteem (1).

The univariate analyses showed the amount of time spent in the day center context and variables such as social integration, gender and civil status were not significant for perceived social status. Further, the findings did not indicate any association between education level and social status, which is contradictory to previous research (25). It is plausible that a psychiatric illness and its potential consequences in terms of disability and stigma can reduce some of the positive influence a higher education may have on social status. The participants in the present study attended day centers for people with psychiatric disabilities and for many it was a considerable period of time since their education experience. A study carried out in the day center context revealed that the median time since the most recent work or education experience was 14 years (23). The distance in time from a person's education experience, a lack of work experience that matches the educational qualification, and the stigma often perceived by people with mental illness (47) may together seriously disturb or rule out the often-established link between education and social status.

Being in a work-oriented or a meeting place-oriented day center was not linked with social status, thus involvement in leisure or a productive occupation appears to not make any difference in perceived social status. These results may be due to the fact that the day centers in the study have satisfied, to some extent their attendees' needs for both leisure and productive activities as has been indicated in earlier studies (6). The reason could be that the orientations

are equally important; engagement in leisure activities may enhance social capital to the same extent as in the work-oriented centers. Both may be stress-reducing and an important factor for recovery and, in particular, important for persons with psychiatric disabilities and having difficulties in using leisure time constructively (48). Moreover, the lack of financial remuneration can result in difficulties in pursuing leisure activities (49) and meeting place-oriented day centers can be a cost-free alternative. A focus for future research could determine whether leisure and vocational rehabilitation services are equally important for the perception of social status.

The results of the univariate analyses in this study showed self-mastery was associated with social status. This concurs with the review by Kraus et al. (1), which concluded that a context-bound high status can not only generate psychological effects in terms of more autonomy but also the feeling of being in control. Self-mastery has in turn shown a relationship with occupational engagement among day center attendees (19) and, interestingly, a new finding in the current study is social status showed a relationship with occupational engagement in the univariate analyses. Occupational engagement has to our knowledge not been explored previously in relation to social status. Occupational engagement did not have as great an impact as perceived health and self-esteem in the multivariate analyses, but must still be seen as a factor of potential relevance for social status in future research.

One of the positive aspects of day center attendance on perceived social status may concern its potential influence on individuals' experiences, such as a feeling that they take on responsibilities in the day center (9). Moreover, being actively engaged, having routines and being productive, as well as participating socially in day centers, could be experienced as leading a "normal" life and going to work (9). This form of rehabilitation may be viewed as being secluded when compared to having work in the open-market job and earning money, Day

centers are sometimes seen as locking people in, counteracting integration into the general community (10), and could be assumed to bring on low perceived social status. Both views might be valid depending on the circumstances. Since this study indicated that having a positive worker role was significantly associated with perceived social status, a day center that fills the function of a work place may thereby render greater social status than a meeting place-oriented center. The difference between work-oriented and meeting place-oriented centers was not statistically significant but cannot be simply dismissed since the p-value was < 0.10. However, neither the day center orientation nor the view of the worker role was seen to be predictors in the regression models. One explanation for this may be that the attendees´ perceived social status was context-bound and the result of being satisfied with where they were, which is one of the avenues towards high social status (1). This may, however, still result in a lock-in effect for the attendees who do not dare to venture towards paid work because of the fear of being in a different social context where their sense of social status may no longer be valid.

Clinical implications

Addressing social status might be one key to succeed in helping individuals towards new goals and counteracting the lock-in effect. According to our findings, the day center staff should be sensitive for when attendees feel stronger and have sufficient self-esteem to move forward from one social context to another where people are perceived to have higher social status. The challenge would be from the staff who could help and support individuals with transition from the day center to work or some other productive activity. The attendees may need to be coached by staff or peers to use newly gained well-being, self-esteem, and sense of control in other settings, outside the day center. Kraus et al (1) describe the importance of knowing the context-specific codes that are important for social status in order to venture into new contexts.

Research on rehabilitation alternatives such as day centers has indicated that these are contexts where individuals may feel less stigmatized than in society in general (50). Another potential challenge to individuals with psychiatric disabilities is feeling degraded when changing context and being with people from a (perceived) higher social class. This can result in self-stigma, which is when individuals with a mental illness not only experience prejudice and discrimination from other people but also internalize these attitudes and make them their own. Self-stigma can generate negative consequences and can be highly self-regulating if individuals avoid areas where they risk feeling discriminated. Research highlights the reluctance among people with psychiatric disabilities to take control over their lives due to this fear (47). Feelings of stigma and self-stigma would be important for staff to attend to; and could constitute another factor connected to perceived social status and an area for future research.

