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# An exploration of the significant issues at work for people with a diagnosed mental health issue, from the perspective of individuals and line managers.

Badger, Lindsay Louise Rose

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University of Plymouth

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**UNIVERSITY OF  
PLYMOUTH**

**An exploration of the significant issues at work for people with a diagnosed mental health issue, from the perspective of individuals and line managers.**

by

**Lindsay Louise Rose Badger**

A thesis submitted to the University of Plymouth  
in partial fulfilment for the degree of

**DOCTOR OF PHILOSOPHY**

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## Author's Declaration

At no time during the registration for the degree of Doctor of Philosophy has the author been registered for any other University award without prior agreement of the Doctoral College Quality Sub-Committee.


Work submitted for this research degree at the University of Plymouth has not formed part of any other degree either at the University of Plymouth or at another establishment.

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## **Abstract**

# **An exploration of the significant issues at work for people with a diagnosed mental health issue, from the perspective of individuals and line managers**

Lindsay Louise Rose Badger

This thesis presents findings from an exploratory, in-depth qualitative research project that focused upon surfacing and exploring the significant issues at work for people with diagnosed mental health issues, from the perspective of individuals and line managers. There is growing awareness of the number of people in work with mental health issues; an estimated one in six workers (Elliott et al., 2008; McManus et al., 2016) and the organisational costs: an estimated £42 to £45 billion per year (Hampson & Jacob, 2020). The current research field of mental health issues at work focuses upon how work can shape individuals' mental health (Woods et al., 2019) and how work can be important for people to recover from mental health issues (e.g., Llena-Nozal et al., 2009), however, it is incomplete and lacks theoretical and conceptual underpinning (Elraz, 2017; Follmer & Jones, 2018). Little is known about the day-to-day experience of work for people with mental health issues and what shapes and influences that experience.

Drawing on semi structured, in-depth interviews with 20 individuals with diagnosed mental health issues and 20 managers, the lived experiences, significant issues and enabling features were explored. Reflexive thematic analysis drawing on the paradox theory with a tension lens resulted in several themes and tensions being identified which were grouped together in three clusters; individual, social/relational, and organisational which are interrelated. Individuals discussed their experience of stigma and discrimination, the importance of the manager and colleagues, and the impact of work design. The managers discussed a people management approach to their managing style, but this was impeded by organisational demands. The biomedical model also influenced the narratives,

The thesis contributes to theory by developing a substantive theory of key issues and enabling features for individuals with mental health issues at work and a detailed research agenda.

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# 1 Introduction

What is work like for people with mental health issues? What shapes their experiences? What enables them to stay at work? These are some of the questions that I was curious about after listening to the stories of individuals with mental health issues as part of my job of supporting people. Their stories were predominantly about negative experiences, how individuals try to survive at work and the challenges that they faced in doing so. My values are about fairness and people being all that they can be, hearing such fraught stories was therefore extremely concerning, so I wanted to find out what was happening to them at work, what was shaping their experiences and if there were any enabling factors that would help people be able to do more than just survive. This curiosity led me to read around the subject, see what other people were saying and what had been researched.

I found that a dominant narrative was the costs that mental health issues have to organisations. The costs can provide a rationale for researching mental health issues at work as can the fact that an estimated one in four people will experience a mental health issue of some kind each year (McManus *et al.*, 2016) with an estimated one in six workers having symptoms of mental health issues at any given (Lelliott *et al.*, 2008; McManus *et al.*, 2016). Mental health issues at work are a significant social and economic issue (Sainsbury Centre for Mental Health, 2007; Centre for Mental Health, 2009; OECD, 2012, 2015; Mental Health Foundation and Unum, 2016; Stevenson and Farmer, 2017; Goetzel *et al.*, 2018).

A recent report estimated that poor mental health and mental health issues amongst employees cost UK companies between £42 to £45 billion each year, consisting of £7 billion due to absence, £27-£29 billion because of presenteeism and approximately £9 billion due to labour turnover costs (Hampson and Jacob, 2020). Mental health issues are a leading cause

of working days lost, estimated at 72million days (Parsonage and Saini, 2017). An estimated 9.8% of all sickness absence in the U.K. can be attributed to mental health issues (ONS, 2022). Every year it costs workplaces an estimated £1,300 per employee, that is all employees, not just those that have diagnosed mental health issues (Parsonage and Saini, 2017; Stevenson and Farmer, 2017). Furthermore, 300,000 people with a long-term mental health issue lose their jobs every year, double the rate of those without a mental health issue (Stevenson and Farmer, 2017). Together, these numbers highlight the high economic costs. On the other hand, there are an estimated 1.5 million individuals with diagnosed mental health issues in work, even though it can be harder to find employment (Stevenson and Farmer, 2017). However, the literature on costs does not provide any insights into what is happening in the workplace for individuals with mental health issues and what shapes their experience, although it does provide an imperative for researching it.

Research that has looked at the topic of mental health issues at work from an individual's perspective has focused upon employment rates, which are very low (Smith and Twomey, 2002; Coutts, 2007; Perkins, Farmer and Litchfield, 2009; McCulloch and Goldie, 2010; Evans-Lacko, Henderson and Thornicroft, 2013; Steadman and Taskila, 2015; Bhugra, Ventriglio and Pathare, 2016; TUC, 2017), how to support people into work (Drake and Bond, 2008; Kinoshita *et al.*, 2013) how the harmful effects of workplaces impact on individuals' mental health and in supporting employees through it (Woods *et al.*, 2019) and paradoxically, how work can play a crucial role in recovery from mental health issues (Warr, 1990; Llana-Nozal, 2009; Leamy *et al.*, 2011; Doroud, Fossey and Fortune, 2015; Barnay, 2016; Nardodkar *et al.*, 2016). Another area of research from the individual's perspective is the high rates of stigma, discrimination and negative perceptions that individuals with mental health issues can face in all aspects of work including recruitment and disclosure (Krupa *et al.*, 2009;

Brohan and Thornicroft, 2010; Russinova *et al.*, 2011; Adams and Oldfield, 2012; Moll *et al.*, 2013; Chang, 2015; Lassman *et al.*, 2015; Mental Health Foundation and Unum, 2016; Elraz, 2017).

A further strand in the literature is the social benefits for organisations if they attend to the needs of their employees (Hennekam, Follmer and Beatty, 2021a). For example, when organisations create inclusive organisations that support individuals with mental health issues, they are likely to see improvements in their reputation, improved culture and increased loyalty from employees and customers (Peterson, Gordon and Neale, 2017).

Research has shown, however, that many organisations are not prepared to respond, support and manage employees with mental health issues (Shann, Martin and Chester, 2014; Norris-Green and Wheatley, 2022). The Chartered Institute of Personnel and Development (CIPD) Good Work Index 2022 found that only about a half of respondents reported that their organisation is supportive of people's mental health (Norris-Green and Wheatley, 2022).

Furthermore, research conducted by Mind found that only 58% of people who had experienced poor mental health whilst working felt confident that they would be supported if they disclosed their issues to their employer (Mind, 2022).

These areas of research, whilst interesting, do not answer my initial questions as they do not provide an insight into what work is like for people with mental health issues, what is shaping that experience or what enables people to be in work. What was clear though, was that managers play a key role in shaping people's experiences (Hauck and Chard, 2009; Peterson, Gordon and Neale, 2017; Thisted *et al.*, 2018). Other researchers argue that to advance the study of employees with mental health issues, more research from the employees' perspectives about their experiences is needed, especially given the complexity

related to managing a mental illness from day-to-day (Follmer and Jones, 2018; Woods *et al.*, 2019; Hennekam, Follmer and Beatty, 2021a).

Managers and those in positions to support individuals with mental health issues and make employment decisions appear to lack the knowledge needed to support individuals (Mizzoni and Kirsh, 2006; Hauck and Chard, 2009; Martin, Woods and Dawkins, 2015; Porter, Lexén and Bejerholm, 2019; Hennekam, Follmer and Beatty, 2021a). Research has found that managers feel poorly prepared when managing individuals with mental health issues (Martin, Woods and Dawkins, 2018), partly due to lack of training (Shankar *et al.*, 2014). Managers are central to the experience that people have at work, what is not known is how the lack of knowledge and training affects how they manage and thus the experience the individuals have of work. It is therefore important that if a full picture is to be gained, that the research hears not only the stories of individuals but also line managers.

Even though there is a wide body of literature looking at mental health issues at work, the research that has been conducted is fragmented, disjointed and with little theoretical underpinning (Elraz, 2017, Follmer and Jones, 2018). Much of this research draws on a quantitative methodological approach that focuses on prediction and costs (Follmer and Jones, 2018). Little is known about the experience of work for individuals with mental health issues, what shapes those experiences, what the key factors are and what influences managers in managing people with mental health issues. This is what my thesis aims to do. Recording the lived experiences of individuals and managers with mental health issues at work can be challenging though, as research has found that there can be pervasive silence in organisations about mental health issues (Moll *et al.*, 2013). Encouraging people to speak about their experiences is essential to this research, to record people's stories, to learn about



the individual's day-to-day experiences and what shapes them, but there is fear of speaking about mental health issues due to stigma and discrimination.

## **1.1 Exploratory research**

Exploratory research can be the preferred methodological approach to a social issue if it meets three conditions. According to Stebbins (2001) these are: when a group, process, activity, or situation has received little systematic empirical scrutiny, when the topic has been mainly examined using prediction and control rather than flexibility and open-mindedness, and when the research on the topic has grown to maturity. According to these conditions the topic of mental health issues at work meets the first two out of the three conditions suggested for exploratory research to be a methodological approach for this thesis. Exploratory research is valuable to gain insights about what is happening within a topic of interest (Saunders, Lewis and Thornhill, 2019). Saunders, Lewis and Thornhill, (2019) suggest that exploratory research is useful when seeking clarity in the understanding of a topic, problem, issue, or phenomena when the precise nature of it is unsure. This is precisely what this thesis is trying to do. According to Vogt (1999) social science exploration should be broad ranging, systematic, purposive, and undertaken to maximise the discovery of generalisations of description and understanding of social life. In other words, exploratory social science research tries to discover new ideas by systematically exploring social groups, processes, and activities (Stebbins, 2001). It is a type of inquiry that is at the early stages and is associated with discovery, creativity, and serendipity (Stebbins, 2001; Casula, Rangarajan and Shields, 2021). The researcher conducting the exploration also characterises the research and so exploration can have an open, flexible, pragmatic approach that is influenced by the investigator's interest (Stebbins, 2001; Casula, Rangarajan and Shields, 2021).

Exploratory research can generate initial insights into an issue and develop questions to be investigated further (Stebbins, 2001; Casula, Rangarajan and Shields, 2021). Insights are needed about the experiences of people with mental health issues and what are the key factors that influences that experience. This study is an exploratory study, it is therefore not possible to formulate specific research questions (Stebbins, 2001), but an overall aim and a set of objectives were created to help further define the scope of the thesis, focus data collection, direct the analysis and how the thesis is written (Bryman, 2012; Saunders, Lewis and Thornhill, 2019).

## **1.2 Research aim and objectives**

The aim of this study is to:

*surface and explore the significant issues at work for people with diagnosed mental health issues, from the perspective of individuals and line managers.*

This research aim draws attention to the exploratory nature of the research which aligns with an inductive and qualitative approach (Stebbins, 2001; Descombe, 2017). This will be discussed further in the methodology chapter, but this means that the research is not generalisable in the statistical, deductive idea of generalisability. However, this approach does provide rich knowledge by using small, purposive samples that can reveal the breadth and nature of the phenomena under study (Braun and Clarke, 2006, 2022; Smith, 2018).

Building on the aim, a set of objectives guide the thesis. The objectives are to:

- recognise the economic, legal, social, and medical context,
- record the lived experience of individuals and line managers,
- uncover the significant issues for individuals and line managers,
- explore enabling features for individuals and line managers,

- develop a research agenda for further research into significant issues at work for people with mental health issues.

Reviewing the economic, legal, social, and medical context of mental health issues at work has meant drawing on a wide range of literature from different disciplines including Human Resources, Psychiatry, Occupational Health, Nursing, Economics, Law, Public Health, Medicine, Psychology, Management, Employee Relations. Such breadth may be one reason why there is a lack of a coherent picture of mental health issues at work. The literature is disparate, from unconnected perspectives with little synergy between them, highly descriptive and lacks a strong theoretical base (Follmer and Jones, 2018). A range of literature written by practitioners also exists and is drawn upon as it provides real-life experiences or observations that can be helpful to practitioners. Examples of this include Chartered Institute of Personnel Development (CIPD) (2016) absence management report and the Centre for Mental Health (2007; 2010) reports on the cost of mental health issues for organisations. Academic literature is subject to a peer review process, whereas practitioner literature is not so both need to be drawn from in the literature review to provide a detailed, robust investigation.

The intention of the research is to record the lived experience and explore significant issues at work for people with mental health issues and so the methodology needs to allow for openness within the data generation process so that the exploration can happen. Using positivistic, deductive methodologies would not enable this exploration, whereas constructionistic, inductive methods can (Bryman and Bell, 2011; Bryman, 2012; Saunders, Lewis and Thornhill, 2019). Further discussion on the issues and debates of ontology, epistemology and chosen research methods can be found in the methodology.

The final objective considers the development of a research agenda for the field of mental health issues at work based upon the existing literature and the data generated in this research. A research agenda includes questions, issues or problems related to a topic and provides a framework of how to explore and answer those questions and provides a focus for further research (Ertmer and Glazewski, 2014). As this study is exploratory, predicting the research agenda is unwise, it should develop through data generation and analysis.

### **1.3 Covid**

The research collection for the thesis was primarily conducted before the pandemic, therefore the challenges and problems associated with Covid-19 are not considered. This PhD research is a snapshot in time (between April 2019 and June 2020) of individuals' experiences of work and managers' experiences managing employees with mental health issues. Covid-19 has been an unprecedented time in history, one that is unique in our lifetime (Venkatesh, 2020). The management of the pandemic led to changes in work, including unemployment, reduction in working hours and working from home (Diab-Bahman and Al-Enzi, 2020; Griffiths *et al.*, 2021). The pandemic has been linked to widespread job loss or job change (Diab-Bahman and Al-Enzi, 2020; Venkatesh, 2020; Griffiths *et al.*, 2021), and increased levels of anxiety, stress, and depression in the general population (Knolle, Ronan and Murray, 2021) suggesting that the experience of work may now be different. Further research is needed to explore the experience of work for individuals with mental health issues and managers experience of managing employees in the post-pandemic world of work.

### **1.4 Definitions and terminology of mental health issues**

Research has struggled to define mental health issues (Evans-Lacko, Henderson and Thornicroft, 2013; Evans-Lacko, *et al.*, 2013; Kalfa, Branicki and Brammer, 2021) but defining

what is meant by mental health issues is essential as there is no agreed language in this field (Beresford *et al.*, 2016). This may be due to the problem of mental health issues being ignored in research about work (Stevenson and Farmer, 2017).

There is a proliferation of terminology used in research including: mental illness, mental disorders, mental health problems, mental health disorders, mental health conditions, mental ill health, and mental health issues. Such variation in language can lead to confusion and lack of understanding as definitions are open to different interpretations and are often influenced by cultural values (Gabriel and Liimatainen, 2000; Rogers and Pilgrim, 2010). The choice of terminology is important as it suggests an allegiance to a particular model of mental health issues (Warner, 2009). For example, the use of the term mental illness implies a biomedical model approach as it denotes belief in the diagnosis and treatment through medical intervention. The term mental health problems can reinforce the false stereotype that individuals who have such conditions are always problematic in the workplace (Department for Work and Pensions and Department of Health, 2009). UK legislation uses the term mental disorder which refers to 'any disorder or disability of the mind' (Mental Health Act, 2007).

Much of the terminology used is based upon a biomedical model understanding of mental health issues. The biomedical/medical model of mental health issues posits that mental health issues are brain diseases and pharmacological treatment is needed to target presumed biological abnormalities (McCulloch, 2006; Deacon, 2013). There is widespread concern about the biomedical model and its associated terminology as it can be unhelpful to label mental health issues based on deficit and pathology as it can lead to stigma and discrimination (Beresford, Nettle and Perring, 2010; Beresford *et al.*, 2016). There is, however, little discussion on alternative terminology (Beresford, Nettle and Perring, 2010; Beresford *et al.*, 2016).

Another challenge in defining mental health issues is that these umbrella terms can reflect nearly 200 different types of mental health issues according to the commonly used Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013). The American Psychiatric Association uses the term mental illness which refers to a clinical disruption in an individual's cognitive abilities, emotional control, or behavioural patterns that indicates an impairment in the psychological, biological, or developmental mechanisms that govern mental functioning (American Psychiatric Association, 2013). Each disorder has a unique set of symptoms (American Psychiatric Association, 2013) and can range in severity and permanence. This can make recognising and managing mental health issues difficult as there is not one approach that can cover all symptoms and issues (Follmer and Jones, 2018).

In this thesis, the term "mental health issues" is utilised as a comprehensive term encompassing diagnosable problems that impact an individual's thoughts, emotions, and behaviours. This term is chosen to avoid a sole emphasis on illness, disorder, or problem and instead provides a broader framework that acknowledges the subjective, diverse, and ever-changing nature of mental health challenges (McCarron, 2013; OECD, 2015). By using mental health issues, an attempt has been made to move away from the biomedical model understanding and towards an understanding that is underpinned by the idea that mental health issues are subjective, varied, experienced within a social world, and can create challenges for people to interact with the social world. Mental health issues encompass the experience of individuals with diagnoses such as schizophrenia, bi-polar disorder, post-traumatic stress disorder (PTSD), obsessive compulsive disorder, depression, and anxiety, amongst others.

Only interviewing people with diagnosed mental health issues provides a boundary for what this thesis is researching. However, current approaches to diagnosis, based upon a

biomedical understanding, divides mental health issues into set criterion with defining features that suggests mental health issues are discrete, separate conditions like physical illnesses (Widiger and Samuel, 2005; Whooley, 2016). Viewing mental health issues as dimensional and dynamic may be a more accurate way to conceptualise people's experiences (Hankin *et al.*, 2005; Slade, 2007; Kendler, 2012).

Another boundary for this research is to differentiate between the focus on mental health issues and health and well-being. Health and well-being have been greatly studied in organisational literature with a focus on identifying specific individual and organisational factors that influence employees' health and well-being (Warr, 1990; Danna and Griffin, 1999; Diener, Oishi and Lucas, 2003; Bakker and Demerouti, 2007). There has been an assumption in much of the health and wellbeing literature that mental health is the absence of mental health issues, but they are not necessarily mutually exclusive (Follmer and Jones, 2018). Keyes (2005) proposed the dual continua model of mental health and mental health issues and argues that even though these constructs are related they are distinct constructs. An individual with diagnosed mental health issues can report high levels of mental health and well-being and some people have poor mental health without a diagnosis (Keyes, 2005; McCulloch, 2006; McCulloch and Goldie, 2010). This approach assumes that individuals with mental health issues can and will experience mental health and well-being unlike a single continuum approach which assumes that a diagnosis of mental health issues excludes individuals with mental health issues from experiencing well-being (Stewart-Brown *et al.*, 2015). Health and well-being is not the focus of this thesis.

Another element of terminology of mental health issues is when describing someone with mental health issues, which comes first, the person or the mental health diagnosis identity. There is a long-standing debate about person-first versus identity-first language in disability

studies (Best *et al.*, 2022). In the 1990s the development and use of person- first language was proposed due to the problem of using labels and the associated bias, devaluing and negative attitudes (Granello and Gibbs, 2016). Person-first language could be a way of separating an individual's identity from any diagnosis or disability (Granello and Gibbs, 2016). Due to these reasons, this thesis uses person-first language so individual with mental health issues is used throughout this thesis. This approach can be seen as a linguistic expression that reflects awareness, dignity, and positive attitudes about people with mental health issues (Jensen *et al.*, 2013). Having dignity in the linguistic expression is a reason why individual with mental health issues is not abbreviated in this thesis as I did not want to abbreviate people, their experiences, or their identities.

### **1.5 Theoretical lens -Paradox theory with a tension- based lens**

During the analysis of the interviews the paradox theory with a tension- based lens became a plausible guiding framework for the writing up of the analysis and discussions. This became apparent after reading Suter, Irvine and Howorth (2022) article on the experiences of managers responding to employees with mental health issues in small and micro businesses. Their use of the paradox meta theory and tension- based framework highlighted how the managers interviewed experienced tensions and how they resolved the conflict (Suter, Irvine and Howorth, 2022). My research aimed to surface and explore significant issues at work for people with diagnosed mental health issues, from the perspective of individuals and line managers and through this exploration paradoxical tensions and how individuals and managers resolved, or did not, became apparent.

Paradox theory is a meta-theory, that focuses on how organisations or individuals experience and cope with tensions arising from contradictory elements (Lewis, 2000; Smith and Lewis,



2011; Quinane, Bardoel and Pervan, 2021; Suter, Irvine and Howorth, 2022). Paradox refers to elements in organisations that are contradictory yet interrelated and exist simultaneously (Lewis, 2000; Smith and Lewis, 2011; Smith, 2014; Fairhurst *et al.*, 2016; Schad *et al.*, 2016; Quinane, Bardoel and Pervan, 2021; Suter, Irvine and Howorth, 2022). Paradox theory can aid researchers to recognise the complexity, diversity, and ambiguity of organisations (Lewis, 2000; Smith and Lewis, 2011). Organisational tensions can be defined as ‘...clash of ideas or principles or actions and the discomfort that may arise as a result’ of organisational conflict (Stohl and Cheney, 2001, pp. 353-54). These organisational conflicts and contradictions can be seen as inescapable and normal and, in some cases, could be embraced (Tracy, 2004). Tensions denote competing elements, such as contradictory demands, goals, interests, and perspectives (Miron-Spektor *et al.*, 2018). Tensions can fuel virtuous cycles that unleash creativity and enable resilience and long-term sustainability but can also cause vicious downward spirals that can threaten individuals' sense of certainty and order, and lead to defensive responses that paralyse action or foster intractable conflicts (Vince and Broussine, 1996; Miron-Spektor *et al.*, 2018).

Paradox theory and tension lens can develop insights into organisations and individuals' experiences of organisations by viewing organisations structures and how they shape organisational life and/or the social processes through which individuals make sense of their organisational life (Lewis, 2000; Smith and Lewis, 2011; Quinane, Bardoel and Pervan, 2021). The starting point, therefore, for a paradox theory tension-centred approach is that organisations are sites of tension and conflict of human activity where conflicting demands shape organisation decision making and the individual experience (Trethewey and Ashcraft, 2004; Quinane, Bardoel and Pervan, 2021). Tension-centred theory offers a framework for understanding and responding to conflicts that can otherwise render organisational policies,

processes, and initiatives ineffective (Bardoel, 2016) and can lead to opportunities of organisational change through constructing alternative perspectives and new concepts (Tracy and Trethewey, 2005). This maybe a reason why a range of topics have drawn upon the paradox theory with tension lens including innovation (Andriopoulos and Lewis, 2009), change (Seo and Creed, 2002) leadership (Smith and Tushman, 2005), work- life management (Bardoel, 2016) and more recently mental health issues at work (Quinane, Bardoel and Pervan, 2021; Suter, Irvine and Howorth, 2022).

Mental health issues at work and the managing of individuals involves tensions. For the individual with mental health issues, previous research suggests that there could be tensions about disclosing or remaining silent (Moll *et al.*, 2013), seeking help but fear of being discriminated against (Baldwin and Marcus, 2006; Chang, 2015; Mental Health Foundation and Unum, 2016; Mental Health Foundation, 2017). For managers the tensions may be through negotiating competing demands (Martin, Woods and Dawkins, 2015), balancing own health and pressure placed upon them (Martin, Woods and Dawkins, 2018; Ladegaard *et al.*, 2019), and managing competing interests and goals (Suter, Irvine and Howorth, 2022).

Tensions can manifest in a range of ways; stress, anxiety, discomfort, challenges in making decisions and responding to organisational situations (Putnam, Fairhurst and Banghart, 2016) which may provide insight into why managers are more likely to be diagnosed with a mental health issue than any other group of employees (Palmer, 2019).