Our results showed associations between depression and social status. It may be relevant to consider factors in the environment that can work against depression. The findings suggest that the ways in which day centers can address health perceptions and related factors may be of relevance to help improve experienced social status within the target group. Mirowsky and Ross (51) showed creative work imprinted by self-expression, resourcefulness, and productive activity involving originality, all of which may be offered in day centers, were more important for health than autonomy, age, education, and household income. If day centers use their resources optimally, for example by fostering self-expression and supporting each individual's originality, then engagement in the day center activities may strengthen the attendees' subjective health and indirectly their perceived social status.

Study limitations

Logistic regression was considered the most appropriate method for multivariate analysis, since the variables were on ordinal scales and generally did not have a normal distribution. The dependent variable had to be dichotomized, which reduces the variance. However, the independent variables were kept as ordinal scales, in order to keep as much as possible of the variance in the original data. The option of setting the p-value for inclusion of variables at a higher level was considered, but would have resulted in a great number of variables in the regression models. The result should be interpreted as a part of the puzzle of knowledge regarding people with psychiatric disabilities in the day center context and does not explain any causal relationships or predict outcomes. As a limitation, self-measures tend to attract social desirable responding. Using interviewers who were unrelated to the day center was one measure taken, for both counteracting social desirability bias and ensuring the participants' confidentiality. For future studies, it would be recommended to add the community version of the social ladder (28) which addresses the status in the local community, in this case within the day center. This would have generated more information on how the participants perceived themselves in relation to their day center and not only to society in general.

Whether day center attendance has an upgrading or degrading effect on social status was not part of the research questions for the current study but would be an interesting topic for a future qualitative study.

Conclusion

The most significant findings were the importance of health and self-esteem in relation to perceived social status. There is a chance that individuals may feel they gain in social status when attending a day center, both because they increase their social capital and feel content

with being with people in similar situations. The findings supported this reasoning, by indicating that the attendees' mean ratings of their social status were close to the middle of the scale. There is a risk that the attendees can feel degraded if the day center is seen as a last resort with only non-paid activities available and no clear pathways towards other recovery alternatives. The fact that perceptions of the worker role were related to social status supports this scenario; however, educational level and day center orientation showed no such association, and the notion that attending a meeting place-oriented center would be degrading did not receive any support in the findings. Not being offered alternatives like a day center, could be even worse and make individuals feel more degraded in society, a reality many individuals with psychiatric disability face every day if they have no place to go.

Acknowledgement

Thanks to the National Board of Health and Welfare and the Swedish Research Council for funding and to all the day center attendees for participating and making this study possible.

References

1. Kraus MV, Tan JJX, Tannenbaum MB. The social ladder: A rank-based perspective on social class. Psychol Inq. 2013;24(2):81-96.

2. Ahnquist J, Wamala SP, Lindstrom D. Social determinants of health. A question of social or economic capital? Interaction effects of socioeconomic factors on health outcomes. Soc Sci Med. 2012;74:930-9.

3. Allen J, Balfour R, Bell R, Marmot M. Social determinants of mental health. Int Rev Psychiatry. 2014;26(4):392-407.

4. McCulloch A. Social environments and health: cross sectional national survey. BMJ. 2001;323:208-9.

5. Socialstyrelsen. Nationella riktlinjer för psykosociala insatser vid schizofreni eller schizofreniliknande tillstånd 2011 – stöd för styrning och ledning. Artikelnr: 2011-1-3. [National guidelines for psychosocial interventions for people with schizophrenia or related disorders, 2011 - support for control and management. Final report. In Swedish.]. Stockholm: National Board of Health and Welfare.2011.

6. Tjörnstrand C, Bejerholm U, Eklund M. Participation in day centres for people with psychiatric disabilities: Characteristics of the occupations. Scand J Occup Ther. 2011;18(4):243-53.

7. Grönberg ME. Från slutna institutioner till institutionaliserat omhändertagande. Karlstad: Karlstad University; 2012.

8. Argentzell E, Leufstadius C, Eklund M. Factors influencing subjective perceptions of everyday occupations: Comparing day centre attendees with non-attendees. Scand J Occup Ther. 2012;19(1):68-77.

9. Tjörnstrand C, Bejerholm U, Eklund M. Participation in day centres for people with psychiatric disabilities - A focus on occupational engagement. Br J Occup Ther. 2013;76(3).

10. Bryant W, Craik C, McKay E. Living in a glasshouse: Exploring occupational alienation. Can J Occup Ther. 2004;71(5):282-189.

11. Andersson M, Eklund M, Sandlund M, Markström U. Freedom of choice or cost efficiency? The implementation of a free-choice market system in community mental health services in Sweden. Scand J Disab Research. 2015:1-16.

12. Leufstadius C, Eklund M, Erlandsson LK. Meaningfulness in work - experiences among employed individuals with persistent mental illness. Work. 2009;34(1):21-32.

13. Araten-Bergman T, Stein MA. Employment, social capital and community participation among Israelis with disabilities. Work. 2014;48(3):381–90.

14. Gahnström-Strandqvist K, Liukko A, Tham K. The meaning of the working cooperative for persons with long-term mental illness: a phenomenological study. Am J Occup Ther. 2003;57(3):262-72.

15. Bryant W, Craik C, McKay E. Perspectives of day and accommodation services for people with enduring mental illness. J Ment Health. 2005;14(2):109-20.

16. Bejerholm U, Eklund M. Time use and occupational performance among persons with schizophrenia. Occup Ther Ment Health. 2004;20(1):27-47.

17. Leufstadius C, Erlandsson L-K, Björkman T, Eklund M. Meaningfulness in daily occupations among individuals with persistent mental illness. J Occup Sci. 2008;15(1):27-35.

18. Shimitras L, Fossey E, Harvey C. Time use of people living with schizophrenia living in a north London catchment area. Br J Occup Ther. 2003;66(2):46-54.

19. Tjörnstrand C, Bejerholm U, Eklund M. Factors influencing occupational engagement in day centers for people with psychiatric disabilities. Community Ment Health J. 2015;51(1):48-53.

20. Bejerholm U, Eklund M. Occupational engagement in persons with schizophrenia: relationships to self-related variables, psychopathology, and quality of life. Am J Occup Ther. 2007;61(1):21-32.

21. Argentzell E, Leufstadius C, Eklund M. Social interaction among people with psychiatric disabilities - does day centre matter? Int J Soc Psychiatry. 2014;60(6):519-27.

22. Åslund C, Starrin B, Nilsson KW. Psychosomatic symptoms and low psychological well-being in relation to employment status: the influence of social capital in a large cross-sectional study in Sweden. Int Journal Equity Health. 2014;13(22).

23. Eklund M, Sandlund M. The life situation of people with persistent mental illness visiting day centers: A comparative study. Community Ment Health J. 2012;48 592-7.

24. Argentzell E, Eklund M. Perceptions of the worker role among people with psychiatric disabilities: Description and investigation of associated factors. Work. 2013;45:289–98.

25. Marmot MG. Status Syndrome. J Am Med Assoc. 2006;295(11):1304-7.

26. Eaton WW, Muntaner C, Bovasso G, Smith C. Socioeconomic status and depressive syndrome: The role of inter- and intra-generational mobility, government assistance, and work environment. J Health Soc Behav. 2001;42(3):277-94.

27. Adler N, Stewart J. The MacArthur Scale of Subjective Social Status. http://www.macses.ucsf.edu http://www.macses.ucsf.edu 2007 [25 februari 2015].

28. Giatti L, do Valle Camelo L, de Castro Rodrigues JF, Barreto S, M. Reliability of the MacArthur scale of subjective social status - Brazilian Longitudinal Study of Adult Health (ELSA-Brasil). BMC Public Health. 2012;12:1096.

29. Eklund M, Erlandsson L-K, Hagell P. Psychometric properties of a Swedish version of the Pearlin Mastery Scale in people with mental illness and healthy people. Nord J Psychiatry. 2012;66:380-8.

30. Pearlin LI, Menaghan EG, Lieberman MA, Mullan JT. The stress process. J Health Soc Behav. 1981;22:337-56.

31. Rosenberg M. Society and the Adolescent Self-Image. Princeton NJ: Princeton University Press; 1965.

32. Oliver JPJ, Huxley PJ, Priebe S, Kaiser W. Measuring the quality of life of severely mentally ill people using the Lancashire Quality of Life Profile. Soc Psychiatry Psychiatric Epidemiol. 1997;32(2):76-83.

33. Schmitt DP, Allik J. Simultaneous administration of the Rosenberg Self-Esteem Scale in 53 nations: Exploring the universal and culture-specific features of global Self-Esteem. J Pers Soc Psychol. 2005;89(4):623-42.

34. Torrey WC, Mueser KT, McHugo GH, Drake RE. Self-Esteem as an outcome measure in studies of vocational rehabilitation for adults with severe mental illness. Psychiatric Services. 2000;51(2):229-33.

35. Bowling A. Just one question: If one question works, why ask several? J Epidemiol Community Health. 2005;59(5):342-5.

36. Tjörnstrand C, Bejerholm U, Eklund M. Psychometric properties of the POES-P assessing self-reported engagement in productive occupations. Can J Occup Ther. 2013;80(2):101-10.