Utilising paradox theory with a tension-based lens is limited in the field of mental health issues at work. The two papers are Quinane (2021) Suter, Irvine and Howorth (2022), both focusing on managers and leaders in organisations. Quinane (2021) identified tensions between privacy/ignorance and disclosure/safety/compassion, 'cannot help' versus 'can help', and individual responsibility versus social responsibility of how senior leaders understood their

role in managing employee mental health. Suter, Irvine and Howorth (2022) found three key tensions of how managers in small or micro business responded to employees with mental health issues: individual vs collective; confidence vs caution; informal vs formal. Both sets of research conducted in-depth, semi-structured interviews that explored managers and leader's experiences, responses to and insights of managing employees with mental health issues. Since this PhD study is exploratory, and the aforementioned papers were published subsequent to the interviews, the analysis of the interviews was carried out using a data-driven, inductive and reflexive thematic approach (Braun and Clarke, 2022). This analysis revealed tensions that emerged for both individuals experiencing mental health issues and managers.

Paradox theory with a tension centred lens can also provide insights into responses to tensions within organisations and how they are addressed (Poole and van de Ven, 1989; Lewis, 2000; Smith and Lewis, 2011). Responses can be proactive or defensive with defensive reactions treating competing tensions as an either- or choice rooted in individuals need for consistency, managing emotional anxiety and defensiveness leading to simplifying the paradox by negating one side of the tension (Smith and Lewis, 2011; Suter, Irvine and Howorth, 2022). According to Poole and van De Ven (1989) there are two approaches to the either-or response – selection or separation. Selection being when one side of the tension are favoured over the other (Poole and van de Ven, 1989; Putnam, Fairhurst and Banghart, 2016), whereas separation is when the sides of the tension are separated according to time, place, or specific issue (Poole and van de Ven, 1989; Seo and Creed, 2002; Bardoel, 2016). Defensive responses can result in anxiety (Lewis, 2000) and may only provide short-term results (Jarzabkowski, Lê and van de Ven, 2013).

In contrast, individuals with proactive responses may engage with tensions by constructively working through them by accepting a both-and response thus recognising how phenomena can be opposing at the same time (Smith and Lewis, 2011; Gaim and Wåhlin, 2016). Approaches to both-and responses can include adjusting strategies where individuals recognise that both elements of the tension are important and interdependent and so pursue accommodation of both (Jarzabkowski, Lê and van de Ven, 2013; Suter, Irvine and Howorth, 2022). Another approach is synthesis, where a new perspective is found that can eliminate the opposition between two elements leading to a novel solution (Poole and van de Ven, 1989; Bardoel, 2016; Schad *et al.*, 2016; Suter, Irvine and Howorth, 2022). Strategies of acceptance and resolution seek to engage tensions and thereby enable sustainability through learning and creativity, flexibility and resilience, and releasing human potential (Smith and Lewis, 2011). These strategies can also contribute to good mental health, performance (Gaim and Wåhlin, 2016), creativity and innovative development (Smith, 2014).

Paradox theory with a tension lens is useful to examine multifaceted and puzzling phenomena (Lewis, 2000) and, as will be discussed throughout this PhD, mental health issues at work is such an issue. Research has sought to provide a business case for organisations to look at mental health issues and the management of individuals and have documented the high costs to organisations and the economy but even though the topic area has occupied researchers within industrial psychology disciplines since the First World War (Rose, 1999), what happens in the workplace for people with mental health issues and their managers still remains under researched (Elraz, 2017; Follmer and Jones, 2018). Using paradox theory and a tension-centred approach through the analysis and discussion provides a theoretical framework for the exploratory research conducted in this research project.

There are challenges with paradox theory, though, which prevent a cohesive understanding of paradox and a unified community of paradox theorists and researchers (Smith and Lewis, 2011). There are debates about the conceptualisation of paradox which is evident in the variety of language that can be used to describe tensions i.e., dilemma and dichotomy and seen by researchers looking at tensions without the use of paradox (Smith and Lewis, 2011). The term paradox will be employed in this thesis to describe the interconnected and contradictory elements of mental health issues in the workplace, while tensions will refer to the aspects that hold significance for individuals and managers when they encounter challenging situations.

Further debates are centred on the ontological nature of paradoxes, are they inherent features of a system like an organisation or are they socially constructed in lived experiences (Clegg, Cunha and Cunha, 2002; Smith and Lewis, 2011). Smith and Lewis (2011) propose that tensions are both features of a system, latent tensions, and are experienced by social actors, salient tensions. Latent tensions become salient with environmental factors such as plurality, scarcity and change and through individual's social construction of tension (Fairhurst *et al.*, 2016; Miron-Spektor *et al.*, 2018). This is the paradox ontological position that this PhD takes.

## **1.6 A guide to the thesis**

In essence, the body of this thesis is divided into four main chapters which cover the literature review, methodology, analysis, and the conclusion. The content of each chapter is self-explanatory, but it needs highlighting that this is an exploratory PhD which does not just shape the data generated but also the development and process of the PhD. This has meant that the next chapter, the literature review, is a narrative review of papers published up until

the start of the data generation in 2019. A narrative review is less certain of the direction of the literature, what is important, what are the key papers and so tends to be less focused and more wide ranging in scope than a systematic review (Bryman, 2012). The narrative literature review covers a wide range of disparate research within the field of mental health issues at work and covers topics such as models of mental health issues, stigma and discrimination, legislation, workplace conditions, the concept of an ideal worker, managers' experience, reasonable adjustments, employment and recovery, and disclosure.

The methodology is the next chapter and sets out how the exploratory research is conducted. Whilst covering necessary discussions on the underlying assumptions of the research philosophy of the research, approaches, and design as well as sampling and data analysis, the methodology also includes a discussion about the position of the researcher. Recognising that qualitative research involves a relationship between the researcher and the study is essential. Researchers continually influence throughout the research process based on their values, beliefs, and previous experiences.

Following that is the analysis chapter which provides an exploration through the individuals and managers experiences and identifies a range of significant issues and enabling features for people with mental health issues at work. The analysis of the interviews draws on literature published since 2019. There has been an increase in academic publications on mental health issues at work since 2019 which has provided further information about the topic area and academic anchors for the analysis as seen in exploratory research.

The conclusion draws together the journey of the thesis and discusses contribution to theory with a substantive theory model that draws together interrelated ideas that can provide an explanation of the experience of work for individuals with mental health issues and key issues

and factors that shape their experience. In the conclusion is a detailed review of the quality of the thesis based upon Tracy's (2010) eight criteria for qualitative research. The final part of the conclusion is a detailed future research agenda based upon reflections during the journey of the PhD. The agenda provides a framework that demonstrates approaches further research in mental health issues at work can take.

## 2 Literature review

The purpose of this literature review is to gain an initial impression of the topic area of mental health issues at work rather than reviewing the literature to find out what the research project can add to the existing knowledge (Bryman, 2012). A narrative review is one that is less certain in the direction of the literature and so tends to be less focused and more wide ranging in scope than a systematic review (Bryman, 2012). A narrative review aligns with exploratory and qualitative research as it does not set out the main theoretical and conceptual underpinnings of the topic area before data generation (Bryman, 2012). Although mental health issues have occupied researchers within industrial psychology disciplines since the First World War (Rose, 1999), what happens in the workplace for people with mental health issues and their managers remains under researched (Elraz, 2017). From this narrative literature review key considerations from the individuals' perspective encompass factors such as appropriate accommodations, apprehension regarding societal judgment and bias, and the decision to disclose their mental health status in the workplace. In the case of managers, significant factors include their perceptions and attitudes towards mental health challenges, their intention to assist individuals while lacking sufficient knowledge or training, and their involvement in facilitating reasonable adjustments through negotiation. The topic area lacks theoretical and conceptual underpinnings (Elraz, 2017; Follmer and Jones, 2018) and so, it is unclear what the key topics of previous research need to be included- another reason for a wide-ranging narrative review.

The focus of this thesis is the exploration of mental health issues at work, looking at; the economic, legal, social, and medical context, the lived experience of individuals and line managers, the significant issues for individuals and line managers and enabling features for



individuals and line managers. An extensive literature search has been conducted to discern the literature base's contribution to understanding.

The literature review was conducted using the key words; mental health issues, mental disorders, mental ill health, mental illness, and psychiatric problems combined with words to capture the work context such as employee, organisation, workplace, worker, manager, managing and human resources (HR). A wide range of topics related to mental health issues at work were found which were based on an array of disciplinary approaches. No coherent picture emerged; it was full of disparate, unconnected perspectives with little synergy between them. The literature is highly descriptive and lacks a strong theoretical base. The search was subsequently refined based on focus and relevance to the aim and objectives of the thesis, it was also guided by two key papers- Follmer and Jones (2018) and Woods *et al.*, (2019). Both conducted a major systematic literature review of the research on mental health issues in the workplace and they had over twenty subheadings and commented that whilst there was a significant number of clusters of research, there was an insignificant amount of research in each cluster from which to draw conclusions and build theory. They drew attention to the lack of a theoretical base and its descriptive nature.

The search, also, revealed a paucity of research-based literature from workplace, organisation, and management perspectives. The research that there is, is narrowly based as the focus has been on types of occupation, workplace conditions and stigma and discrimination and mental health issues. This does not add up to a coherent picture which would enable understanding of the experience of work for people with mental health issues. Consequently, the search was extended to a wider range of disciplines including clinical psychology, psychiatry, and rehabilitation to ensure that all possible sources which might further understanding were examined.

To arrange the wide range of disparate literature of mental health issues at work the literature review has been organised into clusters. These clusters bring together the multitude of strands of literature and research from different academic disciplines that have approached the field in similar ways. The clusters start with the society cluster which discusses narratives surrounding mental health issues, underlying assumptions and models of mental health issues, sociocultural influences on mental health issues, the societal stigma and discrimination experienced by individuals and the legislation and case law that supports mental health issues at work. Following this is the organisational cluster. This highlights the potential costs to organisations and looks at workplace conditions that can impact mental health issues, occupations that have high rates of mental health issues, workplace policies, the underlying assumption of an 'ideal' worker and organisational stigma and discrimination that individuals with mental health issues may face. The manager cluster then looks at the research on managers' experiences and perceptions of managing individuals with mental health issues and negotiating reasonable adjustments. Finally, the individual cluster discusses unemployment and employment of individuals with mental health issues and the link with recovery. Also covered in the individual cluster are perceptions of productivity, experiences of negotiating reasonable adjustments, the stigma and discrimination individuals experience at work, and disclosing mental health issues at work.

## **2.1 Society cluster**

The models and narratives of mental health issues can disable or empower an individual experiencing mental health issues (Woods *et al.*, 2019) as they can form and articulate ideas of knowledge and power that can shape social reality (Alvesson and Karreman, 2000). They can shape perceptions, attitudes and how people with mental health issues are treated in society and workplaces (Woods *et al.*, 2019). They also provide the context within which the

individual's experience takes place. It could thus be assumed that they would shape and influence the experience by shaping and influencing attitudes to mental health issues by all concerned. This in turn is likely to shape behaviours and practice, not just of the individuals but also by organisations and everyone in them.

Even though these models and narratives can be important, most studies of mental health issues at work use a broad conceptualisation of mental health issues (Clair, Beatty and Maclean, 2005; Santuzzi and Waltz, 2016; Elraz, 2017; Follmer and Jones, 2018). To mitigate this in this thesis, the theoretical base of mental health issues is discussed including narratives of mental health issues, the biomedical model, social model, and recovery model. This cluster also discusses sociocultural factors influence on mental health issues, societal stigma, and discrimination of individuals with mental health issues and legislation that supports mental health issues at work.

### **2.1.1 Narratives of mental health issues**

Historical discourses around mental health issues are complex and diverse (Craig, 2014). Explanations of mental health issues and madness are ancient and ubiquitous, and many different assumptions have been made about their origins (Kendall, 1998; Milton, 2004; Glasby and Tew, 2015). At one time or another, mental health issues and madness have been attributed to; divine intervention, evil or bad spirits (Borch-Jacobsen, 2001; Milton, 2004; Lewis and Whitley, 2012; Robison *et al.*, 2012; Craig, 2014), fevers, unbridled passions, strong liquor, the influence of the moon and blows to the head (Kendall, 1998). People with mental health issues have been regarded with revulsion, pity, hilarity, reverence, indifference and often as dangerous and something to fear (Angermeyer and Matschinger, 2003; Milton, 2004; Corrigan, Kerr and Knudsen, 2005).

The rise of modernity and science helped frame the discourse of mental health issues as a sickness or a disease rather than being mad, wicked, or possessed (Kendall, 1998; Borch-Jacobsen, 2001; Lewis and Whitley, 2012). This led to a biomedical approach that frames mental health issues as being caused by biochemical processes, such as depression being caused by issues with serotonin and anxiety resulting from cortisol production (Porter, 2002; Bennett, 2011). A narrative that medical therapies and interventions are needed to alleviate the symptoms of mental health issues for individuals (Hyland, 2011) and the knowledge of these are in the hands of specialised doctors (Foucault, 1973; Porter, 2002) has become dominant. This, though, has led to the silence and de-privilege of the voices of individuals with mental health issues and prioritises the voices of medical and clinical experts (Szaz, 1977, 2011; Glass, 1989; Lakeman, 2010). This is a major criticism of the biomedical model (Crossley and Crossley, 2001; Ridgway, 2001; Crossley, 2006; Chang, 2015). The biomedical explanation of mental health issues has also led to biochemical forms of treatment, such as serotonin uptake inhibitors being used to treat depression, being the main course of treatment for people with mental health issues (Woods *et al.*, 2019).

Many models have emerged and evolved to try to explain mental health issues over the centuries and a significant number of these continue to be current and to affect policy and practice today (Colombo *et al.*, 2003). They attempt to explain the cause, treatments, and outcomes for people with mental health issues but no one model does fully explain or is entirely supported by the evidence base (Colombo *et al.*, 2003; McCulloch and Goldie, 2010; Rogers and Pilgrim, 2010). However, the models imply certain treatments and social responses and may determine how people respond to mental health issues (McCulloch and Goldie, 2010; Thornton and Lucas, 2011) in and outside of the workplace. Looking at these

models is, therefore, important to explore the context of mental health issues at work and what factors could be shaping individuals with mental health issues experience.

### **2.1.2 Biomedical/medical model**

The biomedical/medical model of mental health issues posits that mental health issues are brain diseases and pharmacological treatment is needed to target presumed biological abnormalities (McCulloch, 2006; Deacon, 2013). This model dominates psychiatry, health care settings, funding priorities, public education campaigns, the language used to describe mental health issues, pharmaceutical treatments, research (Rogers and Pilgrim, 2010; Deacon, 2013) and legislation (Beresford, Nettle and Perring, 2010). Consequently, it pervades policy and practice (Beresford, 2002; Beresford, Nettle and Perring, 2010; Beresford *et al.*, 2016). Due to the domination of the biomedical/medical model in other arenas, it can be assumed that it underpins workplace approaches and attitudes towards employees with mental health issues and how they are managed.

The biomedical model seeks to explain mental health issues by medicalising individuals experiencing them. It reduces psychological phenomena, such as thoughts and feelings, to a biological cause (Szaz, 1977, 2011; Pemberton and Wainwright, 2014). The thoughts and feelings of individuals with mental health issues can be seen as wrong and defective (Beresford, 2002) as they are different from what is perceived as normal (Malachowski, Boydell and Kirsh, 2018). This demonstrates that the biomedical model is based on the idea of deficit (Szaz, 1977; Beresford, 2002). It leaves no room within its framework for the social, psychological, and behavioural dimensions of the onset and course of mental health issues and it minimises the relevance of these contributions to mental health issues (Engel, 1977; France, Lysaker and Robinson, 2007; Deacon and Lickel, 2009; Deacon, 2013; Robles *et al.*, 2014; Timimi, 2014). This can lead to an individualistic, reductionist perspective which places

the responsibility on the individual and presents mental health issues as a condition or disorder that needs to be treated or cured (Deacon and Lickel, 2009; Szaz, 2011; Malachowski, Boydell and Kirsh, 2018) which is similar to the approach to physical illnesses (Read *et al.*, 2006). This model can divert attention from the ways in which the workplace and working conditions can cause mental health issues (as discussed in section 2.2.2) by attributing the problems to the individual and to their personal circumstances rather than work based systemic issues (Woods *et al.*, 2019) thereby aligning with a biomedical, individualised approach to mental health issues. For example, institutions can develop narratives that characterise coping with traumatising and dehumanising workplaces, such as policing and medicine sectors, as a normal part of the job and individuals who experience work-related mental health issues can be characterised as weak and not up to the job (Woods *et al.*, 2019). Another way organisations perpetuate an individualised approach to mental health issues is through workplace interventions such as resilience and mindfulness training as they focus on fixing the individual, rather than the workplace (Foster, 2018; Gilbert, Foukl and Bono, 2018).

Research suggests that the general population is increasingly adopting attitudes based upon the biomedical model for understanding mental health issues (Schomerus *et al.*, 2012). This may be due to people being more apt at relating mental health issues to a biological or chemical imbalance, and, therefore have greater biomedical understanding of mental health issues (Blumner and Marcus, 2009; Schomerus *et al.*, 2012; Pescosolido *et al.*, 2013). A systematic review of studies published about the attitudes and beliefs of the general population about mental health issues found that the public's literacy about mental disorders clearly has increased, suggesting that a biomedical model of mental health issues had grown in popularity (Schomerus *et al.*, 2012). At the same time, though, attitudes towards people

with mental health issues have not changed for the better and have even deteriorated. The notion that people with schizophrenia or depression are dangerous has not changed (Corrigan, Markowitz and Watson, 2004; Schomerus *et al.*, 2012; Evans-Lacko and Knapp, 2014; Corrigan and Matthews, 2015). Furthermore, social acceptance of people with mental health issues has not increased since 1990, instead, acceptance of persons with schizophrenia as a co-worker or neighbour has diminished and acceptance as a friend or in-law remained at low levels (Schomerus *et al.*, 2012). This suggests that even though there is a better biological understanding of mental health issues in the general population it has not translated into greater social acceptance of people with mental health issues (Schomerus *et al.*, 2012). Potential negative effects of taking a biomedical explanation of mental health issues may explain why there has been limited change in people's attitudes towards mental health issues as the approach enhances the idea of people with mental health issues being different from other people (Phelan, 2002). It reduces treatment options and increases peoples' worry of unexpected or dangerous behaviour by people with mental health issues (Phelan, 2002; Angermeyer and Matschinger, 2003; Read *et al.*, 2006; Bennett, Thirlaway and Murray, 2008; Schomerus *et al.*, 2012).

Despite the biomedical model being the dominant approach to mental health issues in the past few decades, outcomes and understanding have not improved, despite mental health issues becoming more chronic and severe. The number of individuals disabled by their symptoms has steadily risen (Deacon, 2013). This rise in chronicity and severity suggests that the biomedical model has been ineffectual (Deacon, 2013) as it has failed to achieve consistent prevention and treatment for people with mental health issues (Insel, 2010; Deacon, 2013). This may be due to the preoccupation in identifying a biological cause or

biomarker for mental health issues, however, none have been found (Deacon, 2013; Owen, 2014; Pemberton and Wainwright, 2014; Timimi, 2014).

Another difficulty with the biomedical model is that it is difficult to attain a clear picture of individual's experience of mental health issues (McCulloch, 2006; Rogers and Pilgrim, 2010). This may be due to the dominance historically of professional voices e.g., psychiatrists and G.Ps. Such monopolisation may, in part, be the reason for personal lived experiences of mental health issues being viewed as having little credibility and status (Crossley and Crossley, 2001; Crossley, 2006; Lakeman, 2010). On the same line questions of credibility are habitually levelled against people with mental health issues and their experiences, thoughts and views are often discounted and ignored (Crossley and Crossley, 2001; Ridgway, 2001; Lakeman, 2010; Chang, 2015). This can be seen in the reliance of diagnosis and evidence of the impact of mental health issues by a medical or clinical professional for the assessment for reasonable adjustments, thus, it is the professional who holds the power in such circumstances (Bell, 2015). In comparison, first person narratives can help move thinking beyond the deficit perspective of the medical model which for some is outdated (Ridgway, 2001). When narratives are recorded from individuals their stories though, are often filled with despair, denial, social withdrawal, darkness, being defined by their diagnosis, sense of alienation and oblivion (Ridgway, 2001).

Furthermore, the biomedical/medical model dominates how mental health issues are currently diagnosed by dividing mental health issues into types, based upon set criterion with their own defining features (Widiger and Samuel, 2005). This approach posits a categorical understanding of mental health issues as discrete, separate conditions like physical illnesses (Whooley, 2016) that are either present or absent (Wichers, 2014). Whereas it may be more accurate to conceptualise it as a dimensional, dynamic construct rather than as a discrete



diagnostic entity (Hankin *et al.*, 2005; Slade, 2007; Kendler, 2012) as mental health issues are complex and variable (Clark *et al.*, 2017). There is a growing body of work focusing on the small, everyday elements of life that may impact mental health issues and it has been found that this dynamic, micro-level perspective may explain how everyday situations interplay with mental states and behavioural responses which then impact mental health issues (Wichers, 2014). This body of research suggests that mental health issues are influenced by day-to-day experiences and so can be changeable and dynamic, making it difficult to state precisely what causes mental health issues (Wichers, 2014).

Diagnosis of a mental health issue can conjure up ideas of deficit, dysfunction, danger, and incompetence (Perkins and Rinaldi, 2002; Angermeyer and Matschinger, 2003; Corrigan, Kerr and Knudsen, 2005; Beresford, Nettle and Perring, 2010). Survey research in Germany by Angermeyer and Matschinger (2003) found positive correlations between the label of schizophrenia and the belief that the individual with the label is dangerous which, in turn, led to an increase of fear and a preference for social distance. This effect, though, was not seen when the label was major depression, suggesting that labelling has little effect on public attitudes towards people with depression (Angermeyer and Matschinger, 2003). This may be due to depression being more accepted by the public than schizophrenia (Angermeyer and Matschinger, 2003). The view that mental health issues are a negative phenomenon and are tragic for the individual and those around them is a pervasive perception in society (Chadwick, 1997) which, therefore, percolates into the workplace. These characteristics are incompatible with desirable employee attributes (Follmer and Jones, 2017).

There is widespread evidence that many people with mental health issues suffer disadvantage and discrimination in many aspects of their lives which can disempower and exclude them from society (Baldwin and Marcus, 2006, 2007; Thornicroft *et al.*, 2008; Brohan

and Thornicroft, 2010). This raises questions about the importance of diagnosis and whether the label of the diagnosis helps or hinders individuals. Some individuals though can find diagnosis empowering as they have a recognised illness, which can be used to gain access to possible resources (Yanos, Roe and Lysaker, 2010).

### **2.1.3 Social model**

The social model highlights social, rather than, or as well as, individual 'factors' to explain mental health issues (Beresford, 2002; Beresford, Nettle and Perring, 2010). Social models are concerned with the influence of life events, family dynamics, belief systems, thinking styles on mental health and how society reacts to individuals with mental health issues (McCulloch, 2006). It shifts the emphasis from individual diagnosis and notions of cure, care and treatment tied with the medical model and focuses upon challenging discrimination and trying to secure the human rights of people with mental health issues (Beresford, 2002; Beresford, Nettle and Perring, 2010), thereby aligning with the social model approach to disability (Mulvany, 2000; McCulloch, 2006). The social model approach has been primarily used in discussions of disability in general, with limited application to mental health issues (Oliver, 1990, 2013; Barton, 1993; Shakespeare and Watson, 1997; Mulvany, 2000). It draws a distinction between individual impairment and a disabling society, suggesting that an individual may experience or be seen to have an impairment, but disability is the negative social response to such perceived impairments (Beresford *et al.*, 2016). One of the key differences between the social and medical model is the involvement of individuals with mental health issues in research and the production of publications (Terzi, 2004; Tew *et al.*, 2006; Glasby and Tew, 2015). This, though, is limited within literature on mental health issues (Crossley and Crossley, 2001).

A dominant issue with the social model is the term impairment and what it means. Large scale research exploring the attitude of individuals with mental health issues towards the social model of disability found that the idea of impairment was problematic as many people do not see their mental health issues as a fixed or permanent state. Some people may feel or identify as disabled at some points in their lives, but this can change and fluctuate (Beresford *et al.*, 2016). However, the research found that there was a widespread view amongst individuals with mental health issues that social approaches are more helpful than medical model approaches to mental health issues (Beresford *et al.*, 2016).