37. Bejerholm U, Hansson L, Eklund M. Profiles of occupational engagement in people with schizophrenia (POES): The development of a new instrument based on time-use diaries. Br J Occup Ther. 2006;69(2):58-68.

38. Undén A-L, Orth Gomér K. Development of a social support instrument for use in population surveys. Soc Sci Med. 1989:1387–92.

39. Eklund M, Bengtsson-Tops A, Lindstedt H. Construct and discriminant validity and dimensionality of the Interview Schedule for Social Interaction (ISSI) in three psychiatric samples. Nord J Psychiatry. 2007;61(3):182-8.

40. Overall J, Gorham D. The Brief Psychiatric Rating Scale. Psychol Rep. 1962;10(3):799-812.

41. Crippa JAS, Sanches RF, Hallak JEC, Loureiro SR, Zuardi AW. A structured interview guide increases Brief Psychiatric Rating Scale reliability in raters with low clinical experience. Acta Psychiatr Scand. 2001;103(6):465-70.

42. Wästberg B, Haglund L, Eklund M. Psychometric properties of the worker role self-assessment instrument used to evaluate unemployed people in Sweden, Scand J Occup Ther. 2009;16:238-46.

43. Eklund M, Bäckström M. Factor structure and construct validity of the Worker Role Self-assessment (WRS) when used for people with psychiatric disabilities in Sweden. Eval Health Prof. 2016; epub date Apr 21.

44. Singh-Manouxa A, Adlerb NE, Marmota MG. Subjective social status: its determinants and its association with measures of ill-health in the White hall II study. Soc Sci Med. 2003;56:1321–33.

45. Rosenberg M, Pearlin L. Social class and self-esteem among children and adults. Am J Sociol. 1978;84:53-77.

46. Adler N, Stewart J. Self esteem. http://www.macses.ucsf.edu 2004 [25 februari 2015].

47. Hansson L, Stjernswärd S, Svensson B. Perceived and anticipated discrimination in people with mental illness - An interview study. Nord J Psychiatry. 2014;68(2):100-6.

48. Iwasaki Y, Coyle C, Shank J, Messina E. Role of leisure in recovery from mental illness. Am J Psychiatr Rehabil. 2014;17:147-65.

49. Topor A, Borg S, Girolamo D, Davidson L. Not just an individual journey: Social aspects of recovery. Int J Soc Psychiatry. 2011;57(1):90-9.

50. Mezzina R, Borg M, Marin I, Sells D, Topor A, Davidson L. From participation to citizenship: how to regain a role, a status, and a life in the process of recovery. Am J Psychiatr Rehabil. 2006;9(1):39-61.

51. Mirowsky J, Ross C, E. Creative work and health. J Health Soc Behav. 2007; 48:385-403.

Table 1

Note. Due to missing data the total number of participants varies between the variables

Socio-demographic characteristics (n=93)	*Meeting-oriented (n=39)*	*Work-oriented (n=54)*
Age mean (SD) (min- max)	48 (10) (25-61)	44 (10) (22-63)
Gender (male/female)	25/14 (64%/36%)	30/24 (56%/44%)
Attendance hours/week, mean	12	14
Having children living at home; yes/no;	1/34	9/38
Have a friend; yes/no;	35/4	47/7
Type of housing;		
Supported housing	2	4
Own apartment/house	14/22	13/36
Housing support; yes/no;	19/20	17/37
Educational level;		
Not completed elementary school	3	2
Completed elementary school	14	21
Completed high school	17	24
University or college degree	4	2
Self-reported diagnosis; %		
Schizophrenia and other psychosis	50	39
Mood disorders	25	20
Anxiety, phobia and stress disorders	11	25
Other disorders	14	16

Table II. Associations between social status and the selected correlates

	Correlation coefficient	*P-value*
Age	**.672**	.634
Hours of attendance	**.281**	.217
Health	**-.389**	<.001
Self-esteem	**.419**	<.001
Self-mastery	**.340**	<.001
Occupational engagement	**-.249**	.019
BPRS negative symptoms	**-.008**	.917
BPRS positive symptoms	**.050**	.507
BPRS depressive symptoms	**-.325**	<.001
BPRS general psychopathology	**-.159**	.036
Worker role	**.288**	<.001
Availability of social integration	**.122**	.246

Table III. Results from the logistic regression analyses.

	Perceived social status	*B*	*Wald*	*p*	*Odds Ratio*	*95% C.I. for Odds Ratio*	*Nagelkerke*
Model 1	Health	-1.048	15.639	<0.001	.351	.209 - .589	.298
Model 2	Health	-1.04	9.062	.003	.353	.179 - .695	.441
	Self-esteem	1.855	4.083	.043	6.39	1.057 - 38.6	.441