A challenge to the social model is the importance of acknowledging differences between people, as the social model can group people together solely on their diagnosis and ignore differences that can exist due to issues such as class, gender, race and ethnicity, sexual orientation, and age (Lloyd, 1992; Barton, 1993). This could result in a tendency to see all distress as the same and reinforce the negative labelling of people with mental health issues and could further emphasise the unhelpful perception of individuals with mental health issues as a separate and permanent group (Beresford, Nettle and Perring, 2010)

Another challenge for the social model of mental health issues is that it still draws upon the same underlying assumption that the biomedical model does- the negative values of mental health issues (Beresford, 2002). Thus, dominant ideas and attitudes that individuals with mental health issues are different and dangerous, may continue (Beresford, 2002).

If organisations draw upon the social model of mental health issues, it could be assumed that they would look at ways to create enabling environments for people with mental health issues rather than focusing on changes to an individual's work environment through reasonable

adjustments. Thus, it suggests that organisational culture and the way in which people work are the focus.

#### **2.1.4 Recovery model**

There has been a growing focus in mental health support services on recovery (Tew *et al.*, 2012) with an emphasis on building a worthwhile life, even with symptoms of mental health issues (Roberts and Hollins, 2007; Warner, 2010). The recovery model aims to help people with mental health issues to look beyond mere survival and existence and encourages them to move forward and set new goals (Davidson, 2005; Ramon, Healy and Renouf, 2007; Bonney and Stickley, 2008). The model emphasises that, while people may not have full control over their symptoms, they can have control over their lives (Davidson, 2005; Ramon, Healy and Renouf, 2007; Bonney and Stickley, 2008). Recovery is not about focusing on problems but seeing beyond a person's mental health issues, and recognising and fostering their abilities, interests, and dreams (Jacob, 2015). These abilities, interests and dreams are personal and can include culture, spirituality, and sexuality, which the recovery model states need to be valued, understood, and given priority (Roberts and Hollins, 2007). This approach challenges the traditional biomedical assumption that mental health issues are chronic and debilitating (Clossey, Mehnert and Silva, 2011).

A challenge to the recovery model is the diverse meaning of recovery and the many facets to recovery (Thornton and Lucas, 2011) including finding and maintaining hope, positive identity, building a meaningful life, and taking responsibility and control (Shepherd, Boardman and Slade, 2008). The heterogeneity of mental health issues, though, makes it hard to know what determines individual recovery (Davidson *et al.*, 2006). This may be a reason why there is limited research on the recovery model (Markowitz, 2001; Noiseux *et al.*, 2009)

Taking a recovery model approach to mental health issues in the workplace may see the individual becoming the expert in their symptoms and what they need at work. Therefore, adjustments to work are based on their expertise rather than the medical professions' (Bell, 2015). A recovery model approach would also acknowledge that individuals are multi-faceted, that the management of mental health issues can also be multi-dimensional and so workplace responses and support to individuals needs to be varied and adaptable. If a recovery model underpinned assumptions at work, it could provide a starting point to enable individuals with mental health issues to have meaningful and constructive experiences at work.

### **2.1.5 Sociocultural factors/ cultural influence**

Research has shown that sociocultural factors can impact mental health issues (Evans-Lacko, Henderson, and Thornicroft, 2013; Evans-Lacko, *et al.*, 2013; Evans-Lacko and Knapp, 2014; OECD, 2015). For example, it was found that a cultural context which is more open and accepting of mental health issues is associated with higher rates of help-seeking, antidepressant use and empowerment (Evans-Lacko *et al.*, 2012; Lewer *et al.*, 2015).

Research by Evans-Lacko and Knapp (2014) suggests that structural and sociocultural factors such as a countries benefit systems and flexible working policies are important to workplace perceptions of mental health issues and employee outcomes, such as lower likelihood of taking time off work. However, managers support and help had the strongest association with employees disclosing depression and further associations were found with lower absenteeism and more presenteeism (Evans-Lacko and Knapp, 2014). Managers offers of support does appear to change between countries, with people living in Mexico most likely to report that their manager had offered to help with their depression (67 per cent) in contrast to Japan, where only 16 per cent of those questioned said their managers had offered proactive support (Evans-Lacko and Knapp, 2018). Whereas, in Great Britain the figure was

53 per cent (Evans-Lacko and Knapp, 2018). People living in South Korea (30 per cent) and China (27 per cent) were most likely to say their manager had avoided talking about their depression, whereas, Denmark had the most supportive managers with only two per cent of respondents saying that their manager had avoided the issue. In Great Britain, the figure was 3 per cent (Evans-Lacko and Knapp, 2018). Evans-Lacko and Knapp (2018) also found that employees with depression whose managers did not offer support took more days off work.

Research has found relatively high levels of concealment in countries such as Japan and China in comparison to Western countries (Yang and Kleinman, 2008; Ando, Yamaguchi and Thornicroft, 2013; Evans-Lacko and Knapp, 2014; Richards *et al.*, 2014). This may influence workplace culture in relation to openness and comfort in discussing and disclosing mental health issues (Evans-Lacko and Knapp, 2018). It was found to impact on the productivity of individuals with depression; research shows that where employers create a culture of avoidance of talking about depression, employees end up avoiding work and even when they return to work, they are not as productive as they could be (Evans-Lacko and Knapp, 2018).

### **2.1.6 Societal Views about individuals with mental health issues – stigma and discrimination**

Mental health issues remain one of the most highly stigmatised conditions in society (Mehta *et al.*, 2009; Follmer and Jones, 2017, 2018; Krupa, Sabetti and Lysaght, 2019). There are few people with mental health issues that have not experienced what Goffman refers to as situations where people are barred from full social acceptance (Goffman, 1963). Public stigma of mental health issues is prominent and has been observed and studied, as it represents the prejudice and discrimination directed to individuals by the larger population (Corrigan and Rao, 2012). An understanding of the stigma surrounding mental health issues is important as

stereotypes and stigma can directly affect how others treat people with mental health issues (Follmer and Jones, 2018).

As previously mentioned research has found that the public has many misconceptions about mental health issues (Hinshaw and Cicchetti, 2000; Perkins and Rinaldi, 2002; Angermeyer and Matschinger, 2003; Beresford, Nettle and Perring, 2010; Pryor, Reeder and Monroe, 2011). Perceptions that people with mental health issues are dangerous can promote societies discrimination by withholding opportunities or access to services for individuals (Pryor, Reeder and Monroe, 2011). Stereotypes of incompetence about mental health issues can lead to self-stigma where individuals internalise public perceptions and so withdraw from society (Corrigan and Rao, 2012). It can also lead to individuals with mental health issues choosing not to disclose to friends, family, and employers (Corrigan and Watson, 2002; Evans-Lacko *et al.*, 2012).

Survey research found that the public held negative stereotypes of mental health issues including the view that individuals are dangerous and unpredictable and are difficult to talk to (Crisp *et al.*, 2000). A follow up survey five years later, however, found that there were reductions in the percentage of stigmatising opinions (Crisp *et al.*, 2005). As commented before when looking at the biomedical model (section 1.1.2), a systematic review found that even though the publics' literacy about mental health issues has increased, attitudes towards individuals with mental health issues have not changed for the better and have even deteriorated for some types of diagnosed mental health issues such as schizophrenia (Schomerus *et al.*, 2012). This aligns with analysis within the UK that attitudes towards people with mental health issues had deteriorated between 1994 and 2003 (Mehta *et al.*, 2009).

Another perception of mental health issues is that although they are a serious psychological condition, it is often perceived as less legitimate than physical illness, disorders, or conditions, such as diabetes, by the general population (Adams and Oldfield, 2012; Follmer and Jones, 2018). This may, in part, be due to the lack of knowledge about the aetiology of mental health issues and the inability to detect via laboratory, scientific tests (Wakefield, 2007).

An understanding of the stigma surrounding mental illness is important because stereotypes, misattributions, and discrimination directly affect how others treat individuals with mental health issues and how they treat themselves (Corrigan, Kerr and Knudsen, 2005; Krupa, Sabetti and Lysaght, 2019). Stigmatising attitudes towards mental health issues can become detrimental and discriminatory when they are enacted by society, institutions, workplaces and individuals and can contribute to the exclusion of people with mental health issues (Krupa *et al.*, 2009; Hansson, Stjernswärd and Svensson, 2014; Malachowski, Boydell and Kirsh, 2018). Unemployment and income loss (Sharac *et al.*, 2010), low recruitment success when individuals disclose mental health issues (Krupa *et al.*, 2009), individuals not seeking care or delays in accessing care (Andrews, Henderson and Hall, 2001), limited social network and social support for individuals (Yanos, Rosenfield and Horwitz, 2001), impaired self-esteem (Ilic *et al.*, 2012), challenges in accessing financial resources (Sharac *et al.*, 2010), living in disadvantaged neighbourhoods (Byrne *et al.*, 2013) and accessing healthcare (Rüsch and Thornicroft, 2014) have all been associated with stigma and discrimination of mental health issues.

Negative attitudes or prejudice refer to negative thoughts and emotions, such as anxiety or disgust that a majority group holds against a minority group, such as people with mental health issues (Thornicroft, 2007). Stigma can be defined as a disposition to act in a discriminatory manner towards persons with an attribution that can be considered as



abnormal, flawed or deviant within society (Goffman, 1963), such as, mental health issues (Krupa *et al.*, 2009). Stigma can be described to be made up of four interrelated components: distinguishing and labelling differences, associating human difference with negative attributes, separating 'us' from 'them', status loss and discrimination (Link and Phelan, 2001).

Discrimination is the behavioural manifestation of stigma and prejudice (Nardodkar *et al.*, 2016) and so, legislation and policy measures aimed at reducing and eliminating discrimination hold a potentially empowering position for people with mental health issues (Bhugra, Ventriglio and Pathare, 2016; Nardodkar *et al.*, 2016). Legislation supporting people with mental health issues at work can be complex, but it does aim to reduce discrimination for people with disabilities, which can include mental health issues (Bell and Heitmueller, 2009; Lockwood, Henderson and Thornicroft, 2012; William, Pauksztat and Corby, 2019).

### **2.1.7 Legislative framework and its impact on the workplace for individuals with mental health issues**

Legislation can play an important role in shaping work for people with mental health issues as it provides the basis of employment rights for people with mental health issues and guides organisations on what their legal duties are (Foster, 2007). The UK legislation that supports mental health at work is the 2010 Equality Act that prohibits discrimination of disabled individuals in all areas of life including work (William, Pauksztat and Corby, 2019). This section covers the Equality Act, key findings from employment tribunals and reasonable adjustments.

Substantive protection from discrimination on grounds of disability in the workplace has existed since the Disability Discrimination Act 1995 and now stems primarily from the Equality Act 2010 (Lawson, 2011). On the surface the legislation provides far-reaching protection for people with disabilities including protection from direct and indirect discrimination,

discrimination arising from disability, victimisation and harassment (Lawson, 2011). The Act though, misses the opportunity for the definition of disability to be reformed. The current definition leaves many people with disabilities unprotected and leaves the definition entrenched within a welfarist and medical understanding of disability (Lawson, 2011; Kirton and Greene, 2016).

The Equality Act 2010 defines nine 'protected characteristics': age, disability, gender, race, religion and belief, pregnancy and maternity, marriage and civil partnership, sexual orientation, and gender reassignment (HM Government, 2010).

The Act defines a disability as

*'a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on your ability to do normal daily activities'* (Equality Act, 2010, section 6).

Substantial impairment refers to impairment which is more than minor or trivial and long term means more than 12 months (Cunningham and James, 1998; Gooding, 2000; Government, 2005; Government Equalities Office, 2010; HM Government, 2010, 2011; Lockwood, Henderson and Thornicroft, 2012). In this way equality legislation seeks to distinguish disability from conditions that have little effect or are short-term illnesses (Woodhams and Corby, 2007) and so gatekeeps who can be defined as disabled under legislation (Lawson, 2011). However, the definition in legislation can cover emotional, physical, sensory, and mental health issues and so is wider than previous definitions used in equality legislation (Woodhams and Corby, 2003). The one-size-fits-all approach taken by the Equality Act has been identified as problematic or even dangerous as it provides individualised protection rather than focusing on group-based disadvantages (O'Conneide, 2007; McColgan, 2009; Fredman, 2011; Vickers, 2011). This individualistic interpretation of disability also focuses

upon changing the individual not the barriers in society or specific contexts such as work (Foster, 2007; Foster and Scott, 2015) which may be due to the underlying assumptions of a medical model of disability used for the definition (Barnes and Mercer, 2005; Barnes, 2012). The focus of the definition on impairment anchors the definition in the medical model as disability is determined by the disabled person's impairments or health conditions rather than barriers in society (Woodhams and Corby, 2003, 2007; Barnes and Mercer, 2005; Fraser Butlin, 2011; Lawson, 2011; Barnes, 2012).

The definition has been proved to be challenging for people with disabilities to use as it is ambiguous and lacks clarity (Bell and Heitmueller, 2009; Lockwood, Henderson and Thornicroft, 2012). It is even more challenging for people with mental health issues. Evidence presented in 2016 to a House of Lords Select Committee enquiry into the impact of the Equality Act on disabled people suggested that those with mental health issues were less likely to be regarded as disabled and be able to access the Act's protections, including access to reasonable adjustments (House of Lords Select Committee on the Equality Act 2010, 2016). One challenge for individuals with mental health issues is that their conditions often fluctuate and can be episodic in nature and so can be challenging to prove the substantial and long-term negative effects named in the definition of disability (Bell and Heitmueller, 2009; Bell, 2015).

The challenge of applying the definition of disability to mental health issues can be seen in employment tribunals such as *Goodwin v Patent Office* (1998) which initially argued that the claimant's conditions had no substantial impact on their ability to carry out normal day-to-day activities. This was overturned though by the Employment Appeal Tribunal. They focused on the wording used and how the definition was intended to work. To discern whether a condition meets the criteria for disability under the Equality Act 2010, the questions that need to be

asked are: is there an impairment, is there an adverse effect, is it substantial and long term? According to the Employment Appeal Tribunal substantial was not intended as a high hurdle but rather as to whether the condition effects are more than trivial. Deciding if something has an adverse effect involves looking at what a person cannot do or can only do with difficulty.

The definition also reflects a medical model approach to disability (Lawson, 2011; Kirton and Greene, 2016), which has its issues when applied to mental health issues. One of the impacts of a medical model approach is the need for medical evidence to support individuals' claim that their mental health issues fall under the definition of disability. For example, *J v DLA Piper UK LLP* (2010) looked at the situation where a job offer had been withdrawn following disclosure of a history of depression. It demonstrated that an employee needs to show that their health condition counts as a disability before showing how the employer discriminated. G.P. evidence can be very useful for this purpose and from this case it was found that tribunals should give weight to evidence from a G.P. Furthermore, *Sadgehi v TJX UK* (2017) tribunal found that there is a need to have a proper medical opinion and evidence to confirm the condition and its impact. This tribunal though, argued that employers need to be aware of mitigating circumstances of medical conditions including mental health issues and the impact medication can have.

The Equality Act 2010 continues the provision that was set out in the Disability Discrimination Act 1995 which was different to other equality legislation as it allowed for different treatment of people with disabilities through the concept of reasonable adjustments (Hepple, 2010, 2011; Adams and Oldfield, 2012). Organisations are legally required to make reasonable adjustments that may include changes to the way things are done, changes to the environment and to the provision of auxiliary aids and services (Adams and Oldfield, 2012). This is to ensure that individuals with a protected characteristic, such as disability, have the

same access to everything as people without a disability, failure to do so constitutes discrimination (Bell and Heitmueller, 2009; Geo, 2010; Department of Health, 2011; Lawson, 2011; Bell, 2015; Department for Work and Pensions, 2017). The obligation to take reasonable steps to ensure individuals with disabilities do not face disadvantage only applies, though, where the employer knows, or has constructive knowledge, of the individual's disability (Lawson, 2011).

Case Law provides an opportunity to see the understanding of reasonable adjustments in practice and demonstrates that there are challenges to implementing reasonable adjustments for organisations. Bell (2015) provides an in-depth review of case law of reasonable adjustments and concludes that they can reconcile the individual's needs with the organisation's business requirements, but there are inconsistencies within case law which can make it difficult for organisations to know how to implement reasonable adjustments, including what is meant by reasonable (Harlan and Robert, 1998), what steps should an employer take to make reasonable adjustments, and it being unclear what organisations are obligated to do in each individual case (Bell, 2015).

### **2.1.8 Interpretation of the society cluster**

The societal cluster has provided an overview of some of the key underlying assumptions, narratives, and models of mental health issues. In doing so, this literature review has started to explore objective one of the thesis: to recognise the economic, legal, social, and medical contexts. It has highlighted that perceptions of mental health issues in this society can be negative and although alternative models such as the social model or the recovery model may provide insights into individuals' experiences, the biomedical model dominates

understanding of causes, treatments, and outcomes for individuals with mental health issues. This approach shapes legislation, the individualised response to reasonable adjustments, and the negative attitudes, stigma, and discrimination that individuals face in society. It can be assumed that the biomedical model also dominates the understanding of mental health issues in the workplace. Key issues for the workplace and individuals experience may include the individualised responses organisations have to mental health issues at work, especially seen in the negotiation of reasonable adjustments. Another issue may also be in the underlying assumptions that individuals with mental health issues are incompetent, dangerous, and unpredictable and if this attitude is held by organisations, managers, and individuals themselves, further information, though, is needed to explore the impact on the experience of work for individuals.

## **2.2 Organisation cluster**

The organisation cluster first considers the costs of mental health issues to workplaces, this provides a compelling business case for looking at and developing strategies to manage mental health issues. Types of occupations that can be associated with increase rates of mental health issues and then workplace conditions that can impact mental health are discussed. After that, workplace policies and whether organisations have them and if they are useful is looked at. Following on the concept of an 'ideal' worker is discussed as it may influence the stigma and discrimination individuals with mental health issues can face at work. These areas provide an overview of workplace factors that may influence individuals' experiences of work.

Mental health issues pose a serious challenge to organisations. Prior research shows that mental health issues costs to companies exceeds several billions of pounds a year through

increased absenteeism, presenteeism and staff turnover (Sainsbury Centre for Mental Health, 2007; Mental Health Foundation, 2016, 2017; Mental Health Foundation and Unum, 2016; Deloitte, 2017). The identification of the costs of mental health issues to organisations has been a dominant approach in research (Follmer and Jones, 2018; Woods *et al.*, 2019). Many of the studies used retrospective database analysis to identify the costs to organisations and together they highlight the substantial economic burden experienced by organisations due to costs associated with mental health issues (Follmer and Jones, 2018).

Sickness absence due to mental health issues costs organisations between an estimated £4.3 billion (Mental Health Foundation and Unum, 2016) and £7.9 billion a year (Deloitte, 2017). Mental health issues are one of the main reasons for sickness absence, for example NHS Digital (2017) research on GP's Fit to Work notes found that in 2016-17 31.3 % of all fit notes issued were for mental and behavioural disorders compared to 18.0 % for musculoskeletal connective tissue disorders or issues. Of this, 21.5 % of mental and behavioural episodes were for more than 12 weeks, compared to 2.8% for diseases of the respiratory system (NHS Digital, 2017). With these percentages it is understandable that mental health issues, including depression and anxiety, are often argued to be the leading, single, most important cause of workplace absenteeism in the UK (Almond and Healey, 2003; Davies, 2014). Department of Work and Pensions (2013) report that mental health issues have become the most specified reason for sickness absence. According to the OECD (2012) workers with a mental health issue are absent from work for health reasons more often than other workers (32 % versus 19 %), and when they are absent, they are away for longer (6 versus 4.8 days of absence).

Reduction in productivity and presenteeism by people with mental health issues also contributes to the high costs to organisations; an estimated £6.5 billion (Mental Health

Foundation and Unum, 2016) to £26.4 billion per annum (Deloitte, 2017). A survey for CIPD found that 95% of people reporting poor mental health stated that it affects their performance at work (CIPD, 2016). However, analysis of the British Workplace Employment Relations Survey (WERS) by Jones, Latreille and Sloane (2016) did not find a clear link between mental health issues and productivity. They found that the association between productivity and mental health issues was sensitive to sector, time period, measure of psychological health used and what aspect of performance was considered (Jones, Latreille and Sloane, 2016). Another factor that influences productivity seems to be the diagnosis, for example, a range of research has consistently shown associations between a diagnosis of bipolar disorder and reduced productivity at work (Dion *et al.*, 1988; Simon *et al.*, 2008; O'Donnell *et al.*, 2017). The costs to organisations provide an opportunity to make visible (Foley, Kidder and Powell, 2002; Hultin, 2003; Zanoni and Janssens, 2015) that there are challenges for people with mental health issues in work and the management of them from low employment rates (Perkins, Farmer and Litchfield, 2009) to high rates of sickness absence (Almond and Healey, 2003; Davies, 2014; CIPD, 2016; ONS, 2017) and possible low productivity (CIPD, 2016; Follmer and Jones, 2018). These high costs could be used as the basis to compel businesses to pay attention to mental health issues in the workplace. This approach though suggests that an organisation's focus is on increasing productivity and reducing costs, rather than supporting individuals at work for ethical or care rights reasons.

### **2.2.1 Types of occupation**

Several studies have examined the extent to which certain jobs are associated with mental health issues (Fan *et al.*, 2012; Follmer and Jones, 2018). For example, research using a representative sample of Washington state employees found that the prevalence of depression was 2 times more for individuals employed as machine operators, lorry drivers



and health care assistants than for the overall state population (Fan *et al.*, 2012). Similar findings looking at substance abuse by drawing on data from the U.S. National Institute of Mental Health's Epidemiological Catchment Program, report that labourers, transportation, production, and farming employees had a greater risk, over their lifetimes, of developing substance abuse disorders, whereas technicians and household services, professional, and sales employees were at a lower lifetime risk of substance abuse disorders (Roberts and Lee, 1993). People employed in executive, professional, administrative support, and household services jobs had a higher lifetime risk of developing major depression (Roberts and Lee, 1993). What is unclear, however, is the possible influence that mental health issues have on what job an individual may self-select (Follmer and Jones, 2018).

There also appears to be different suicide rates across occupational groups, for example, suicide appears to be more frequent for military personal (Mahon *et al.*, 2005). Analysis of the mortality data from death registrations in England and Wales, between 2001 and 2005, found that the highest suicide rates relative to other causes of death were in health professional and agricultural occupations as there could be a link between access and knowledge of methods of taking one's own life (Meltzer *et al.*, 2008). Roberts, Jaremin and Lloyd (2013), however, found that suicide rates for these professions have declined over time, whereas manual occupations such as coal miners, labourers, in building trades, plasterers, fork-lift drivers, and carpenters saw significant increases over time in suicide rates. These occupations have undergone major changes in socio-economic conditions over time and other factors such as re-employment prospects, the ability to adapt to change and to manage stress may all combine to affect suicide rates for the occupations (Roberts, Jaremin and Lloyd, 2013).

## 2.2.2 Workplace conditions that can impact mental health

There has been an increase in research looking at the relationship between work, workplaces and mental health which focuses on how workplaces impact mental health and how work and workplaces can enhance mental health (Llena-Nozal, 2009; LaMontagne *et al.*, 2014; Leka and Nicholson, 2019; Woods *et al.*, 2019). Seminal work such as Karasek (1979) demonstrates a clear link between psychosocial work factors and mental health. The demand-control model and the effort-reward model approach the association from different psychosocial factors, but both demonstrate the clear link between them and mental health (Llena-Nozal, 2009).

The demand–control model examines the potential harmful impact that job strain and perceived stressors have on mental health (Karasek, 1979; Karasek *et al.*, 1981; Stansfeld *et al.*, 1999). It argues that there are two dimensions that impact stress at work: job demand and perceived control of one’s own work (Karasek, 1979; Karasek *et al.*, 1981, 1988; Stansfeld *et al.*, 1999; Wood, 2008). Job demands can also include the challenge of conflicting demands. Perceived control includes decision authority and skill discretion (variety of work and opportunity for use of skills) (Karasek, 1979; Stansfeld *et al.*, 1999; Stansfeld and Candy, 2006). The model has been developed to include a third dimension- perceived social support at work. This was combined with the other two dimensions to create the demand-control-support model (Clumeck *et al.*, 2009). The model proposed that the worst influence on an individual’s health derives from a high demand, low control type of job (Karasek, 1979), research supports this premise (Johnson and Hall, 1988; Stansfeld and Candy, 2006; Clumeck *et al.*, 2009; Inoue *et al.*, 2010).

Research has found that a high-strain job with low social support can have the worst effects on health (Johnson and Hall, 1988). A meta-analysis of research into psychosocial work

stressors and common mental health issues (anxiety and depression) found that the low job control, high job strain (or psychological demands), and low social support, were associated with increased risk of common mental health issues (Stansfeld and Candy, 2006). Further research has found that low job control and high job strain are significantly associated with the development of depression (Clumeck *et al.*, 2009; Inoue *et al.*, 2010). Longitudinal research by Clumeck *et al.*, (2009) found that high strain jobs predicted sick leave because of depression for men and that job control predicted sickness absence due to depression for both men and women. This research, though, was unable to support the demand-control-support model as no association was found between social support and sickness absence due to depression. Inoue *et al.*, (2010) study looking at men in manufacturing factories in Japan found that high job control was associated with a lower risk of long-term sick leave due to depressive disorders providing robust evidence that workplace conditions such as job strain, job control and social support can impact and are a risk factor in mental health issues (Johnson and Hall, 1988; Stansfeld and Candy, 2006; Clumeck *et al.*, 2009).

The effort- reward imbalance (ERI) model argues work-related benefits depend upon a reciprocal relationship between effort and rewards at work (van Vegchel *et al.*, 2005) and predicts increases in the risk of stress-related illnesses due to an imbalance between high effort and low rewards (Siegrist, 1996). Efforts, according to this model, represent job demands and/or obligations that are imposed onto the employee (van Vegchel *et al.*, 2005). Rewards are distributed by the employer (and by society) and consist of money, esteem, job security and career opportunities (van Vegchel *et al.*, 2005). The ERI model claims that when work is characterised by both high effort and low rewards there is a reciprocity deficit between costs and gains and this imbalance can cause sustained stress reactions (Siegrist, 1996; van Vegchel *et al.*, 2005; Llana-Nozal, 2009).

A meta-review of studies looking at the ERI model found a range of empirical support that the combination of high efforts and low rewards increase the risk of poor health, including mental health (van Vegchel *et al.*, 2005). For example, emotional exhaustion and burnout were significantly prevalent among nurses who experienced ERI (Bakker *et al.*, 2000). Further research has found that effort-reward imbalances were associated with depressive disorders and mental health issues among men (Niedhammer *et al.*, 2006).

Many studies looking at these two theories, though, tend to rely on cross-sectional data or on specific industry samples from which it can be difficult to generalise to the wider population (Llena-Nozal, 2009). For instance, the 'Whitehall II' study researched British civil servants and found evidence that social support and control at work protect mental health, while high job demands and effort-reward imbalances are risk factors for future psychiatric disorder (Stansfeld *et al.*, 1999). Use of cross-sectional data from large data sets provides evidence that job demands and effort-reward imbalances are associated with mental health issues. There is, however, little qualitative research investigating individuals' experience of these.

There are several other psychosocial factors that have been associated with mental health, including psychosocial safety climate which has found that workplace safety-related policies, practices, and cultural norms can impact an individual's mental health by influencing job design (Dollard and Bakker, 2010). Workplace arrangements and conditions have also been examined as to how they influence mental health (Woods *et al.*, 2019). One example is precarious working.

Precarious work can be seen as employment that is uncertain, unpredictable, reduced social benefits and statutory regulations (Benach *et al.*, 2014) and therefore, risky from the point of view of the worker (Kalleberg, 2009). It is non-standard, part-time, or contingency work, and is

characterised by temporary nature, powerlessness, limited benefits, and low earnings (Benavides *et al.*, 2006). Precarious working has been found to be consistently associated with poor mental health and wellbeing and increased mental health issues (de Witte, 1999; Kalleberg, 2009; Moscone, Tosetti and Vittadini, 2016; Han *et al.*, 2017).

De Witte (1999) found the association between precarious work and psychological well-being is a robust one and that the association remains significant after controlling for occupational status, gender, age, and different job characteristics. Further research has found similar results with precarious workers having an increased vulnerability to psychological distress (Kachi, Otsuka and Kawada, 2014), depression (Quesnel-Vallée, Dehaney and Ciampi, 2010; Yoo *et al.*, 2016; Han *et al.*, 2017) and suicide (Kraut and Walld, 2003; Min *et al.*, 2015) when compared to non-precarious workers. Han *et al.*, (2017) examined data from the Fifth Korea National Health and Nutrition Examination Survey and found that precarious employment was significantly associated with reported experiences of depressive mood and with suicidal ideation for male employees and workers with low or middle low-income levels (Han *et al.*, 2017). Similarly, another study, using data from a nationally representative cohort in the United States, found that temporary work was associated with an increase in depression symptom severity (Quesnel-Vallée, Dehaney and Ciampi, 2010). Furthermore, analysis of the Korean Welfare Panel Study found that individuals in precarious work showed a significant increase in the odds of having depression (Yoo *et al.*, 2016). Employees with precarious work have also relatively higher rates of suicidal ideation (4.4% among non-precarious workers compared to 10.0% among precarious workers) and suicide attempts (0.2% among non-precarious workers versus. 0.7% among precarious workers) (Min *et al.*, 2015). In contrast there is some evidence that this link is not always the case, for example, research using survey data from Finland found that both men and women on fixed-term (insecure)

employment had better self-rated health compared to individuals on permanent contracts (Virtanen *et al.*, 2002). Similarly, research utilising the British Household Panel Survey data, between 1991–2000, found that atypical employment did not have long-lasting detrimental effects on mental health of workers (Bardasi and Francesconi, 2004). These pieces of research, though, used different definitions of insecure working than the previous literature, that may explain why differences were found.

Study of the relationship between precarious employment and the mental health of workers is bi-directional as there is a relationship between job instability and health (Moscone, Tosetti and Vittadini, 2016). Individuals with mental health issues are less likely to be in employment, have lower productivity levels, lower salaries, and more absenteeism than workers without mental health issues (OECD, 2012, 2014, 2015; Frijters, Johnston and Shields, 2014; Mental Health Foundation and Unum, 2016; Mental Health Foundation, 2017). Therefore, individuals with mental health issues may be less likely to be in stable, non-precarious work than others (Moscone, Tosetti and Vittadini, 2016). Research by Moscone, Tosetti and Vittadini (2016) attempted to research this bi-directional relationship and found that precarious employment is associated with the development of mental health issues that require medical treatment. Furthermore, more days of working under temporary contracts, as well as frequent changes in temporary contracts, significantly increase the probability of being depressed, especially for older workers (Moscone, Tosetti and Vittadini, 2016).

There is a clear picture of the association between job demands, work strain, effort-reward imbalance, and precarious working on employee's mental health. It suggests that reducing these workplace stressors can be beneficial to employees. Little is known, though, about people with mental health issues experience of work and what impact these factors may have on them. Qualitative research, therefore, could be crucial to record the insights from

individuals' experiences. Another organisational area that can help reduce job stressors and mental health issues could be workplace policies (Gabriel and Liimatainen, 2000).

### **2.2.3 Workplace policies**

Existing research suggests that even in high-income countries, effective workplace policies for prevention and support of mental health issues is often limited or even lacking. An OECD report stated that no country in their analysis, demonstrated an advanced strategy for helping employees with mental health issues at work, however a few individual companies were developing more rigorous approaches and policies to mental health issues (OECD, 2015).

Henderson *et al.*, (2013) found that between 2006 and 2010 there was significant increase in organisations reporting formal policies on stress and mental health and many managers and employees felt that the policies were well understood and effective in helping employees stay in work and helping improve mental health. A smaller proportion of those surveyed, though, stated that the primary design of the policy was to help their organisation avoid legal action (Henderson *et al.*, 2013). In contrast, research by Fairclough *et al.*, (2013) suggests that many organisations are not prepared to support and manage people with mental health issues, even though their policies, procedures and leadership may state they are. Fairclough *et al.*, (2013) research was conducted in America though, which may be why there is the difference with Henderson *et al.*, (2013). According to research conducted by CIPD (2016), it was discovered that fewer than 50% of survey participants believed their organisation effectively supports individuals facing mental health issues. Specifically, 46% of respondents felt their organisation provided either very or fairly good support, while 20% indicated that their organisation did not provide adequate support or did not support such employees at all. This may be due to the lack of training for line managers; only 10% of employees reported that their organisations offered and delivered training for line managers to manage and support

people with mental health issues (CIPD, 2016). Another factor may be lack of confidence as Shann, Martin and Chester (2014) found approximately 25% of organisational leaders report a lack of confidence in their ability to support employees effectively with depression and only 13% reported they were very confident in their abilities.

In-depth case study research of four organisations by Cunningham, James and Dibben (2004) found that there is a gap between policy and practice with each organisation having detailed policies and procedures to manage individuals with ill health and disability, but the extent of the support was dependent on the good will of managers and colleagues. This gap between policy and practice was largely due to lack of knowledge and skills that managers had (Cunningham, James and Dibben, 2004). The gap between the espoused and enacted policies and processes by managers, though, is not just seen in policies about ill health and disability but in other people management policies too (Purcell and Hutchinson, 2007). This gap is often explained by managers' lack of knowledge and training (Cunningham, James and Dibben, 2004) and limited training (CIPD, 2016) Other factors include lack of interest, work overload, conflicting priorities and self-serving behaviour (Grint, 1993; McGovern *et al.*, 1997; Fenton-O'Creevy, 2001; Harris, 2001; Whittaker and Marchington, 2003).

#### **2.2.4 'Ideal worker'**

An 'ideal worker' is an abstract representation of a worker who is a devoted employee, without outside responsibilities impinging their job, is always ready, willing and able to work, often male, able-bodied with a resilient body, who can conform to the demands of an employer (Acker, 1992; Foster and Wass, 2013; Jammaers, Zanoni and Hardonk, 2016; Randle and Hardy, 2016). The idea of a standard worker is at the core of explaining organisational behaviour (Rose, 1988; Foster and Wass, 2013; Jammaers, Zanoni and Hardonk, 2016). There is some debate about whether the notion of an 'ideal worker' applies



to the experience of work for disabled people (Acker, 1992) but organisational focus on productivity, efficiency and what behaviour makes an individual an 'ideal worker' can exclude people with impairments (Foster and Wass, 2013).

Foster and Wass (2013) analysis of Employment Appeal Tribunals brought under the Disability Discrimination Act 1995 highlights that modern jobs have a complex design based upon the assumptions of what constitutes an 'ideal worker', and these assumptions are deeply embedded in organisations' practices, policies, and culture. These assumptions include job complexity, multi-tasking, inter-changeability of roles, and team-based performance management and rewards. For an individual not to be able to perform in any one task, but still able to make a meaningful contribution, the results can be severe and even lead to dismissal (Foster and Wass, 2013).

The concept of an 'ideal worker' can provide an understanding of the stigma and discrimination by organisations that disabled individuals face (Foster and Wass, 2013; Vedeler, 2014). However, little research has looked at individuals with mental health issues and whether some of their experiences of stigma and discrimination could be due to the assumptions of an 'ideal worker'.

### **2.2.5 Stigma and discrimination**

The societal stigma and discrimination faced by individuals with mental health issues may be strong in employment (Baldwin and Marcus, 2006, 2007; Pescosolido *et al.*, 2010; Shaw Trust, 2010; Lockwood, Henderson and Thornicroft, 2014; Hanisch *et al.*, 2016; Hipes *et al.*, 2016; Follmer and Jones, 2018). It is difficult for people with mental health issues to gain employment (Konur, 2002; Bunbury, 2009; Lockwood, Henderson and Thornicroft, 2014). The estimated unemployment rate for people with serious mental illnesses ranges from 70 to 90%

(Marwaha and Johnson, 2004; Luciano and Meara, 2014). The employment rates are significantly lower for individuals with mental health issues than for those without (Baldwin and Marcus, 2007). The impact of being labelled with mental health issues can impact an individual's long-term employment, job prospects and career (Whitley and Henwood, 2014). Manning and White (1995) explored the attitudes of 200 personnel directors in public limited companies. They found that 50% of employers never/ occasionally employ someone who is currently suffering from mental health issues and 60% would never/ occasionally employ someone suffering from schizophrenia. Similarly, in a vignette-based study, personnel managers expressed reluctance to hire an individual who was labelled as depressed compared to a diabetic person, especially for high status jobs (Corrigan, Larson and Kuwabara, 2007). Furthermore, research by Biggs *et al.*, (2010) reported that whilst job coaches understood the benefits of work for individuals with mental illness and were comfortable putting such individuals forward for jobs, many managers had concerns about the ways in which a disorder would disrupt workers' productivity and so had reservations about hiring individuals with mental health issues.

Krupa *et al.*, (2009) proposed that stigma and discrimination towards individuals with mental health issues at work are due to assumptions that people with mental health issues lack both the task and social competence for work; are dangerous or unpredictable in workplaces; mental health issues is not a legitimate illness; working is not healthy for people with mental health issues; and providing employment is an act of charity. Corrigan, Larson and Kuwabara (2007) also found that individuals with mental health issues can induce feelings of fear in others, which predicted avoidance behaviours such as withholding help in obtaining or maintaining a job. Other negative assumptions include individuals with mental health issues, particularly those with depression or bipolar disorder being perceived as low in competence

and warmth, while employees with anxiety were perceived as low in competence (Follmer and Jones, 2017).

Research suggests that people at work can have an unfavourable attitude towards people with mental health issues (Nakayama and Amagasa, 2004) including, not being willing to work closely with someone with a diagnosis of depression and unwilling to socialise with them (Pescosolido *et al.*, 2010). Other research found that a third of the British population do not believe that people with mental health issues should have the same right to a job as anyone else (Fevre *et al.*, 2013).

These studies provide some of the assumptions and negative views held about mental health issues and why the general population, employees, and managers have concerns about the employability of individuals with mental illness (Dietrich, Mergl and Rummel-Kluge, 2014).

These negative perceptions may be due to a lack of knowledge of mental health issues in workplaces for example, research of Japanese employees revealed that participants lacked knowledge of depression and suicide, including behaviours and beliefs of individuals who are at risk for taking their own life (Nakayama and Amagasa, 2004).

### **2.2.6 Interpretation of the organisation cluster**

The organisation cluster adds to the exploration of objective one of the thesis which is to recognise the political, economic, legal, social, and medical context that the society cluster started by adding information on the high cost to organisations of mental health issues at work. The costs highlight that mental health issues at work maybe an important topic for businesses to manage.

The organisation cluster also starts to explore objective three, which is to uncover the significant issues for individuals and line managers as a range of factors that can impact on

an individual's experience of work has been discussed. These include types of occupation, as some are associated with higher risks of mental health issues and rates of suicide, psychosocial factors at work, such as job demand, perceived control, and reward and whether organisations have policies on mental health issues in place. Research has shown that even when workplaces have policies, how an individual is managed is down to the goodwill of their managers. Another factor maybe the concept of 'ideal' worker as it can shape what behaviours and levels of productivity are expected by organisations from employees. This concept can lead to stigma and discrimination and as discussed, there are negative attitudes towards employees with mental health issues.

### **2.3 Manager cluster**

Managers are likely to be the first point of contact for employees with mental health issues and may also receive the first request for accommodations (Haafkens *et al.*, 2011). Line managers are crucial in implementing organisational responses to employees with mental health issues, but their perspectives have been largely unrepresented in the literature (Martin, Woods and Dawkins, 2018). What literature there is looks at managers' perceptions of employees with mental health issues (Martin, 2010; Shankar *et al.*, 2014; Kirsh, Krupa and Luong, 2018; Porter, Lexén and Bejerholm, 2019), their experiences of managing individuals with mental health issues (Shankar *et al.*, 2014; Martin, Woods and Dawkins, 2015; Jansson and Gunnarsson, 2018) and reasonable adjustments (Cunningham, James and Dibben, 2004; Foster, 2007; Foster and Fosh, 2010).

### **2.3.1 Managers' experiences and perceptions of managing individuals with mental health issues**

Managers' perceptions of mental health issues and managing individuals are important as they can shape workers experience of work due to their involvement in workplace culture and communications, allocating and managing job duties, team development and ensuring that the organisation's production/ service goals are met (Kirsh, Krupa and Luong, 2018).

Perceptions can also influence how managers handle processes, especially negative attitudes and can create barriers for individuals seeking and accessing support (Martin, 2010).

Some managers think that mental health issues are difficult to understand and that they can negatively affect the workplace (Porter, Lexén and Bejerholm, 2019). The difficulty to understand maybe due to mental health issues being perceived as intangible and that individuals often do not explicitly pronounce them (Jansson and Gunnarsson, 2018). Another influence on perceptions of mental health issues may be a lack of managers' understanding and knowledge (Mizzoni and Kirsh, 2006; Hauck and Chard, 2009; Porter, Lexén and Bejerholm, 2019).

Managers consistently report that their perceptions of mental health issues are influenced by previous experiences of managing individuals (Shankar *et al.*, 2014; Lexén, Emmelin and Bejerholm, 2016; Porter, Lexén and Bejerholm, 2019). Also the personal experience of family and friends shapes managers perceptions (Lexén, Emmelin and Bejerholm, 2016; Porter, Lexén and Bejerholm, 2019). Even though managers have these experiences some find it difficult to employ people with mental health issues (Pettersen and Fugletveit, 2015). This may, in part be due to lack of resources such as HR, staff trained in mental health issues and time to dedicate to supporting individuals, especially for small and medium businesses (Shankar *et al.*, 2014). Another reason for the challenges to managing people with mental

health issues may be the competing roles that managers are required to perform (Khilji and Wang, 2006; Nehles *et al.*, 2006; Hutchinson and Purcell, 2010; Haafkens *et al.*, 2011).

Managers hold responsibility for managing operational demands such as operational costs, providing technical expertise, organising work allocation and rotas, monitoring work processes, checking quality, dealing with customers/clients, measuring operational performance (Cunningham and Hyman, 1999; Nehles *et al.*, 2006; Haafkens *et al.*, 2011). As well as people management responsibilities such as monitoring, reporting, and improving workplace performance (Hales, 2005), recruitment, selection and on the job training (Evans, 2015). The competing demands of operations and people may be one of the reasons for line managers reporting lack of time for people management (McGovern *et al.*, 1997; Renwick, 2003; Nehles *et al.*, 2006; Hutchinson and Purcell, 2010).

Qualitative research looking at managers' experiences of managing mental health issues found that managers become aware that there may be a mental health related problem when employees behavioural pattern changes, including being late, unfocussed, forgetful, changes in ability to do their job and difficulties in social relations such as quick to anger, irritability and withdrawal (Jansson and Gunnarsson, 2018; Kirsh, Krupa and Luong, 2018). Other interview research also found that managers became aware of employee's mental health issues through disclosure and by investigating problems associated with performance (Martin, Woods and Dawkins, 2015). Managers, though, feel poorly prepared when managing employees experiencing mental health issues (Martin, Woods and Dawkins, 2018), in part due to lack of training (Shankar *et al.*, 2014). Additionally, certain managers express the belief that they lack the expertise of mental health professionals, thus they do not consider it their responsibility to identify signs of mental health concerns.(Shankar *et al.*, 2014).

The managers interviewed by Kirsh, Krupa and Luong (2018), in contrast, felt that they were responsible for supporting the person experiencing possible mental health issues. According to Martin, Woods and Dawkins (2015) managers supporting individuals try to understand what the employee is going through and encourage them to seek help from a medical professional. Other managers, though, feel individuals should be responsible for seeking help (Hauck and Chard, 2009). Managers may also adjust an employee's duties or hours, seek additional support for the individual, and try to manage the relationships with other colleagues (Martin, Woods and Dawkins, 2015; Jansson and Gunnarsson, 2018). The managers interviewed by Peterson, Gordon and Neale (2017) said that the accommodations made for people with mental health issues were generally no greater than those for other employees.

Managers suggest that ways to manage the effects of mental health issues at work is to be responsive and communicate through open-minded dialogue but also state that managers need to be responsive and attentive to all employees (Jansson and Gunnarsson, 2018). Other managers report that there is a concern with overstepping the privacy of employees, this can hinder open communication (Thisted *et al.*, 2018).

Managers have also reported a challenge with providing the support to the individual and maintaining their own personal mental health and wellbeing (Kirsh, Krupa and Luong, 2018; Martin, Woods and Dawkins, 2018). Interview research found that even though managers had a genuine desire to support individuals it can come at an emotional price for managers (Kirsh, Krupa and Luong, 2018). The high levels of pressure felt by managers to balance the needs of the individual, other workgroup members and the demands of senior managers and organisational outcome (Martin, Woods and Dawkins, 2018) may be a factor. Considering that survey data has found that managers are more likely to have a diagnosed mental health issue than any other group of employees (Palmer, 2019), support is needed for managers to

balance the demands placed on them (Martin, Woods and Dawkins, 2018; Ladegaard *et al.*, 2019).

### **2.3.2 Reasonable adjustments**

Who is responsible for reasonable adjustments in the workplace seems to be a source of contention as HR professionals report that line managers and supervisors were the most likely to make the decisions about reasonable adjustments (Bruyère, Erickson and VanLooy, 2004). Cunningham, James and Dibben (2004) in-depth case studies of employees who successfully returned to work after long-term sickness absence, support this. They found that individuals were reliant on the goodwill of their colleagues and managers instead of the practices and policies produced by the organisation and HR. Foster (2007) found the same and concluded that what is a legal obligation has been turned in to a lottery based upon the goodwill of line managers and employers. Adherence to legislation being dependent on the goodwill of managers is concerning and indeed ironically, is indicative of the need for legislation.

This gap between HR policies and procedures and line manager's practice may be indicative of the devolution of employee welfare and management to line managers by HR (Gooderham *et al.*, 2015; Beeck, Wynen and Hondeghem, 2016; Intindola *et al.*, 2017).

The goodwill of line managers and colleagues may be dependent on their knowledge of mental health issues and Cunningham, James and Dibben (2004) argue that managers have a lack of knowledge and skills. This may be due to inadequate or lack of training. This view is supported by Foster and Fosh (2010) research which found the difficulties for individuals with disabilities to gain reasonable adjustments were due to the confusion of their managers.



### **2.3.3 Interpretation of the manager cluster**

The limited research suggests that some managers hold negative attitudes about individuals with mental health issues due to lack of knowledge, understanding and training. Some managers, though, want to support employees with mental health issues and draw on previous experience or their own personal experience to do so. The responsibility for implementing reasonable adjustments seems to rely on the goodwill of managers, which can be influenced by their attitudes and personal experiences. The managers cluster starts to explore objectives three and four of the thesis to uncover the significant issues for individuals and line managers and explore enabling features for individuals and line managers. Key issues appear to be lack of knowledge, understanding and training, and competing demands, whereas enabling features are suggested to be previous experience and personal experience of mental health issues.

## **2.4 Individual cluster**

There is some research that has attempted to portray the experience of mental health issues from the individual employee's perspective (Follmer and Jones, 2018), including the detrimental effect that unemployment has on mental health (Clark, Georgellis and Sanfey, 2001; Clark, 2003; Llana-Nozal, 2009), the potential positive impact of employment on recovery (Warr, 1987; Llana-Nozal, 2009; Leamy *et al.*, 2011; Doroud, Fossey and Fortune, 2015; Barnay, 2016; Nardodkar *et al.*, 2016), barriers to employment (Henry and Lucca, 2004; Erickson, Jaafari and Lysaker, 2011; Baker and Procter, 2014; Harris *et al.*, 2014), experience of negotiating for reasonable adjustments (Goldberg, Killeen and Day, 2005; Mak, Tsang and Cheung, 2006; Foster, 2007; Brenninkmeijer, Houtman and Blonk, 2008), the experience of stigma and discrimination (Krupa *et al.*, 2009; Russinova *et al.*, 2011; Adams and Oldfield, 2012; Martin, Woods and Dawkins, 2015) and the disclosure of mental health issues at work

(Brohan and Thornicroft, 2010; Irvine, 2011; Moll *et al.*, 2013; Lassman *et al.*, 2015; Mental Health Foundation and Unum, 2016).

Chang (2015) conducted several in-depth interviews with two individuals who were experiencing severe mental health issues while employed. The interviews revealed that the symptoms of their mental health issues disrupted their work performance, and they faced conflict between their job responsibilities and the need for medical support. The medication they were taking caused side effects that further impacted their performance. Additionally, they consistently encountered unfair treatment in the workplace, with employers and co-workers exhibiting different attitudes once they became aware of their mental health challenges. This led to rejection, being ignored, and even teasing, resulting in social isolation (Chang, 2015). Although these findings are significant there is limited research which has thoroughly examined the work experiences of individuals with mental health issues, aside from studies focusing on those in rehabilitation programs (Chang, 2015).

#### **2.4.1 Unemployment, employment, and recovery**

Llena-Nozal (2009) longitudinal analyses of four OECD countries indicates that for people of a working age, the worst labour market scenario for their mental health is to be inactive/unemployed and that improvements in an individual's mental health are seen when they enter employment. Furthermore, being employed (with appropriate working conditions) plays a role in protecting individuals from mental health issues (Barnay, 2016).

Employment rates for people with mental health issues are very low; unequal to the rates in the general population and other people with disabilities (Smith and Twomey, 2002; Coutts, 2007; Perkins, Farmer and Litchfield, 2009; McCulloch and Goldie, 2010; Evans-Lacko, Henderson, and Thornicroft, 2013; Steadman and Taskila, 2015; Bhugra, Ventriglio and

Pathare, 2016; TUC, 2017). Analysis of the Labour Force Survey found that only 1 in 4 (26.2%) people with a mental health issue lasting (or expected to last) more than a year were in work (TUC, 2017). It has also been found that prolonged unemployment increases the incidence of mental health issues (Paul and Moser, 2009).

Supporting people with mental health issues into work has been a focus in research, possibly due to the high costs of unemployment of people with mental health issues. Research such as Kinoshita *et al.*, (2013) and Drake and Bond (2008) argue that supported employment schemes are currently the best approach to supporting people with mental health issues into work. However, the success rates of people finding a job are low and the durability of the success is low.

Employment can play a crucial part in recovery from mental health issues (Warr, 1987; Llana-Nozal, 2009; Leamy *et al.*, 2011; Doroud, Fossey and Fortune, 2015; Barnay, 2016; Nardodkar *et al.*, 2016). A systematic literature review found that employment can support the recovery processes via connectedness, hope and optimism about the future, identity, meaning in life and empowerment (Leamy *et al.*, 2011). Additionally, Doroud, Fossey and Fortune (2015) found that engagement with employment can be an important part of recovery for people with severe and enduring mental health, as engaging in meaningful and valued work supported recovery through fostering connections with others, creating hope, identity, meaning and empowerment. Work can also offer opportunities for control, using skills, confidence building, security, interpersonal contact (Warr, 1987), integrating with society and increasing self-esteem (Perkins and Rinaldi, 2002; Hitch, Pepin and Stagnitti, 2013; Mental Health Foundation and Unum, 2016; Nardodkar *et al.*, 2016).

A survey conducted by The Mental Health Foundation and Unum (2016) reported that the majority of people with lived experience of mental health issues stated that their job, and being at work, were important to protecting and maintaining their mental health; 47% of respondents said that employment was very important for their mental health and a further 39% stated that it was fairly important. There are several barriers, though, that can affect individuals' ability to obtain work, including gaps in their previous employment history, displays of symptoms (e.g., poor concentration, organisation, and planning), low mood, low confidence, and poor communication skills stemming from mental health issues (Erickson, Jaafari and Lysaker, 2011; Harris *et al.*, 2014). Similarly, findings from focus group research found that the majority of individuals believed that their mental health issues had cost them previous job opportunities. This may in part be due to negative self-perceptions, their symptoms interfering with their work, and loss of their skills and abilities (Baker and Procter, 2014). Furthermore, Henry and Lucca (2004) found that social stigma was also a barrier to employment for individuals with mental health issues.

#### **2.4.2 Productivity**

A consistent narrative in the mental health issues at work field is that mental health issues impact productivity and performance (Chang, 2015; Follmer and Jones, 2018). For example, qualitative interviews with employees experiencing depression revealed regular discrepancies between desired performance and actual performance which resulted in presenteeism and absence from work if it was not resolved (Sallis and Birkin, 2014). Additionally, depression severity significantly predicted job performance, with individuals experiencing the most severe depressive symptomatology reporting the greatest impairments of performance (Asami, Goren and Okumura, 2015). Furthermore, research by Steadman and Taskila (2015) found a strong association between duration and types of symptoms of depression and employment

performance. Among the symptoms reported, cognitive dysfunction, insomnia, emotional distress, and fatigue were identified as having the most significant impact on performance. Similarly, qualitative focus groups research and longitudinal research found that cognitive dysfunction, such as impaired concentration, decision making and patience, were reported to be negatively impacted by participants with mental health issues (Haslam *et al.*, 2005; Adler, 2006). It has also been found that mental health issues are associated with an increase in conflict with colleagues (Haslam *et al.*, 2005; Adler, 2006).

Research suggests improvements with symptoms of mental health issues may not, in themselves, improve productivity and performance as other factors such as personality and work characteristics have been shown to be as influential, if not more so, than the symptoms of mental health issues (Lerner *et al.*, 2004; de Vries *et al.*, 2015).

### **2.4.3 Individuals' experience of negotiating for reasonable adjustment**

As discussed in section 2.1.6, reasonable adjustment can be a legal requirement for organisations to support individuals with mental health issues, however, the individuals' experience of negotiating for them demonstrates it can be challenging (Foster, 2007; Mcdowell and Fossey, 2015). They can be important though, for example, Brenninkmeijer, Houtman and Blonk (2008) longitudinal cohort study of employees with sickness absence due to mental health issues found that work modification/ reasonable adjustments led to a reduction in depression symptoms. Furthermore, approximately 20% of employees with severe mental illness believed that receiving accommodations could have prevented their job termination (Mak, Tsang and Cheung, 2006). Longitudinal research by Bolo *et al.*, (2013) found that employees who did receive accommodations had a lowered risk of mental illness, whereas those who did not receive accommodations but required them, were more likely to have a mood or anxiety disorder at the one year follow up.

Even though reasonable adjustments can be important, it seems that they are not often put in place. Research by Wang *et al.*, (2011) found that only approximately 30% of individuals interviewed received accommodations and those with symptoms lasting longer than twelve months were less likely to receive accommodations than others. There is also a difference in the types of adjustments that are approved and implemented. A systematic literature search by Mcdowell and Fossey (2015) found that the most reported work-related accommodations were flexible scheduling/reduced hours, modified training and supervision, and modified job duties/descriptions. The least common type of accommodation was physical modification to the workplace. There is also a need for individuals to be able to build up their hours of work and gradually increase their duties to develop confidence and stamina (Secker *et al.*, 2003). For people with mental health issues the adjustments that are needed are weekly meetings with supervisors, exchanging work tasks with others, quieter workplaces, a change in job and reduced work hours (Wang *et al.*, 2011).

Employees with mental health issues appear to have limited knowledge of reasonable adjustments and what they may be entitled to (Goldberg, Killeen and Day, 2005), and even when they do, the process of gaining reasonable adjustments can be highly stressful (Foster, 2007). Semi-structured interviews exploring individuals' experience of reasonable adjustments found that about half of the interviewees experienced stress and ill health because of poorly managed workplace reasonable adjustment processes and two thirds reported bullying from their line manager in this process (Foster, 2007). All the interviewees reported that the formal disability policy, processes, and practices were not influential in the successful negotiation of reasonable adjustments. Instead, it was the attitudes of line managers and department heads that were (Foster, 2007).

#### **2.4.4 Stigma and discrimination**

Stigma, negative stereotypes, and common myths can impair employees with mental health issues (Krupa *et al.*, 2009; Elraz, 2017). Adams and Oldfield (2012) qualitative research revealed that employees perceived organisations lacked awareness and understanding regarding mental health issues. This included organisations being less accepting and knowledgeable about mental health concerns and displaying more scepticism compared to physical health problems, and treating mental health as a taboo topic that hindered open discussion. Attitudinal barriers and social exclusion are often the hardest obstacles to overcome and usually are associated with individuals' feeling shame, fear, and rejection (Gabriel and Liimatainen, 2000). Furthermore, negative attitudes and prejudice towards mental health issues at work have been shown to contribute to limited disclosure (Martin, Woods and Dawkins, 2015).

Qualitative analysis of surveys by Russinova *et al.*, (2011) found that employees with serious mental health issues experienced a range of manifestations of stigma and discrimination from subtle to the more significant in two domains of work. The first domain relates to individuals' specific job duties, work performance and outcomes and the second domain incorporates a wide range of interactions with co-workers and supervisors (Russinova *et al.*, 2011).

Examples of the first domain include negative responses to reasonable adjustments, discrediting a person's professional competence, discrimination in hiring processes, an individual being denied advancement within their work, and even having employment terminated due to disclosure of mental health issues (Russinova *et al.*, 2011). Stigma and discrimination such as social exclusion in the workplace, the use of derogatory or disrespectful language directed at individuals with mental health issues, and the use of

insensitive language when talking about mental health issues or individuals with mental health issues in general, including jokes and ridicule, are all examples of the second domain.

#### **2.4.5 Disclosure**

To disclose, or not, for people with mental health issues is complex and often a difficult decision to make (Goldberg, Killeen and Day, 2005; Wheat *et al.*, 2010; Irvine, 2011; Moll *et al.*, 2013; Lassman *et al.*, 2015; Mental Health Foundation and Unum, 2016). Disclosure can be defined as the deliberate informing to someone in the workplace about one's issue. However, not all disclosures are deliberate (Ellison *et al.*, 2003). Legally, disclosure can enable people to request reasonable adjustments and make a claim if treated unfairly (Lassman *et al.*, 2015). Many people, however, do not disclose due to fear of, or prior experience of, stigma, discrimination, or harassment (Brohan *et al.*, 2012; Lassman *et al.*, 2015; Mental Health Foundation and Unum, 2016).

In the Attitudes to Mental Illness survey (2011), the proportion of people who felt comfortable discussing mental health with their employer was estimated at 43% (The Health and Social Care Information Centre, 2011). Furthermore, survey research conducted by CIPD (2016) found that of employees who described their mental health as poor, only 43% had disclosed their mental health issues to their employer or manager. However, they found that 44% of all employees would feel comfortable disclosing mental health issues to their current employer or manager (CIPD, 2016). Research by the Mental Health Foundation and Unum (2016) report higher rates: 58% of people who had been diagnosed with mental health issues disclosed to their employer.

There are many reasons why people do not disclose their mental health issues at work, including expectations and previous experience of stigma and discrimination (Wheat *et al.*,



2010; Brohan *et al.*, 2012; Lassman *et al.*, 2015; Mental Health Foundation and Unum, 2016). A systematic review of literature published between 1990 to 2010, found that people feared that they would not be hired if disclosed, experience unfair treatment in the workplace, would lose credibility in the eyes of others, be gossiped about, and be rejected for promotion (Brohan *et al.*, 2012). Other reasons for not disclosing included: feeling that mental health issues are private and are too intimate to share in the workplace (Brohan *et al.*, 2012; Mental Health Foundation and Unum, 2016) and did not want to be a burden to others (Brohan *et al.*, 2012).

Conversely, individuals report the reasons to disclose include: wanting to be role models, to gain reasonable adjustments, to be honest as there can be a fear that lack of honesty could lead to dismissal, to explain unusual behaviours and to obtain emotional support from those at work (Brohan *et al.*, 2012). Even when people choose to disclose, though, disclosure is often partial, with only a select group of people being informed and individuals' choosing how much information is shared (Irvine, 2011; Brohan *et al.*, 2012; Moll *et al.*, 2013). In an institutional ethnographic study by Moll *et al.*, (2013), employees with mental health issues often engaged in concealment practices by employing various strategies to manage information related to their past histories or ongoing struggles with mental health. These strategies included working harder to hide any difficulties and minimize the impact on their job performance, such as working on weekends or staying late to compensate for less productive days. Another approach identified was strategic disclosure, where individuals carefully chose what, when, and to whom they would disclose their mental health issues (Moll *et al.*, 2013). One method employed by individuals to determine the right time for disclosure was by making indirect references to personal experiences with mental health issues and observing how others responded (Moll *et al.*, 2013). Brohan *et al.*, (2012) also found that individuals

strategically timed their disclosure to wait until they felt secure in their position, or with their colleagues, to disclose. Another way that individuals with mental health issues strategically disclose is by choosing what information to share and often only sharing what is felt to be safer information e.g., choosing specific illnesses (Brohan *et al.*, 2012; Moll *et al.*, 2013).

#### **2.4.6 Interpretation of the individual cluster**

The individual cluster focuses on objective three, which seeks to uncover key concerns faced by individuals and line managers. The existing literature highlights several noteworthy issues for individuals with mental health issues. One key aspect is the role of employment in the recovery process, yet individuals often face low employment rates and encounter various forms of stigma and discrimination when they are employed. Additionally, individuals think that their mental health conditions have an impact on their perceived productivity. While reasonable adjustments can be crucial for supporting individuals, they are frequently not implemented effectively. Another significant concern identified in the literature is the fear of stigma, discrimination, and harassment if individuals disclose their mental health issues. However, some research suggests that there can also be positive outcomes associated with disclosure. These factors emerge as important considerations for individuals, although the existing literature focuses more on specific elements rather than providing a comprehensive understanding of their overall work experience.

### **2.5 Concluding remarks**

Four clusters of literature have been presented in this narrative literature review: societal, organisational, managerial, and individual. Within each cluster literature is drawn from a range of academic disciplines in an attempt to provide an overview of the important research within the mental health issues at work field. This, though, does not provide answers to the

objectives of the thesis. Provided, however, are some indications of what important issues and enabling features there may be for individuals and line managers. Important factors for individuals include reasonable adjustments, fear of stigma and discrimination and disclosing at work. For managers important factors that have been identified are perceptions and attitudes towards mental health issues, a desire to support individuals but not having the understanding or training to, and the role they play in the negotiation of reasonable adjustments. Even though there are these indications of the important issues and factors there is limited research from the perspectives of those experiencing work with mental health issues and managers managing people.

The next chapter will explore and discuss relevant methodological considerations needed to surface and explore what people with diagnosed mental health issues and line managers consider to be the significant issues for them at work. To do this research philosophy, approach, strategy, and design are considered to ensure that the research will align with exploratory research and fulfil the aim and objectives of the thesis.

### 3 Methodology

Generating and utilising a robust and reliable methodology will help enable this PhD research to comprehensively explore the significant issues at work for people with diagnosed mental health issues from the perspective of individuals and line managers and to understand more fully the lived experience of work for individuals and managers. In order to do this, it is vital to discuss ontological and epistemological issues as well as research design and techniques to ensure that the research will contribute to existing knowledge bases (Bryman and Bell, 2011; Bryman, 2012; Creswell, 2016). Further important issues to be discussed includes sampling, the role of the researcher and research ethics. The very nature of exploratory qualitative research requires a close relationship between researchers and the object of their study (Stebbins, 2001; Bryman, 2012) therefore it is vital to understand the axiological assumptions and the potential influences this may have on data gathering and analysis (Saunders, Lewis and Thornhill, 2019). For this thesis, research ethics is also a very important discussion as mental health issues are often seen as a taboo, sensitive topic within the workplace (Shaw Trust, 2010; BHSF Occupational Health, 2018), therefore ethical issues and researcher protection will be discussed (BHSF Occupational Health, 2018) with a view to maximising protection from harm for all participants.

There is a range of methodologies that can be drawn from for the research of this thesis. The constraints on what was chosen was based upon the best fit for the research aim and objectives. The exploratory nature of the thesis also guided the methodology choices. As the literature review shows, there is a need to develop the knowledge of individuals' experiences of work (Follmer and Jones, 2018; Woods *et al.*, 2019). Little is currently known about the lived experience of work for individuals with mental health issues, the significant issues and enabling features and the influence of the manager and so exploratory research is needed.

Exploratory research shapes all aspects of the methodologies of this thesis. A visual representation can be seen in figure one.

There are several frameworks that embody the role of ontology and epistemology in research and provide a structure for researchers to work through. For example, Easterby-Smith, Thorpe and Jackson (2013) used the notion of a tree trunk with ontology and epistemology as the core, whereas Saunders, Lewis and Thornhill (2019) developed the research onion which highlights the wrap around nature of ontology and epistemology to research methodologies and methods. The research onion is a framework showing the different elements of research methodologies, it shows how they are connected, and it provides a clear, simple, but concise pictorial way of navigating research philosophy, methodologies, and methods as shown in figure one. Exploratory research forms the outer layer, it is not ontology or epistemology but, in this research, exploratory research is a meta-theory that influenced all aspects of the methodology. Each layer will be discussed in turn, with links made to the research aim and objectives and the literature reviewed in the previous chapter. Exploratory research is discussed, then the ontological position of constructionism, followed by an examination of the epistemological position of social constructionism. Next, an inductive approach to research is reviewed and then qualitative research is analysed. Following this is a discussion on sampling and access considerations. Interviewing and thematic analysis are then discussed. What is not in the research onion is axiology and quality criteria of qualitative research, but they are important to this research therefore they are discussed in this methodology chapter. Due to the exploratory, constructivist, inductive approaches to this research the first person 'I' will be used.

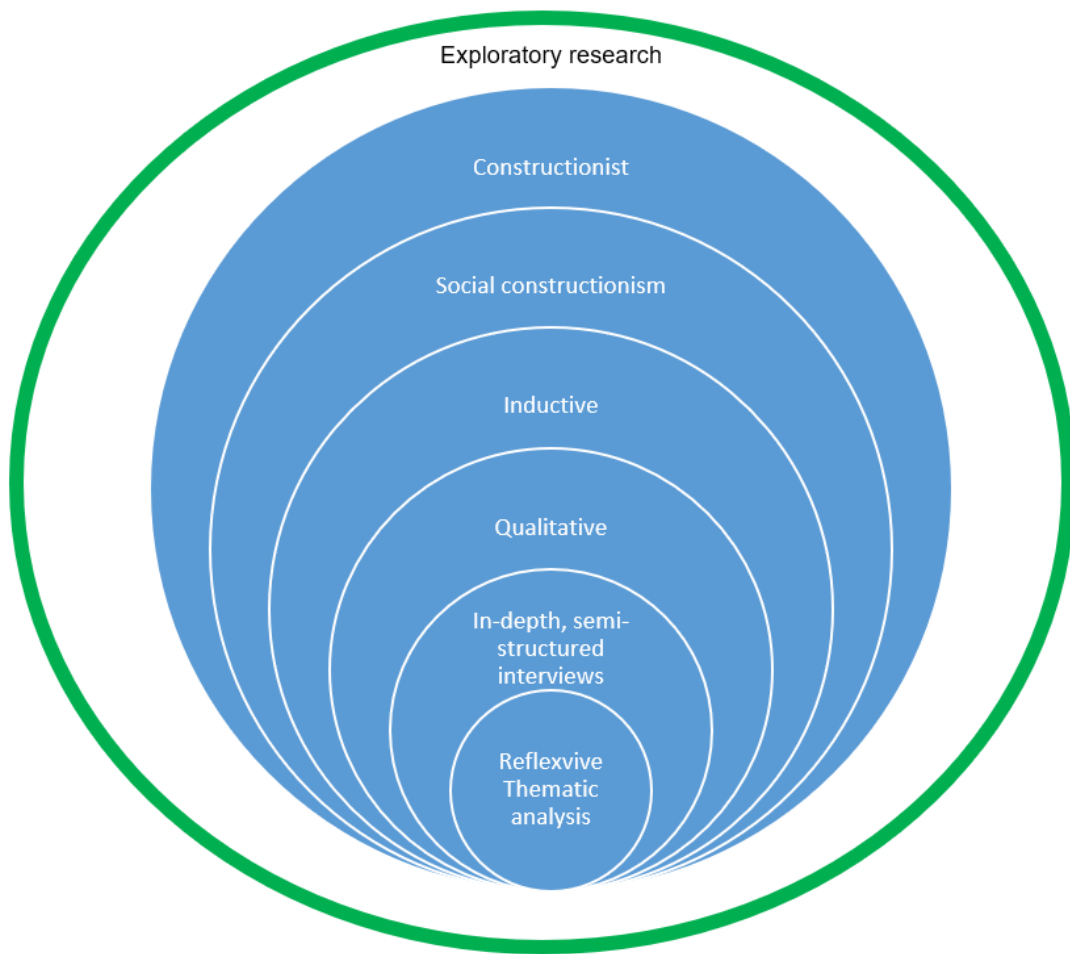


Figure 1: The layers of the research onion for this thesis. Source: Authors own

### 3.1 Exploratory research

There is a wide range of research within mental health issues at work: how workplace conditions impact mental health issues (Llena-Nozal, 2009; LaMontagne *et al.*, 2014; Steadman and Taskila, 2015; Barnay, 2016; Leka and Nicholson, 2019; Woods *et al.*, 2019), issues of stigma and discrimination (Thornicroft *et al.*, 2008; Krupa *et al.*, 2009; Elraz, 2017), and how work can be important for individuals recovery from mental health issues (Warr, 1987; Llena-Nozal, 2009; Leamy *et al.*, 2011; Doroud, Fossey and Fortune, 2015; Barnay, 2016; Nardodkar *et al.*, 2016). The general experience of work for people with mental health

issues, however, is an under researched area. What is not known is the day-to-day experience of work; the positives as well as the negative aspects of work and enabling and disabling factors for individuals with mental health issues. Even Chang's (2015) case study research, as discussed in section 2.4, has focused on negative factors, not enabling ones.

Research suggests that line managers play a key role in the experience of the workplace for individuals with mental health issues (Foster, 2007; Haafkens *et al.*, 2011; Martin, Woods and Dawkins, 2018) but very little research has been conducted to look at this. It also suggests that dealing with employee's mental health issues may be common for managers but that it is a complex and demanding part of their job that requires specialist knowledge, skills, and support (Hauck and Chard, 2009; Shankar *et al.*, 2014; Martin, Woods and Dawkins, 2015; Pettersen and Fugletveit, 2015; Porter, Lexén and Bejerholm, 2019).

Exploratory research can be the preferred methodological approach to a social issue if it meets three conditions, according to Stebbins (2001). These are; when a group, process, activity, or situation has received little to no systematic empirical scrutiny; that it has mainly been examined using prediction and control rather than flexibility and open-mindedness; and/or has grown to maturity (Stebbins, 2001). Even though there is a wide body of literature looking at mental health issues at work, what research has been conducted is fragmented, disjointed, with little theoretical underpinning (Elraz, 2017; Follmer & Jones, 2018). Much of the research draws on a quantitative methodological approach that focuses on prediction (Follmer and Jones, 2018). There is also little research that has looked at the lived experience of individuals with mental health issues, the day-to-day experience of work, the significant issues and enabling features. According to Stebbins (2001) criteria, the topic of significant issues at work for people with diagnosed mental health issues, from the perspective of individuals and line managers, meets the first two criteria of exploratory research. There is

little research on it and what has been done has used quantitative, predictive methods.

Exploratory research provides an opportunity to look at individuals' experience of work and the line managers' influence. This may elicit new ideas, new areas to research and be directed by people's stories and their narratives, rather than blindly testing previously generated hypotheses which may have been done if confirmatory research was conducted. Confirmatory research is the preferred approach for social scientists with most researchers using quantitative or qualitative methods to prove, or corroborate developed hypotheses (Reiter, 2013, 2017). Confirmatory research allows for the clear formulation of a theory that can be tested through the development of hypotheses. It can bring order to the research process by operationalising terms, formulating theories and hypotheses that then direct the development of the research design and methodology which are best suited to address the research questions and hypotheses (Reiter, 2013, 2017). This approach provides standardised procedures based upon deductively testing hypotheses (Hempel, 1966; Popper, 2002; Reiter, 2013).

A confirmatory approach neglects to scrutinise where theories and hypotheses come from and so neglects the biases that can go into theory and hypothesis formulation (Reiter, 2013, 2017). Research, however, is influenced by multiple factors including: who we are as researchers, our interests, backgrounds, training, and culture. They all influence the questions that are asked, how they are asked and what is accepted as evidence (Haraway, 1988; Bryman, 2012; Reiter, 2017; Braun and Clarke, 2022). Confirmatory research often fails to appreciate potential biases, limitations, and views and so mitigation or control of these biases cannot happen (Reiter, 2017).

Confirmatory research would be difficult to conduct in this thesis as there is limited research into the significant issues at work for people with diagnosed mental health issues, from the



perspective of individuals and line managers and into the criticisms of the general topic area discussed in the literature review. Exploratory research, therefore, provides an opportunity to look at individuals' experience of work with curiosity. Its value lies in gaining insights about what is happening within a topic of interest when the precise nature of the phenomena is unsure (Strydom, 2013; Rahi, 2017; Saunders, Lewis and Thornhill, 2019). In other words, exploratory social science research tries to discover new ideas by exploring social groups, processes, and activities (Stebbins, 2001). Exploration aims to generate new ideas and weave them together to form a theory that emerges directly from the data (Stebbins, 2001; Glaser and Strauss, 2012) rather than testing an already developed theory, as in confirmatory research (Reiter, 2013, 2017).

The purpose of exploratory research is to seek new insights and find out what is happening. It attempts to ask questions and assess phenomena in a new light and so lends to qualitative data generation methods (Stebbins, 2001; Strydom, 2013; Denscombe, 2017; Rahi, 2017). The approach to exploratory research is often inductive (Stebbins, 2001; Casula, Rangarajan and Shields, 2021) and so recognises that reality is partially socially constructed (Reiter, 2017). This means that exploratory research needs to consider the positionality of the researcher as they ask the questions, collect the data, and analyse it and is thus the one who constructs knowledge (Bryman, 2012; Easterby-Smith, Thorpe and Jackson, 2013; Gray, 2014; Reiter, 2017). To conduct robust exploratory research (Reiter, 2017) this thesis followed a constructionist ontology, social constructionism epistemology and an inductive approach and aimed for self-reflexivity to be at the core of the research.

Exploratory research is often criticised for lack of methodological rigor and only being tentative in results (Thomas and Magilvy, 2011; Casula, Rangarajan and Shields, 2021). To help this research have methodological rigor quality criterion for qualitative research was

applied (Tracy, 2010) . The criteria was used in the conclusion chapter to provide a framework for reflection and critique of the research conducted in order to determine its success in exploring the stories of what work is like for people with mental health issues and in uncovering the key features so that understanding can be developed.

An alternative approach to exploratory research that could have been used in this thesis was grounded theory as it argues that when there is a systematic approach to qualitative data collection and analysis then the research is capable of developing theory (Gray, 2014). Like exploratory research, grounded theory suggests that theories are not applied to the data but emerge from the data (Gray, 2014). However, this is where the two approaches differ, with grounded theory not only discovering and developing theory but also in verifying theory through systematic data collection (Strauss and Corbin, 1998). Another difference is that it is recommended that researchers taking a grounded theory approach should not be steeped in the literature as it can impede creative efforts (Strauss and Corbin, 1998). This has not been done in this thesis as the starting point of the research was to explore the existing literature base to see if it answered the questions I had, as discussed in section 1. Hence, a grounded theory approach was not taken.

### **3.2 Nature of reality and existence – ontology of constructionism and epistemology of social constructionism**

Ontology is the study of the nature of reality and existence -what is truth and reality, whereas epistemology is the study of the nature of knowledge- the how we know what we know (Williams and May 1996; Bryman and Bell, 2011; Bryman, 2012; Creswell, 2016; Saunders, Lewis and Thornhill, 2019). Ontology and epistemology form part of the philosophical view of the world which helps determine the approach taken to research and what knowledge is

therefore produced and created (Johnston, 2014). Discussion of the ontological and epistemological position of the research allows for the underlying assumptions of research, reality, data, and knowledge to be examined and explained (Bryman, 2012; Easterby-Smith, Thorpe and Jackson, 2013; Gray, 2014).

There are two dominant approaches to ontology: objectivism and constructionism (Bryman, 2012). These have different assumptions of what truth and reality is (Williams and May, 1996; Bryman and Bell, 2011; Bryman, 2012; Creswell, 2016; Saunders, Lewis and Thornhill, 2019). More specifically, they diverge on whether social phenomena can and should be considered objective entities that have a reality external to social actors, or whether they can and should be considered social constructions built by the perceptions and actions of social actors (Bryman, 2012). When considering mental health issues from these two perspectives, similarities can be drawn with the different models of mental health issues, see section 2.1 for more information. The biomedical model argues that there are biological and chemical bases for mental health issues (Klerman, 1977; Laurance, 2003; Rogers and Pilgrim, 2010; Royal College of Psychiatrists, 2010; Deacon, 2013), suggesting that they are factors that influence people's lives which are external to social actors' interaction with the world (Bryman, 2012). This aligns with an objectivist approach to ontology as objectivism argues that social phenomena are independent and external to social actors (Bryman, 2012). In comparison, social and recovery models assume that external social factors contribute to the development of mental health issues (Shepherd, Boardman and Slade, 2008; Noiseux *et al.*, 2009; Bennett, 2011; Thornton and Lucas, 2011), and the disabling nature of mental health issues is due to life events, family dynamics, belief systems, and the way society reacts to individuals (McCulloch, 2006). This implies that mental health issues are developed and evolved through

people's interaction with the world, this aligns with a subjectivism ontological approach (Gray, 2014).

Objectivism asserts that social phenomena exist independently from social actors and that they are external facts beyond the reach or influence of people (Bryman, 2012). Much of the research within the mental health issues and work field appears to be based on the underlying assumption of reality that mental health issues are a phenomenon that is external to the social actors involved and is researched as a variable using positivist, quantitative approaches (Follmer and Jones, 2018). A systematic literature review by Follmer and Jones (2018) found that 86% of published research utilised quantitative study designs, whilst the remainder used mixed-methods design. Many of these quantitative studies were descriptive and focused on means and frequencies, and so, limited the ability to draw predictive or explanatory conclusions from the findings (Follmer and Jones, 2018). This approach does not currently provide a holistic picture of what the day-to-day, positive and negative experience of the workplace is for individuals. This suggests that a different approach to researching the area is needed, for example, research that draws on a constructionist ontology.

In comparison to an objective approach of ontology, the constructionist ontology argues that social phenomena are influenced by social actors, and that social phenomena are developed and evolved through the ongoing interaction of social actors with the world (Gray, 2014). This implies that social phenomena are not only produced and created through social action, but that they are in a constant state of change and revision (Bryman, 2012). Constructionism also argues that the reality of knowledge is socially constructed by and between the people who experience it, and that social phenomena is a consequence of the context and is shaped by cultural, historical, political, and social norms (Easterby-Smith, Thorpe and Jackson, 2013).

When looking at mental health issues through the constructionist ontological paradigm there is alignment with the theoretical perspective of the social model as taking a social model view of mental health issues implies that the concept can be socially constructed by social actors and it is shaped by historical, cultural, and social factors such as minority status and socio-economic status (Hacking, 2000; López and Guarnaccia, 2000; Crossley and Crossley, 2001; Mancini and Rogers, 2007; Gewurtz and Kirsh, 2009; Bennett, 2011; Anderson, 2013). Thus, a constructionist ontological approach appears to follow the social model view of mental health issues. Most of the mental health issues at work research, however, has been underpinned by the biomedical model (Woods *et al.*, 2019) which aligns with an objectivist ontological paradigm leading to the dominance of positivist, quantitative methodologies (Follmer and Jones, 2017). This approach has led to a disparate, fragmented, and disjointed literature base with little theoretical underpinning (Elraz, 2017; Follmer & Jones, 2018). In order to develop better understanding of mental health issues at work, drawing on a social model and, therefore, constructionist ontology, may provide alternative methodologies to develop understanding of individuals with mental health issues experience of work and the experience of line managers.

The ontological assumptions of the nature of reality and existence help shape the assumptions about how knowledge can be studied. Epistemology debates within research philosophy are concerned with the study of knowledge; the how we know what we know (Williams and May, 1996; Bryman and Bell, 2011; Bryman, 2012; Creswell, 2016).

Traditionally, research has been based on approaches and methods developed from the natural sciences, that everything in the social world is knowable through research (Williams and May, 1996). This is done by breaking the subject of research down into smaller and smaller components (Sawyer, 2000) which are verified through observation to be true or false

(Williams, 2000). This is the positivist approach to research and has been very influential on the social sciences (Williams, 2000), it dominated the field until the 1960's (Gray, 2014). Positivism follows on from an objectivism ontology and has two underlying assumptions; reality is external and objective, and knowledge is only significant if based upon observations of this external reality (Bryman, 2012; Gray, 2014). Within business research, institutions are studied as entities, and research on individuals focus on their traits, roles, and identities (Cunliffe, 2008). This philosophical approach implies that research should only be concerned with external, measurable subjects, however, as many researchers noted, the social world is more complex, and messy, with people influencing the world they are in by generating ideas, sharing, and reflecting upon them (Sawyer, 2000). This is very different from the phenomenon that the natural sciences study. Thus, it can be argued, a positivist approach utilised by natural sciences would be inadequate to investigate the social world (Alvesson and Sköldbberg, 2009).

Even though, it has been argued to be an inadequate approach to studying the social world (Williams and May, 1996; Alvesson and Sköldbberg, 2009; Bryman, 2012), much of the research within the mental health issues at work field, takes a positivistic approach. For example, Jones, Latreille and Sloane (2016) analysis of the Workplace Employment Relations Study (WERS) examined the link between productivity and mental health issues, but the measures of mental health issues used were based upon questions about psychological health, which may not necessarily be asking questions about mental health issues. This suggests an ignorance of the complex nature of mental health issues. The closed questions reduce the social issue of mental health issues into a phenomenon which ignores it's complex, multifaceted nature.(Sawyer, 2000; Bryman, 2012; Wichers, 2014; Clark *et al.*,

2017). An alternative to a positivistic approach therefore needs to be the aim of this research in order to fully explore the complexities and range of perspectives.

Sawyer (2000) argues that researchers need to take careful consideration of the multiple factors that cause phenomena in the social world. One way to consider this is through a social constructionism approach to research. This approach argues that reality and knowledge is constructed through social processes such as social interactions and language (Gergen, 1994; Williams and May, 1996; Nightingale and Cromby, 1999; Williams, 2000; Bryman, 2012; Burr and Dick, 2017; Braun and Clarke, 2022). It is based on the idea that social realities are not separate from individuals and that they are interwoven and shaped by everyday interactions and language (Cunliffe, 2008). This approach is primarily focused on explaining the processes by which people describe, explain, or otherwise account for the world in which they live (Gergen, 1985). By looking at the way people described, explained and accounted for their experiences the research for this thesis explored the experience of work for people with mental health issues and line managers' practice.

Burr and Dick (2017) provide the example of a tree. What we perceive as a tree, from a social constructionism perspective, is a result of how classifications (such as 'flowers', 'shrubs' and 'weeds') are produced through language rather than being a consequence of what we perceive. This is not to suggest that trees do not have various characteristics that we perceive which could be identified and charted, but rather that the defining characteristics of trees are primarily a product of language (Burr and Dick, 2017). When approaching mental health issues from a social constructionism perspective, it does not suggest that the symptoms of mental health issues are not real but that the characteristics of mental health issues are a product of construction through social interactions and language. Studying illnesses, including mental health issues through a social constructionist lens, focuses on how social factors

shape understanding of and how we act towards health, illness, and healing (Brown, 1995; Andrews, 2012). This enables the exploration of multiple factors that can shape the knowledge base that creates assumptions about the prevalence, incidence, treatment and meaning of illness (Brown, 1995). These factors include class, race, gender, language, technology, culture, institutional and professional norms (Brown, 1995). Social constructionism moves the focus of research from attempting to find biomedical facts to looking at the multiple social forces that combine to create and modify the phenomenon (Brown, 1995). This includes how the phenomena is identified and acted upon, the impact of underlying social structures, roles of professionals, institutions, governments, media, patients, peoples' own experiences, and families (Brown, 1995). This approach allows for research on mental health issues to move away from focusing on diagnosis, illness, and biomedical causes of mental health issues but rather to focus on the individual and their experiences of the workplace and how that is constructed by their interactions with the social world. Even though there was a wide range of literature on mental health issues at work, there remained a significant knowledge gap when it comes to understanding the actual experience of work for individuals with mental health issues in their work environments (Follmer and Jones, 2018). Therefore, research taking a social constructionism approach was needed.

Social constructionism asks to suspend assumptions and look further than commonly accepted categories or understandings which have been researched through positivism observation (Gergen, 1985). Mental health issues and work research has been dominated by a positivistic approach which has reduced mental health issues to diagnosis and symptoms. Work has also been reduced to specific elements such as reasonable adjustments (Foster, 2007), employment rates (Smith and Twomey, 2002; Coutts, 2007; Perkins, Farmer and Litchfield, 2009; McCulloch and Goldie, 2010; Evans-Lacko, Henderson and Thornicroft,



2013; Steadman and Taskila, 2015; Bhugra, Ventriglio and Pathare, 2016; TUC, 2017) and disclosure (Goldberg, Killeen and Day, 2005; Wheat *et al.*, 2010; Irvine, 2011; Moll *et al.*, 2013; Lassman *et al.*, 2015). This approach has led to a disjointed, disparate knowledge base about mental health issues at work that lacks depth and understanding (Follmer and Jones, 2018). Thus, this objective basis of knowledge proposed by a positivist approach to knowledge has not moved the literature, knowledge, and theory around mental health issues at work forward. In comparison, a social constructionist approach provides a different methodology to explore the topic of what work is like for people with mental health issues and to uncover the key features.

A challenge to social constructionism is that it leads to the view that there is no definitive truth to the nature of the world or of people (Burr and Dick, 2017). Instead that truth is constructed, by social interactions and language so are multiple perspectives on any given event, person, or object (Burr and Dick, 2017). This means that there is a preference for qualitative methods and an understanding that the researcher is also constructing knowledge (Braun and Clarke, 2022).

A criticism of social constructionism concerns the degree of reality in phenomena, so is phenomena objectively real or are they solely constructed by social interaction and language (Brown, 1995; Burningham and Cooper, 1999; Cunliffe, 2008; Andrews, 2012). The criticism is levelled at strict, radical, or extreme social constructionism which can be argued to deny physical reality (Sismondo, 1993). Most studies using a social constructionism philosophy, however, adopt a mild form where there is no denial of the existence of reality but that the meaning of reality is socially constructed (Berger and Luckmann, 1991; Sismondo, 1993; Burningham and Cooper, 1999; Andrews, 2012). This mild form is the approach to social constructionism that this thesis has taken. It argues that mental health issues can and do

exist, but the naming, meaning and impact are socially constructed. Taking this approach means that the focus of the research was on the meaning of people’s experience of work and the significant factors, not their symptoms or diagnosis of mental health issues.

### 3.3 Research approach- inductive

The research approach is an important part of the overall research design and is an essential part of the research achieving its aim and objectives (Easterby-Smith, Thorpe and Jackson, 2013). Induction, deduction, and combined approaches to research are associated with how theory will feature in research studies and how theory will be developed (Saunders, Lewis and Thornhill, 2019). Table one, provides a simplistic overview of the differences between these three approaches.

*Table 1: Different research approaches, description of what they are and the associated research strategy Source: Developed from Bryman (2012) and Saunders et al. (2019).*

Research approach	Description	Research strategy
Inductive	A ‘bottom up’ approach where the information collected drives the development of theory	Qualitative
Deductive	Deduction is a ‘top down’ approach which aims to clarify or test theories developed at the beginning of the study	Quantitative
Combined	Inductive and deductive approaches are combined	Mixed Method

The approach that was utilised in this research is based upon an inductive reasoning as it aims to generate understanding and insights (Bryman, 2012; Saunders, Lewis and Thornhill, 2019). An inductive approach argues that broad generalisations and theory emerge from the primary data and so the narratives of the interviewees direct the possible theories that can be

developed, as opposed to deductive approaches, which would be testing theories generated from the literature (Bryman, 2012).

The field of mental health issues at work can be argued as an emerging field with current literature being highly descriptive and lacking a strong theoretical basis (Follmer and Jones, 2018). The literature, therefore, is insufficiently developed for a deductive approach to be possible as there are no theories to clarify or test (Bryman, 2012; Saunders, Lewis and Thornhill, 2019). An inductive approach, therefore, was the best approach for this thesis. Furthermore, the nature of this research project was exploratory which aligns with an inductive, qualitative approach to data generation (Stebbins, 2001; Casula, Rangarajan and Shields, 2021).

### **3.4 Research strategy- qualitative**

Within social science research there is extensive use of three research strategies- qualitative, quantitative, and mixed methods (Bryman, 2012; Saunders, Lewis and Thornhill, 2019). Each of these strategies approach data collection differently due to differences in ontological and epistemological positions. If research is looking to analyse relationships using statistical or numerical methods then quantitative methods are appropriate (Saunders, Lewis and Thornhill, 2019). In comparison, research that aims to explore and interpret people's opinions and experiences, then qualitative methods are the most suitable (Bryman, 2012). Mixed method designs include at least one quantitative and one qualitative data collection technique and provides the opportunity to simultaneously generalise from a sample to the population and gain a richer, contextual understanding of the phenomena being studied (Hanson *et al.*, 2005; Gray, 2014).

Following on from a constructionist ontological stance, a social constructionism epistemological view and an inductive approach to research, a qualitative research design was utilised. Qualitative research techniques lend themselves to exploratory research (Creswell, 2016; Saunders, Lewis and Thornhill, 2019) and as the current literature creates an unclear picture of mental health issues at work, exploratory research is needed to seek understanding. Follmer and Jones' (2018) systematic literature review found that only 11% of previous research utilised qualitative methods whereas 86% utilised quantitative study designs. Even though there is a wide range of quantitative research there is still a lack of understanding of the day-to-day experiences of work for people with mental health issues and significant factors, therefore, a qualitative research design provided an opportunity to seek clarity on the experience of work for people with mental health issues and managers' experiences.

Qualitative research presents an opportunity to listen to people tell their life stories, and therefore can yield rich and complex data. These stories can give researchers a window into lives that might be very different from their own (Warr, 2004). The voices of people with mental health issues have become a central theme in the psychiatric literature but it is often only sporadically and insincerely supported by research (Crossley and Crossley, 2001), with very little in the area of work (Boardman *et al.*, 2003; Chang, 2015). Not only are individuals with mental health issues' voices not supported in the research, but there is also very little heard from line managers (Martin, Woods and Dawkins, 2015; Woods *et al.*, 2019). The combination of these stories may provide a window into the world of work and managing mental health issues not seen before. A qualitative research strategy allows for these stories to be collected, and so providing insights not seen in the current literature.

### **3.5 Sampling and Access considerations**

Selecting and gaining access to appropriate and relevant people is fundamental to the success of any study (Bryman and Bell, 2011; Easterby-Smith, Thorpe and Jackson, 2013; Saunders, Lewis and Thornhill, 2019). There are various strategies and approaches to sampling and the relevance of each is determined by the underlying nature of knowledge and the selected research design (Easterby-Smith, Thorpe and Jackson, 2013). The research approaches and design for this thesis were exploratory and qualitative which intended to achieve depth of understanding and saturation about a topic (Miles, Huberman and Saldana, 2013). This is often achieved by small samples of individuals who have been purposefully selected to provide rich information about the chosen topic (Palinkas *et al.*, 2015). This purposeful sampling technique is widely used in qualitative research as it provides an opportunity for breadth, depth, and a wide scope of information to be collected from specific individuals who hold a lot of information about the chosen research (Palinkas *et al.*, 2015).

When planning qualitative research, it is important to determine whom and how many individuals are needed to ensure that breadth, depth, and scope of information is collected (Bryman, 2012; Saunders, Lewis and Thornhill, 2019). It has been previously found that there are challenges in recruiting for research which looks at mental health issues (Howard *et al.*, 2009; Kanuch *et al.*, 2016). These include challenges to accessing individuals with mental health issues, the sensitive nature of the topic and individual's fear of lack of confidentiality (Claveirole, 2004; Tee and Lathlean, 2004). To ensure an adequate number of individuals were recruited, an opportunistic/ convenience sampling technique was utilised followed by a snowballing technique. This approach can provide opportunities to collect data relevant to the research questions (Bryman, 2012) and can ensure that the research is open to wherever the data leads (Gray, 2014).

I utilised my professional network by sending emails with information about the research to my contacts, including individuals with mental health issues and managers. If an interest was expressed, they were sent information about the research, its purpose, and aims (see appendix 1 for information sent). If they then said they would be happy to participate, an interview was arranged. This was how most interviewees, both individuals with mental health issues and managers were recruited. Convenience sampling is a sampling technique that opens recruitment until enough data has been collected (Luborsky and Rubinstein, 1995). This approach to sampling, however, can be haphazard and seen as an unplanned approach (Gray, 2014). Using my professional network developed from supporting people with mental health issues and drawing on my connections was an attempt to manage the difficulty in recruiting people with mental health issues. I also utilised snowball sampling technique as some of the interviewees passed the research information onto colleagues and managers in their organisation. A few interviewees were recruited this way.

Convenience sampling can be useful for exploratory research as it allows for access to participants to test out ideas (Bryman, 2012; Gray, 2014). The convenience of the researcher, however, takes precedence rather than the needs of the topic (Gray, 2014). The problem with convenience sampling is that it is impossible to generalise the findings because it is not known if the sample is representative (Bryman, 2012). This research, however, did not set out to be generalisable or representative as it was a small scale, exploratory research project that aimed to surface and explore the significant issues at work for people with diagnosed mental health issues, from the perspective of individuals and line managers.

Snowballing sampling can be a useful strategy for researching particularly hard to access or vulnerable groups (Gray, 2014) and as individuals with mental health issues are often described as vulnerable this is appropriate (Claveirole, 2004). Snowball sampling is a

technique for finding research subjects where one subject gives the researcher the name of another subject, who in turn provides the name of a third, and so on (Vogt, 1999). Hendricks, Blanken and Adriaans (1992) argue that snowball sampling provides a way for explorative, qualitative, and descriptive data on sensitive, illegal, or deviant issues to find potential participants. It enables access to hidden, less visible populations that could be considered as deviant or vulnerable (Atkinson & Flint, 2001). Vulnerability may be due to the stigma in society (Atkinson & Flint, 2001), such as that seen by people with mental health issues.

Snowball sampling technique has many limitations including participants are not randomly drawn but are dependent on the subjective choices of the researcher and the respondents themselves and generalised claims to the wider population cannot be made (Atkinson & Flint, 2001; Griffiths et al., 1993; Kaplan et al., 1987). However, as has already been stated, this research was exploratory and aimed to elicit new ideas and new areas to research that are directed by people's stories and their narratives, generalising to the wider population is not a goal.

The aim of the research was to match individuals with mental health issues and their line manager, in order to gain in depth understanding of their different viewpoints of the same context by utilising opportunity and snowball sampling techniques. This, though, did not happen as the majority of individuals interviewed did not want to pass the research information on to their managers. Even though this meant that very few managers were recruited this way, it was an important part of this research that the individuals were in control of who they shared the information with due to issues of disclosure, stigma and discrimination, see 2.1.6, 2.2.5 2.4.4 for discussions on these issues. An important advantage of sampling this way was that ethical issues were managed, and the individuals interviewed expressed their consent by passing on, or not passing on, the information on the research.

These sampling methods also meant that 20 individuals with mental health issues were recruited and openly talked in-depth about their experiences. I am not sure that they would have done if other methods had been chosen.

This approach though, meant that differences in views within the same organisational context has not been achieved, and that there has been no identification of an organisational-wide view on enabling features. To achieve this in the future, organisational case studies, like the one conducted by Moll *et al*, (2013), could be carried out. For organisational case studies though, awareness and care need to be taken with issues of disclosure, stigma and discrimination. Organisational case studies mean that the case- the organisation, is the focus of the research (Bryman, 2012), whereas this thesis research focused on the experience of work for people with mental health issues.

### **3.6 Research design – interviews**

Research designs are the various ways in which research can be conducted and executed (Bryman and Bell, 2011). The chosen research design must flow from the underlying research philosophy and approaches (Easterby-Smith, Thorpe and Jackson, 2013). This research was concerned with the recording of peoples' stories and exploration of the significant issues and factors at work for people with diagnosed mental health issues. The underpinning research philosophy to do this was constructionism and social constructionism, inductive approach, and qualitative research strategy. There are several different qualitative research designs that could have been utilised, see table two, for summaries of their strengths and weaknesses (adapted from Bryman, 2012). The most common designs used to develop an in-depth and extensive understanding of the research issues are interviewing and observation (Jamshed, 2014; Creswell, 2016).



Table 2: Different qualitative methods and their strengths and weaknesses. Source: Adapted from Bryman (2012).

Method	Strength	Weakness
Interviews	Rich, deep data, Exploration of individual's stories, opinions, views, Good for sensitive topics, Flexible.	Researcher influence, Reliability and validity, Length of time it takes to transcribe, Time and cost.
Focus groups	Rich, deep data, Can uncover the influence that the group has, More like real world as our knowledge is created, through interactions with others, Good for sensitive topics.	Issues with confidentiality Researcher influence, Dominant members of the group could control what is being discussed, Length of time it takes to transcribe, Time and cost.
Participant Observations and ethnography	Can be unobtrusive, Can be conducted in natural settings.	How to gain access with participants, Issues with gaining informed consent, deception, The influence the researcher has on the setting.

Due to the lack of a literature base on mental health issues in the workplace, a research design that allows for exploration of the field was needed, one that provided a window into the world of work and managing mental health issues not seen before. This enabled identification of what is important and what is not within this field. Each approach, as seen in table two, has their own strengths and weaknesses.

To ensure that the aim and objectives are met, the opportunity to probe to gain understanding and explore connections was necessary. Hence interviews were chosen as the research design. This was as opposed to observations and ethnography, which would focus on observing and witnessing the experience only, with possibly no opportunity to probe. (Bryman, 2012). Focus groups can provide data that allows for the examination of how

meaning and stories are created in a group by the interaction with each other which aligns with the social constructionism epistemology (Bryman, 2012; Gray, 2014) discussed previously. For sensitive topics, though, focus groups may not be appropriate because of the potential to cause discomfort among participants due to disclosing personal, intimate details of their lives (Madriz, 2000). Focus groups, therefore, are not a suitable research design for this research project. Observations, ethnography and focus groups could not answer the research aim and objectives as well as interviews.

The research interview is a conversation with a purpose between two or more people which enables the researcher to ask questions and actively listen to individuals' experiences of a certain phenomenon (Saunders, Lewis and Thornhill, 2019). Taking a subjectivism, constructionism approach to interviews argues that they are co-produced by the interaction between the interviewer, the questions they ask and the interviewee's knowledge, views, experience, and perceptions (Saunders, Lewis and Thornhill, 2019). The interviewer responds to the interviewee's views, and interprets the data collected during the analysis (Denzin, 2001). This approach to interviewing recognises that the interviewer holds a central role in the process of constructing knowledge and meaning, therefore, it was essential that researcher positionality and reflexivity was conducted to reflect and evaluate the interview process and the impact that they have on the constructed knowledge and meaning (Saunders, Lewis and Thornhill, 2019), see section 3.9.

Interviews have the benefit of being flexible as they can be interviewee led, it is the interviewee themselves that can drive the conversation (Gray, 2014). They also, provide an opportunity to access individuals' meanings, perspectives and interpretations which enables individual differences to be embraced (Willig, 2013). Interviews can also be sensitive to diverse ways of expressing oneself (Willig, 2013). It was important, therefore, to ensure that

the data was interviewee driven and focused on individuals' meaning, perspective and interpretations. In order for this to happen the interviews were based on open-ended questions that focused on recording people's stories rather than specific questions. Interview schedules (see appendices 2 and 3) were used that were more of a checklist of what I wanted to cover in the interviews rather than specific, focused questions.

There are many different types of interviews; structured, unstructured, semi-structured, narrative, and problem-centred (Schembechler, 2005; Saunders, Lewis and Thornhill, 2019), see table three, that are effective in researching social phenomenon, in a way that quantitative methods do not (Corbin and Morse, 2003). For sensitive research areas, such as mental health issues, many researchers choose a qualitative design using in-depth interviews (Liamputtong, 2007). Face-to-face interviews can provide an ideal method when exploring sensitive topics (Elmir, Jackson and Wilkes, 2011; Dempsey *et al.*, 2016) as interviewing can yield rich and meaningful information, whilst at the same time allowing individuals to feel safe and at ease when discussing difficult or sensitive experiences with a stranger (Knox and Burkard, 2009). Interviewing assumes that people have knowledge about the social world and that this is obtainable through verbal communication (Liamputtong, 2007). Interviews aim to elicit and collect rich and complex information from a particular individual's perspective on a specific topic (Liamputtong, 2007; Bryman, 2012; Saunders, Lewis and Thornhill, 2019). They are especially valuable for collecting stories from vulnerable and marginalised people (Liamputtong, 2007) and, as discussed previously, people with mental health issues voices and stories are often unheard. Interviews offer the opportunity for individuals to speak about their lives, and lived experience in great depth, and therefore will provide unique stories (Liamputtong, 2007).

*Table 3: Different types of interviews, their purpose, and the role of the interviewer. Source; Developed from Scheibelholfer (2005) and Saunders, Lewis and Thornhill (2019)*

Type of interview	Role of the interviewer	Format of the questions asked	Purpose
Structured interview	Interviewer completed questionnaires	Pre-determined, standardised questions	Collect quantifiable data
Semi-structured interview	Asking questions Probing answers Intervening in people's answers	Pre-formulated questions which are often a combination of open and closed	Open ended testing of theories
Unstructured interview	Non-directive, creating time and space for the interviewee to talk freely	Interviewee is given the opportunity to talk freely about a topic	Explore in depth a general topic
Narrative interview	Passive but engaged, allowing for the interviewee to say what they want	Prepared open-ended questions	Exploring phenomenological, latent structures
Problem-centred interview	Gradually changing from passive to intervening	A combination of open-ended questions, prepared questions, and other research methodologies	Developing theories

Structured, semi-structured and unstructured are the most common interviewing techniques deployed in social science research (Gray, 2014; Zhang and Wildemuth, 2017). Structured interviewing is an interview that has a set of predefined questions, and the questions are asked in the same order for all interviewees (Zhang and Wildemuth, 2017). This standardisation can reduce effects of researcher bias as it is a questionnaire delivered orally and so produces quantifiable results (Saunders, Lewis and Thornhill, 2019). This was not appropriate for this research project as it does not align with the research ontology and epistemology nor will it explore people's experiences and stories, the aim of this research.

In comparison, semi-structured interviews can be used in exploratory research (Saunders, Lewis and Thornhill, 2019) as it is a flexible and powerful tool that can capture the voices and the ways people make meaning of their experiences (Rabionet, 2011). Semi structured interviews can also provide an opportunity to give a voice for people who may not have much of a voice in research (Atkinson & Silverman, 1997). The interviewer has a list of issues and questions to be covered but, the order they are asked, and the coverage of all questions can change depending on the direction the interview takes (Gray, 2014). This allows the researcher to follow new leads and directions that the interviewee brings up (Bryman and Bell, 2011; Gray, 2014; Saunders, Lewis and Thornhill, 2019). This is vital when the aim of the research, like this one, was to explore subjective meanings that interviewees have on certain topics, concepts, or events (Gray, 2014). Semi-structured interviews, though, can be slow and time consuming to collect data and can be hard to ensure anonymity (Gray, 2014)

In exploratory, inductive research, in-depth interviews can provide an opportunity to find out what is happening and to understand the context of the research topic (Saunders, Lewis and Thornhill, 2019). In unstructured interviews, the researcher has no predefined theoretical framework, and thus no hypotheses and questions about the social realities under investigation (Zhang and Wildemuth, 2017; Saunders, Lewis and Thornhill, 2019). The researcher has conversations with interviewees and generates questions in response to the interviewees' narration and so the interview might generate data with different structures and patterns (Gray, 2014; Zhang and Wildemuth, 2017).

Semi-structured interviews provide an opportunity for the interviews to be shaped by the literature in which key issues already identified are discussed with the interviewees. In the mental health issues at work field, these key issues are challenging to identify due to the fragmented, disparate current state of the literature (Follmer and Jones, 2018), however,

there were some indications of what may have been important, including: reasonable adjustments, fear of stigma and discrimination and disclosing at work for individuals. For managers possible important factors were perceptions and attitudes towards mental health issues, a desire to support individuals but not having the understanding or training to, and the role they play in the negotiation of reasonable adjustments. Therefore, in-depth, semi-structured interviews were conducted. This allows for topics that were indicated to in the literature review to be covered but also the space for individuals to talk about what was important to them. Topic guides provided a great framework for the interviews as there was also a lot of freedom of discussion. See appendix 2 and 3 for topic guides for individuals and line managers.

The topic guides were developed from the conversations I had had before the PhD journey and through the exploration of the literature. I ensured that the topic guides could help remind me of the areas that the literature had suggested were important. For the interviews with individuals with mental health issues this included stigma and discrimination, disclosure, impact of mental health issues on work and reasonable adjustments. Other areas for questions were the general experience of work, sickness absence, being managed and training. For the interviews with managers the topic guide, based on the literature review, included reasonable adjustment negotiations and performance management. Furthermore, the interview guide included general experiences, what shaped managers thinking, sickness absence management, disclosure, and training.

Forty in-depth, semi-structured interviews were conducted. Twenty were with individuals with diagnosed mental health issues and twenty with line managers who had experience of managing people with mental health issues. See 3.8 for more information on the interviewees. The shortest interview was one hour whereas the longest was three and a half hours. In

general, the interviews with managers were shorter than those with individuals with mental health issues but all interview data generated was rich, in-depth and complex.

### **3.7 Analysis of the interviews – reflexive thematic analysis**

In order to capture the information from the interviews, they were recorded on an audio-recorder, transcribed and anonymised (Jamshed, 2014). These have been stored on my personal laptop in a password-protected file. A third party completed the transcriptions and then the narratives were anonymised by using pseudonyms for individual's names and companies and changing any information that could be used to identify the participants. Five participants asked for the anonymised transcript to be sent to them to ensure that they were happy with the anonymisation; all were happy with the changes made to the interviews to ensure confidentiality and anonymity.

Due to the exploratory, social constructionism, inductive, qualitative approach to the research the analytical framework to analyse the interviews needed to be flexible, interpretive, inductive and acknowledge the role of the researcher in the data generated. Building upon analysis skills I developed during my master's in social research and work as a research assistant, thematic analysis was where I initially looked for an approach to analysis. Thematic analysis (TA) is an analytical method that identifies, analyses and reports patterns (themes) with the collected data (Braun and Clarke, 2006). TA goes further than merely describing the data but interprets various aspects of the research data and research topic (Boyatzis, 1998). There are many benefits of using thematic analysis for the analysis of the interview data collected. TA provided a flexible and useful research tool, which can potentially provide a rich and detailed, yet complex, account of data (Braun and Clarke, 2006).

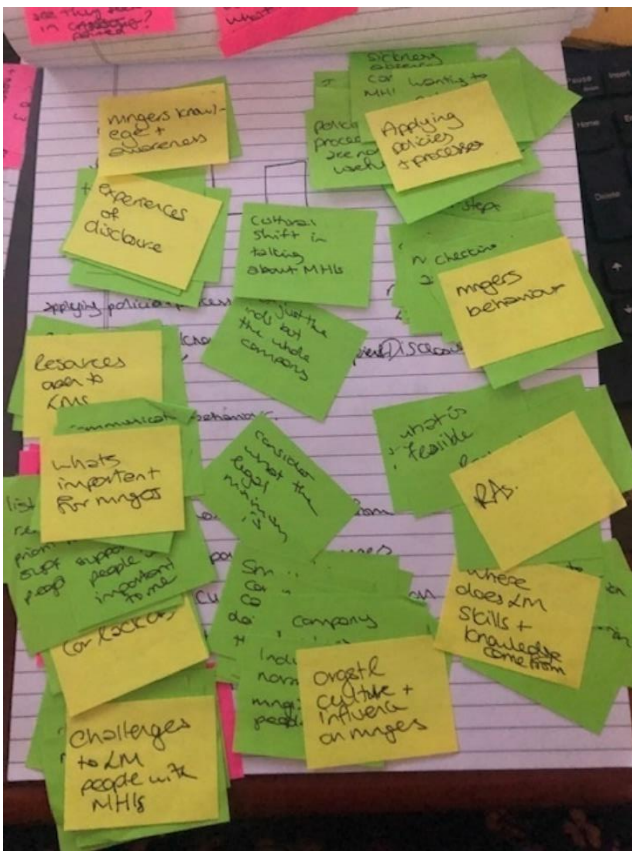
There are different types of TA including reflexive (Braun and Clarke, 2021b, 2021a, 2022), coding reliability (Boyatzis, 1998) and codebook (King, 2012) each with different methods and approach to the researcher subjectivity. As has been discussed, a social constructionism, inductive and qualitative approach recognises that the researcher is central to the research process and construction of data therefore, and a thematic analysis that acknowledges this was necessary. Reflexive TA argues that the researcher is active in the research and data construction, and this can be seen as a resource (Braun and Clarke, 2022). I discovered reflexive TA during the analysis of the data generated as I was grappling with understanding thematic analysis and the rich in-depth data that had been generated and what to do with the fascinating stories I had recorded. Whilst reading around the subject of TA I discovered Braun and Clarke's book on TA and articles they have published on the subject (Braun and Clarke, 2021a, 2022). This brought together my thinking of TA, that I as the researcher was the interpreter of the data generated and that I was influencing the direction of the analysis.

Reflexive TA has limitations, including the difficulty in providing guidance for a flexible approach to analysis (Boyatzis, 1998; Braun and Clarke, 2006, 2022; Anderson, Fontinha and Robson, 2019). This can lead to uncertainty of how researchers have analysed their data and so researchers need to be clear about the steps they undertook in analysis (Braun and Clarke, 2022). Another possible issue with reflexive TA is the influence the researcher has in data generation and constructing the analysis, if this is not made clear it can impact the quality of the research (Braun and Clarke, 2022). To minimise this, I made clear the stages that I went through in the analysis journey and through reflexivity, the possible impacts I have had. The influence of the researcher can also make it difficult to evaluate the research and to compare it with other studies (Attride-Stirling, 2001; Braun and Clarke, 2006).



Coding and analysis were guided by Braun and Clarke's (2006, 2022) guidelines for thematic analysis with reflexive notes made throughout the process to aid the development of my thinking and evolution of themes. To start, I familiarised myself with the data generated by reading the interview field notes and anonymised transcriptions several times. Data collection was over the period of a year and so I started analysing the transcriptions before the full data set was available. I used post-it notes as I read the transcripts to write down initial ideas of coding and as I read through more transcripts these codes started to group together as there were similarities across the interviews.

Once initial coding was completed, I looked for patterns in the coding and across the interviews and started to group the codes into themes (Braun and Clarke, 2006, 2022). I physically did this by grouping the codes on the sticky notes, see figure two. It was useful to think of the themes as if I was trying to explain to someone what the interviewees had said in a short, concise manner. During this searching for themes phase I was steered by what the interviewees had, said so having an inductive, data-driven approach rather than being directed by theory and ideas from previous research (Braun and Clarke, 2022).



*Figure 2: Post-it notes of initial coding and grouping them to start working out the themes for the managers interviews. Source: Authors own.*

At this point in the analysis process, I became overwhelmed by the amount of data that had been generated and so decided to move from paper and pen to NVivo- 12 computer software. The coding on Nvivo was based upon the initial codes and themes that I had already generated through post-it notes and grouping them. By using NVivo-12 I read through the transcriptions again and new codes and themes were generated. Using NVivo-12 provided an opportunity to look at the data generated as a whole. This holistic approach enabled in-depth exploration of how the narratives from the perspectives of the individuals and line managers were similar or diverged.

The exploration of the whole dataset enabled the themes to be revised by looking at the specific meaning of each theme, what the overall story of the analysis said and creating names for the themes. This resulted in eleven themes being generated:

- Perceived positive and negative impacts that mental health issues can have on work,
- Attitudes and perceptions of individuals with mental health issues at work,
- The experience of disclosure of mental health issues at work for both individuals with mental health issues and managers,
- Diagnosis/ labelling of mental health issues can be a significant issue for individuals and managers,
- Enabling and challenging factors managers experience when managing individuals with mental health issues,
- Important characteristics of manager behaviour when managing individuals with mental health issues,
- Colleagues and the part they play in the experience of work for individuals with mental health issues,
- Workplace resources of support and help for mental health issues,
- The experience of workplace policies and processes for individuals and managers
- Individuals and managers experience of reasonable adjustments,
- Work design and workload are significant issues for individuals with mental health issues.

The length of the analysis journey was due to my chronic illnesses flaring up and needing time away from this research. This meant that I dipped in and out of analysis. Dipping in and out of analysis meant that even though I was not sat at my desk, working on the transcripts

and later in NVivo, I had been thinking about the data, making links between the interviews, reflecting, and making notes on these ideas. The dipping in and out meant that I approached the analysis from different emotional states, different levels of physical pain and different levels of cognition. Reflecting on the impact this had on my analysis journey led to realisations that the journey had been a long one, that I was passionate about the subject area, that the interviews provided rich and in-depth data generation, that there were multiple ways to look at and analyse the data generated and that the way I analysed the data was from a desire to develop understanding of patterned meaning across the interviews to produce a coherent and compelling interpretation grounded in the interviews (Braun and Clarke, 2022).

### 3.8 Participant information

Twenty individuals with mental health issues and twenty managers were recruited through convenience and snowball sampling. See table four and five for their pseudonyms and the demographic information collected. Individuals with mental health issues included fourteen females and six males, they varied in job role and sector. When asked about their mental health diagnosis a range of mental health issues were described, including post-traumatic stress disorder (PTSD), depression, anxiety, and bipolar disorder. This shows the wide range of mental health issues that the individuals interviewed experienced and that some of these can be classed as severe mental health issues. Fifteen of the individuals had disclosed at work.

*Table 4: Pseudonyms and demographic information collected of interviewees with mental health issues. Source: Authors own.*

	Job role	Sector	Diagnosis	Gender	Disclosed at work
Mary	Rehabilitation assistant	Health care	Borderline personality disorder	F	yes

Katie	Nurse	Health care	Depression PTSD	F	Depression disclosed
Matthew	Business Analyst	IT	Clinical Depression	M	no
Grace	Special Needs Teacher	Education	Anxiety disorder	F	Yes
Sally	Sales assistant	Retail	Anxiety disorder	F	Yes
Lilly	Data entry Clark	Logistics	Chronic PTSD, Anxiety, General anxiety disorder Depression, Personality disorder, Emotionally Unstable Personality Disorder	F	Yes
Lisa	Senior service desk analyst	IT	Depression General anxiety disorder, Obsessive compulsive disorder, PTSD	F	yes
Margaret	Business support manager	Insurance	Social anxiety, depression	F	No
Jasmine	Health care assistant	Health care	Depression, Anxiety, Tourette's	F	yes
Juliet	Physiotherapist	Health care	Anorexia, PTSD, anxiety, depression	F	Yes
Sean	Senior user researcher	Insurance	Depression, Anxiety, Autism	M	Yes
Olivia	Research assistant	Science	Depression Anxiety	F	Yes
Charlotte	Employee relations manager	Aerospace	Anxiety, Depression	F	Yes

James	Contracts co-ordinator	Health care	General anxiety disorder, Manic depression bipolar disorder	M	No
Liam	Customer service assistant	Retail	Depression, Anxiety	M	Yes
Lucas	Senior operations manager	Hospitality	Manic depression, alcoholism	M	Disclosed alcoholism
Elizabeth	Model maker	Theme Park	Social anxiety disorder	F	Yes
Rosie	Cancer nurse	Healthcare	General anxiety disorder, Health anxiety disorder, Obsessive Compulsive disorder	F	Yes
Lucy	Senior co-ordinator	IT	Anxiety, depression, stress	F	Yes
Alex	Customer service executive	Sales	Depression, anxiety	M	Yes

Manager interviewees included eleven females and nine males who held a variety of roles in a range of sectors. Five of the managers held a senior leader position and they were all male.

*Table 5: Pseudonyms and demographic information collected of the managers interviewed. Source: Authors own.*

	Job role	Sector	Gender
Anne	Development fund contract Manager	Civil Service	F
Sue	Customer Liaison manager	Public service	F
John	Team manger	Logistics	M
Tim	Support team manager	IT	M
Susan	Supervisor	IT	F
Emma	SEN teacher	Education	F
Sophie	Senior HR Consultant	Public sector	F
Thomas	Duty manager	Leisure	M

Amelia	Support nurse specialist	Healthcare	F
Ben	Business consultant	Across sectors	M
William	Senior operations manager	Hospitality	M
Oliver	Head Teacher	Education	M
Elijah	CEO	Tourism and hospitality	M
Abigail	Business manager	Education	F
Adrian	Head Teacher	Education	M
Charles	Director	HR consultancy	M
Tilly	Service Manager	Retail	F
Gemma	HR advisor	Education	F
Angela	Centre co-ordinator	Charity	F
Natalie	Senior keeper	Zoology	F

### 3.9 Role of the researcher/ axiology

As previously stated, the philosophical approach taken was constructionism which argues that knowledge is constructed. The researcher will have an influence on the construction of the data and findings (Bryman, 2012; Gray, 2014; Braun and Clarke, 2022). The researcher is part of any research, their own cultural and social ideas, feelings, and perceptions become part of the research itself as they influence the way the research is framed, examined, and interpreted (Warr, 2004; Gray, 2014). In other words, it is arguably, impossible to engage with qualitative research which explores the lives of others from a research position of assumed neutrality and objectivity (Braun and Clarke, 2022). By the very nature of qualitative research, the relationship between the researcher and the objects of the study, in this case the interviewees, are more direct than in quantitative research (Bryman and Bell, 2011; Bryman, 2012; Braun and Clarke, 2022). The researcher is not an independent, neutral observer and cannot avoid their own subjectivity during the research (Warr, 2004; Bryman and Bell, 2011; Bryman, 2012; Gray, 2014; Braun and Clarke, 2022).

Reflexivity is one way that the research can have the quality criteria of qualitative research sincerity (Tracy, 2010), for others it is a way to ensure validity (Creswell and Miller, 2000).

Reflexivity can be done through a research diary which should be a record of the researcher's thoughts, concerns, issues, or insights which can help develop a reflexive stance towards the research (Miles, Huberman and Saldana, 2013). A research diary, therefore, was kept for the duration of thesis which recorded my reflections on what I did, why I did it and the possible influences these may have had. This was done in a notebook as I prefer pen and paper for reflections.

Part of reflexivity is to acknowledge what underlying assumptions the researcher holds (Bryman, 2012; Saunders, Lewis and Thornhill, 2019; Braun and Clarke, 2022). I have worked in supporting people with mental health issues for many years. This has shaped my view that mental health is not a disability and that the focus should be upon recovery. This view has potentially influenced the questions posed, how they were asked, and how the information collected was analysed. During my working career I have worked with a lot of individuals who experience a wide range of mental health issues, social injustice, and suffering. This has meant that skills of reflection, detaching from issues, listening, and coping with exhaustion have been essential to learn and develop. This work has also led to a lot of experience of working with individuals with mental health issues where recognising signs of distress is very important. I am also a qualified master practitioner of NLP coaching. This helped to develop the skills of framing questions and managing answers in an effective and open way. These skills and experiences helped me manage the interview process, actively listen, and manage my own health and wellbeing. I have innate values of fairness, justice, and equity. I also believe that people can be all that they can be, I derive a lot of satisfaction in supporting people in this quest.

The issue of the researcher's own safety and welfare needs is often thought of as a cursory or ad hoc issue (Bloor et al., 2010). Researching a sensitive topic such as mental health issues



cannot just affect the interviewee but also the researcher. Mose & Field (1995) argue that if a topic of research has to do with experience of illness, the stories collected by the qualitative researcher can include discussions of suffering and social injustice that may be of a shocking nature to the researcher. Research by Dickson-Swift *et al.*, (2007) found that the challenges faced by qualitative researchers researching sensitive topics include building rapport, use of self-disclosure, hearing untold stories, feelings of guilt and vulnerability and exhaustion. This supports findings by Campbell (2001) and Johnson & Clarke (2003) who found that some of the challenges faced by researchers include role conflicts, accessing participants and the impacts of undertaking in-depth interviews on sensitive topics.

Drawing on my skills and experiences from previous work has helped me navigate some of these challenges. The interpersonal interaction between social researchers and those whose experiences are being researched involves a kind of participation that is more than the practical research activity tasks of conducting interviews, transcribing, and analysing the information collected (McCosker, Barnard and Gerber, 2001). This is because it requires immersing oneself in the stories of people's lives and listening, reading, and thinking about them many times over (Warr, 2004). Researchers get to know intimate stories from a stranger's life, even though they may have spoken to the researcher for only an hour (Warr, 2004). It, therefore, is important that the researcher finds the right distance between themselves, and the setting being studied, but this is not an absolute science and involves on-going conscious thought and effort (Irvine and Gaffikin, 2006). To attempt to manage this distance I drew on skills of active listening, reflection and following the interview topic guides. Reflections were needed during the interviews to ensure that I was navigating the interaction with the interviewee well, this included watching for non-verbal cues of discomfort, keeping quiet when the interviewee was showing signs of thinking, active listening and ensuring that I

was following the topic guides. Post-interview reflection included thinking about my behaviour, what I learnt, considering the significant parts of the stories and what I would like to do differently in the next interview.

### **3.10 Research ethics**

While all research topics have the potential to be sensitive (Corbin and Morse, 2003), some research, like this thesis, may elicit more distress and emotion than others. This can place the individuals involved at risk of experiencing emotions such as sadness, anger, anxiety, and fear (Elmir, Jackson and Wilkes, 2011). Although sensitive research may pose an element of risk to individuals, avoiding conducting this research may be seen as disempowering the individuals who would be involved and evading responsibility (Dickson-Swift *et al.*, 2007; Elmir, Jackson and Wilkes, 2011; Dempsey *et al.*, 2016). Lee (1993) argues that sensitive research is any research which can potentially pose a threat to those who are involved. One way to manage this is through sufficient ethical procedures (Mertens and Ginsberg, 2008) which the researcher is the guardian of (Bahn and Weatherill, 2013).

Mental health issues can be seen as a sensitive topic as individuals who have mental health issues can be placed in a vulnerable situation. This can be made up of workplace cultures and practices that are reluctant to recognise mental health issues as debilitating conditions, even though mental health issues can be designated as a disability under the Equality Act (2010) (Elraz, 2017). It was essential that the needs of the individuals were paramount in this research (McCosker, Barnard and Gerber, 2001).

Research ethical approval through the University of Plymouth ethical procedure (Pellowe, Lucznik and Martin, 2018) was granted for the research project, see appendix 4. This ensured the research was carried out according to the principles of integrity, academic excellence,

accountability, inclusiveness, and professionalism (Pellowe, Lucznik and Martin, 2018). Six key research ethical issues were discussed and managed, these were informed consent, openness and honesty, right to withdraw, protection from harm, de-briefing and confidentiality (Bryman, 2012; Gray, 2014; Pellowe, Lucznik and Martin, 2018; Saunders, Lewis and Thornhill, 2019). The British Psychology Society (BPS) and British Sociological Association (BSA) research ethic codes were adhered to to guide practice on all these issues.

### **3.10.1 Informed consent**

In accordance with the British Psychological Society (BPS) Code of Human Research Ethics (The British Psychological Society, 2014) and Code of Ethics and Conduct (The British Psychological Society, 2018) researchers should ensure that participants from vulnerable populations are given ample opportunity to understand the nature, purpose, and anticipated outcomes of any research participation, so that they may give informed consent. To ensure that this happened, once participants had agreed to take part in the research the briefing document (appendix 1) and informed consent form (appendix 5) were sent to give them the opportunity to understand the research and its aims and objectives. The informed consent form ensured that the participants read, understood, and agreed to participate in the research. The forms were discussed at the beginning of the interview to ensure the interviewees had as much information and understanding as they could. There was an opportunity to talk through, discuss and ask questions about the research. Discussion at the beginning of the interview went through the recording of the interview, transcriptions and how the interviews were anonymised, stored, and used.

### **3.10.2 Openness and Honesty**

As can be seen in the briefing and de-briefing documents (appendix 1 and 6), participants were given as much information as possible to ensure that the research was open and honest

and that they were treated with respect and dignity. The information was also discussed in the interview so that any questions could be asked, and the participants could request a copy of their transcript to make sure they agreed with the transcriptions.

### **3.10.3 Right to Withdraw**

All participants had the right to withdraw. This was made clear in the briefing document. They could withdraw up until the end of data collection – 01/02/2021. If they choose to withdraw at any stage all information collected from the participants would be permanently deleted and not used in any analysis, write up or publication. This was made clear in the briefing document, see appendix 1.

### **3.10.4 Protection from Harm**

In many of its forms, social research intrudes into the lives of those studied. While all research topics have the potential to be sensitive, some research, like this, may elicit more distress and emotion than is the norm. Some participants in research may find the experience a positive and welcome one, whereas for others, the experience may be disturbing (British Sociological Association, 2017). This may place the individuals involved at risk of experiencing emotions such as sadness, anger, anxiety, and fear. As previously said, although sensitive research may pose an element of risk to individuals, avoiding conducting this research may disempower the individuals who would be involved and evading responsibility.

Wherever possible I needed to attempt to anticipate, and to guard against consequences for research participants that can be predicted to be harmful (British Sociological Association, 2017). Therefore, this research followed the BPS and the BSA guidelines for working with vulnerable people. This includes no deception, the right to withdraw at any point, and empowering individuals. To empower individuals, I gave them a choice of how the interviews

were conducted e.g., face-to-face, skype, zoom, or telephone. The individuals also provided possible times and locations for the interviews so that they felt they had choice and control. This was very clear on the briefing form.

The briefing and de-briefing forms included signposting to external support services that participants could access if it was needed. The participants also received a copy of the information sheets, see appendices 7 and 8, which provided links to many different sources of information, including legal advice, advice on rights at work and support for mental health issues. At the end of the interviews, there was time to go through these and answer any questions that arose and/or signpost to relevant services.

The focus of the research was on the experience of work, not the experience of the mental health issue. However, discussing any experiences can be challenging. During the interviews, I drew on my experiences of conducting interviews and working with people with mental health issues to ensure that the questions were sensitive to the individual's needs. I have been a research assistant conducting interviews with a wide range of people, am a qualified coach and have worked extensively with people with mental health issues. Therefore, with a combination of my work experiences, qualifications, and research experience I felt confident I was sensitive in asking questions and guiding individuals through their experiences to minimise harm.

### **3.10.5 Debriefing**

At the end of the interviews, participants were given a debriefing form (appendix 6). This was sent to them via email to ensure that they could access it. This form included a brief description of the research, contact information for the researcher and supervisor, reiteration of the right to withdraw and signposting to possible services if needed. The de-briefing form

also included information on the anonymisation of transcripts and their right to provide feedback on them. At the end of the interviews, I talked through the de-briefing information- the purpose of the research, what happened to the recordings and anonymisation and signposting to relevant services. This provided an opportunity for the participants to ask any questions about the research and any concerns they had. My contact information was on the de-briefing form. I made it clear that the participants were able to contact me in the future with any further questions, queries, or concerns about the research.

Also provided to them was an information sheet with more signposting to services and external sources of guidance and advice, see appendices 7 and 8. At the end of the interviews, these were talked through to make sure participants felt de-briefed.

### **3.10.6 Confidentiality**

The narratives were anonymised using pseudonyms for companies, giving participants different names, and changing any information that could be used to identify the participants to maintain confidentiality and anonymity. This was made clear on the briefing and de-briefing document which I provided to the participants via email. The anonymised transcripts were sent to the participant to ensure that they were happy with the level of anonymisation. I did this level of anonymisation during my master's dissertation research and whilst working as a research assistant for the Institute of Leadership and Management and so have practice in doing this.

The transcripts are stored on my professional laptop within a passcode-protected folder, which only I have access to. In a separate passcode-protected folder contact information is stored to ensure that I sent them their transcripts (if requested) and answered any questions they had.

In the briefing and de-briefing form, it was clear that the anonymised transcripts would be used for the PhD thesis and subsequent publications only.

### **3.11 Quality criteria**

Taking exploratory, social constructionism, inductive, qualitative approaches to research can mean that typical assessment of the quality of the research do not apply as the purpose of qualitative research is different to quantitative research where quality is assessed with reliability and validity evaluations (Lincoln and Guba, 1985; Lloyd, Gatherer and Kalsy, 2006; Tracy, 2010; Bryman, 2012; Levitt et al., 2017; Smith, 2018; Smith and McGannon, 2018).

There is a range of approaches to assess the quality of qualitative research including looking at issues such as sensitivity to context, commitment, rigour, transparency, and coherence (Yardley, 2000). Whereas Lincoln & Guba (1985) propose two primary criteria for assessing qualitative research: trustworthiness and authenticity. The proliferation of different approaches and concepts for qualitative excellence can illustrate the complexity of qualitative research and the different methods (Tracy, 2010).

Tracy's (2010) approach to assessing the quality of qualitative research draws together a range of best practices and provides eight universal criteria that can be applied across paradigms and methods (Tracy, 2010). The eight criteria are: worthy topic, rich rigor, sincerity, credibility, resonance, significant contribution, ethics, and meaningful coherence. Each criterion can be achieved through a variety of skills which are flexible, depending on the studies aim and objectives (Tracy, 2010). Figure three provides an overview of the criterion and the ways that quality can be achieved.

Criteria for quality (end goal)	Various means, practices, and methods through which to achieve
Worthy topic	The topic of the research is <ul style="list-style-type: none"> <li>• Relevant</li> <li>• Timely</li> <li>• Significant</li> <li>• Interesting</li> </ul>
Rich rigor	The study uses sufficient, abundant, appropriate, and complex <ul style="list-style-type: none"> <li>• Theoretical constructs</li> <li>• Data and time in the field</li> <li>• Sample(s)</li> <li>• Context(s)</li> <li>• Data collection and analysis processes</li> </ul>
Sincerity	The study is characterized by <ul style="list-style-type: none"> <li>• Self-reflexivity about subjective values, biases, and inclinations of the researcher(s)</li> <li>• Transparency about the methods and challenges</li> </ul>
Credibility	The research is marked by <ul style="list-style-type: none"> <li>• Thick description, concrete detail, explication of tacit (nontextual) knowledge, and showing rather than telling</li> <li>• Triangulation or crystallization</li> <li>• Multivocality</li> <li>• Member reflections</li> </ul>
Resonance	The research influences, affects, or moves particular readers or a variety of audiences through <ul style="list-style-type: none"> <li>• Aesthetic, evocative representation</li> <li>• Naturalistic generalizations</li> <li>• Transferable findings</li> </ul>
Significant contribution	The research provides a significant contribution <ul style="list-style-type: none"> <li>• Conceptually/theoretically</li> <li>• Practically</li> <li>• Morally</li> <li>• Methodologically</li> <li>• Heuristically</li> </ul>
Ethical	The research considers <ul style="list-style-type: none"> <li>• Procedural ethics (such as human subjects)</li> <li>• Situational and culturally specific ethics</li> <li>• Relational ethics</li> <li>• Exiting ethics (leaving the scene and sharing the research)</li> </ul>
Meaningful coherence	The study <ul style="list-style-type: none"> <li>• Achieves what it purports to be about</li> <li>• Uses methods and procedures that fit its stated goals</li> <li>• Meaningfully interconnects literature, research questions/foci, findings, and interpretations with each other</li> </ul>

*Figure 3: A summary of Tracy's (2010) eight criteria of quality qualitative research and ways for research to achieve. Source: Tracy (2010).*

Using a criteria or framework for what comprises quality qualitative research can be helpful in encouraging dialogue between the scientific community (Tracy, 2010), and can frame qualitative work in a systematic and structured way (LeGreco and Tracy, 2009). Reflections on how well this research has performed according to Tracy's (2010) quality criteria will be discussed in the conclusion chapter.

### **3.12 Concluding remarks**

This chapter has gone through each element of the methodology to provide a detailed picture of how the data was collected, how it was analysed, how participants were protected, and



importantly the underlying assumptions about reality, how knowledge was constructed and how I, the researcher influenced the data collection and analysis. I have followed Saunders, Lewis and Thornhill (2019) research onion to demonstrate how the multilayers of research philosophy, approach, strategy, design and analysis fit together. Specifically, exploratory research was conducted due to the lack of research into the experience of work for individuals with mental health issues and so the research was not driven by pre-existing theory and knowledge.

The perspective of constructionism ontology was adopted, wherein the perception of reality is built upon the notion that social phenomena are shaped by the actions of individuals within a social context (Gray, 2014). This view recognises that social phenomena are developed and evolved through the continuous interaction between individuals and the world around them (Gray, 2014). Following on, the studies' epistemological approach was social constructionism which argues that knowledge is constructed through social processes such as social interactions and language (Gergen, 1994; Williams and May, 1996; Nightingale and Cromby, 1999; Williams, 2000; Bryman, 2012; Burr and Dick, 2017; Braun and Clarke, 2022). These approaches align with the social model of mental health issues.

The subsequent approach to this research was inductive and the strategy qualitative. An inductive approach was taken due to the incomplete understanding of the experience of work for people with mental health issues and so theory development was data driven. Qualitative, in-depth semi-structured interviews can allow for exploration of the interviewee's stories and so develop understanding of the topic area. Taking this approach, though, has meant that the researcher was central to the research process and so it has been important to discuss researcher axiology.

Reflexive thematic analysis is a method of analysis that followed on from the assumptions made about reality, knowledge and approach to research discussed in this methodology. The researcher is also central to reflexive thematic analysis. Reflexivity throughout the research process was conducted. Also discussed in this chapter was sampling, participant information, research ethics and quality criteria. Research ethics was important in this thesis due to the sensitive nature of mental health issues. How to assess the quality of the research was also discussed as this research does aim to be of high quality.

This chapter has highlighted and discussed how the research explored the aim to surface and explore the significant issues at work for people with diagnosed mental health issues, from the perspective of individuals and line managers. And how the research explored the objectives:

- Recognise the economic, legal, social, and medical context,
- Record the lived experience of individuals and line managers,
- Uncover the significant issues for individuals and line managers,
- Explore enabling features for individuals and line managers,
- Develop a research agenda for further research into significant issues at work for people with mental health issues.

The following chapter will discuss the analysis of the data generated from this research study.

This chapter reports the themes and patterns from the data generated which is linked to literature.

## 4 Analysis

The aim of this thesis was to surface and explore significant issues faced by individuals with diagnosed mental health issues in the workplace, as seen through the eyes of both individuals and managers. By taking into account the economic, legal, social, and medical aspects, the thesis sought to document personal experiences of individuals and managers, identify key issues affecting them, explore potential strategies to empower individuals and managers, and establish a research plan for future studies on the important workplace issues concerning individuals with mental health issues. To do this, data was generated through semi-structured in-depth interviews with individuals with diagnosed mental health issues and line managers. Reflexive thematic analysis was conducted that developed codes and themes (Braun and Clarke, 2022), see table six for a summary of these themes and their characteristics. There is a discussion of how these themes were developed, the story of the analysis and the subjectivity of the researcher in the methodology chapter, section 3.9.

*Table 6: Summary of the themes. Source: Authors Own.*

	Theme	Characteristics
A	Perceived positive and negative impacts that mental health issues can have on work	The impact of mental health issues on work can vary, with potential positive, negative, or minimal effects.
B	Attitudes and perceptions of individuals with mental health issues at work	Fear of stigma and discrimination was a significant issue and appeared to be in many areas of work for people with mental health issues: recruitment, being judged, being seen as weak, being less capable, sickness absence, and not being taken seriously
C	The experience of disclosure of mental health issues at work for both individuals with mental health issues and managers	Deciding to disclose or not to was an important issue but disclosure was not an all-or-nothing process. People disclosed selectively and strategically by deciding what they said, when they said it and to whom
D	Diagnosis/ labelling of mental health issues could be a significant issue for individuals and managers	Diagnosis and labelling could be helpful as it could help feel more normal, access support and receive less bullying and harassment.

		Diagnosis could lead to stigma, discrimination, and self-stigma
E	Enabling and challenging factors managers experience when managing individuals with mental health issues	Managers wanted to support individuals but there could be an impact on their health and wellbeing. Challenge balancing the individual needs and the collective demands including organisational and the pressures on the team
F	Important characteristics of manager behaviour when managing individuals with mental health issues	Enabling factors included managers behaving with professionalism, building trust and managers listening, informal communication and managers being open and honest. Issues with managers behaviours included lack of professionalism and gossiping, not trusting managers, not being listened too and formal communication
G	Colleagues and the part they play in the experience of work for individuals with mental health issues	Colleagues could enable individuals by providing support, being friendly and open, and supporting returning to work, however, they could also hinder through gossiping and being judgemental and inconsiderate
H	Workplace resources of support and help for mental health issues	For some of the individual's workplace resources could be helpful. Many issues identified including inability to access, reduction in services, services being stretched and unsupportive HR professionals
I	The experience of workplace policies and processes for individuals and managers	There was a preference for policies and procedures to be applied flexibly but formal processes and policies could help managers' practice and help ensure that they were doing what was required of them by the organisation
J	Individuals and managers experience of reasonable adjustments	Reasonable adjustments could be a significant factor for individuals and managers are the person that individuals discussed reasonable adjustment with, but managers can lack the knowledge and the skills necessary to support individuals through reasonable adjustments
K	Work design and workload are significant issues for individuals with mental health issues	The way work was structured, how workloads were managed (or not), the control and autonomy individuals had at work and flexibility at work, was a significant factor

These themes can be grouped into three clusters, much like the clusters in the literature review, the clusters bring together the themes and related literature to develop a picture of what work is like for individuals with mental health issues, managers experiences and

significant factors and issues for both the individual and managers. The three clusters which emerged were: individual, social/relational, and organisational.

The analysis is presented with the individuals and manager interviews merged to uncover the similarities and differences between their narratives. To support the analysis and discussion, quotes have been used from the transcribed interviews. As this was an exploratory piece of research that has used reflexive thematic analysis there is a high number of illustrative quotes of substantial length to ensure that the lived experiences are fully portrayed. These quotes are verbatim so do include swearing. According to Braun & Clarke (2022), a rough 50-50 balance between data excerpts and analytic narrative ensures that the data generated can speak for itself. Deciding upon which extracts of interviews to include in this analysis was challenging as the data generated is rich. Braun and Clarke's (2022) recommendations on how to select quotes were followed: select vivid examples, select extracts across the whole range of interviews, use a range of quotations for each of them. The literature referred to in the analysis includes the literature discussed in the narrative literature review in chapter two as well as literature that has been published since 2019. When presenting the analysis of exploratory research, like this study, there can be a need to draw on literature that was not included in the literature review as the literature review does not provide enough information on the topic area (Stebbins, 2001). In doing this, the links can provide exploratory research with intellectual anchors (Stebbins, 2001).

During the analysis of the interviews, it became evident that paradox theory with a tension-based lens could be a guiding framework for the analysis and discussions. This became apparent after reading Suter, Irvine and Howorth's (2022) article on the experiences of managers responding to employees with mental health issues in small and micro businesses. Their use of the paradox meta theory and tension-based framework highlighted how the

managers interviewed experienced tensions and how they resolved the consequent conflict (Suter, Irvine and Howorth, 2022). Paradox theory is a meta-theory, that focuses on how organisations or individuals experience and cope with tensions arising from contradictory elements (Lewis, 2000; Quinane, Bardoel and Pervan., 2021; Smith & Lewis, 2011; Suter Irvine and Howorth, 2022), as discussed in section 1.5. Tensions denote competing elements, such as contradictory demands, goals, interests, and perspectives (Miron-Spektor *et al.*, 2018). Paradox theory and tension lens can enable the development of insights into managers' and individuals' experiences of organisations by viewing organisations structures and how they shape organisational life and/or the social processes through which individuals make sense of their organisational life (Lewis, 2000; Quinane, Bardoel and Pervan, 2021; Smith & Lewis, 2011).

The tensions which surfaced from the research are:

- Positive versus negative impacts of mental health issues,
- Disclosing versus not disclosing to protect from stigma and discrimination,
- Diagnosis is helpful versus negative attitudes and perceptions of the label,
- Seeking help and support versus the difficulty in accessing services,
- Needs of the individual versus needs of the collective,
- Managers supporting individuals needs versus the impact it has on their own mental health and wellbeing,
- Managers wanting to support versus the demands and pressures of their role,
- Informal versus formal,
- Colleagues being supportive versus colleagues' negative behaviour,
- Managers are first contact versus managers lack knowledge and skills,

- Keeping busy versus workloads too high,
- Work can be a safe space versus stigma, discrimination, and negative perceptions.

These will be discussed within each theme and, when appropriate, how these tensions were responded to, however, not all the tensions were responded to in the interviews. Tensions can be responded to by either/ or responses or both/and responses (Poole and van de Ven, 1989; Smith and Lewis, 2011; Putnam, Myers and Gailliard, 2014; Quinane, Bardoel and Pervan, 2021; Suter, Irvine and Howorth, 2022). Either/or responses can simplify the paradoxical tension by negating one side through selecting one element, or through separation where each element is separated by location, level or being temporary (Poole and van de Ven, 1989; Seo and Creed, 2002; Suter, Irvine and Howorth, 2022). In contrast both/and responses embrace the contradictions inherent in paradox and so responses can be adjusted by recognising that both elements are important and pursue accommodation of both or through synthesis, where a new perspective is found which eliminates the opposition between the two elements (Poole and van de Ven, 1989; Jarzabkowski, Lê and van de Ven, 2013; Schad *et al.*, 2016; Suter, Irvine and Howorth, 2022).

The exploratory nature of the research enabled a curious adventure through research (see section 3.1); flexibility in recording people's lived experience through semi-structured in-depth interviews and storytelling in reflexive thematic analysis (Braun and Clarke, 2022). This meant that the research was a rich examination of mental health issues at work which resulted in a complex tapestry of findings that is supported by research (Braun and Clarke, 2022). Part of that rich tapestry is an overall picture of individuals and managers experiences. After that, the significant issues and enabling factors of work for individuals and managers are discussed.

These are contextualised with literature and the tensions that became apparent are discussed. The significant issues and enabling factors are: the impact of mental health issues





Figure 4: Word cloud for the interviews with individuals and managers generated in NVivo 12. Source: Authors own.

Individuals and managers at the beginning of their interviews answered the opening prompt- tell me about your experience. This provided a starting point which helped to shape the direction of the questions which were subsequently asked. From this open-ended question the narratives from the individuals centred around surviving work, rather than flourishing. This was the same narrative I heard in conversations before the PhD which led me to the topic area, as discussed in chapter 1. The people interviewed were people in work and for many that made them feel they were managing their mental health issues and yet the narrative was still one of surviving. As discussed in the narrative literature review and literature published since, there is a focus on the negative impacts of mental health issues (Haslam *et al.*, 2005; OECD, 2012; Steadman and Taskila, 2015; Thisted *et al.*, 2018; Hakulinen *et al.*, 2020; Gühne *et al.*, 2021) and the negative attitudes and perceptions about people with mental health issues (Smith and Twomey, 2002; Russinova *et al.*, 2011; Bhugra, Ventriglio and Pathare, 2016; Stevenson and Farmer, 2017; TUC, 2017), however, there must be factors in work that can help individuals with work, be in work, stay in work and flourish at work.

The overall experience of work for individuals was mixed, some felt that their mental health issues did not affect their work. Jasmine discussed that her mental health issues and neurodivergence does not impact her ability to do her work but does impact the social aspects of work:

*It's hard, because like, my job itself, it doesn't affect it necessarily, but it affects the social aspects of my work, such as like, in theatre obviously it's easy to interact with my colleagues, because like, I have set things, I ask, I have a professional character, if that makes sense? But when it comes to like, actual feelings and talking to my managers and my colleagues, and like, that's where it gets hard [...] To deal with and stuff. (Jasmine)*

Matthew discussed how his mental health issues first manifested at work:

*And then I think I remember, sort of the trigger was my task manager at the time, sort of, was trying to talk to me about something, and I was staring at this Word document, and I can picture the document, but I can't picture anything else of what was going on, and I must have been looking at it for about 30-40 minutes, without doing anything. He just kind of kept glancing sideways at me apparently, and finally got my attention and he was like "right, you need to go and talk to somebody because I really don't think you should be here at the minute". And I sort of resisted it at first, because as I say, I wasn't the most self-aware of that sort of thing back then, and umm, eventually did start talking to a couple of people at work about it. Initially just a colleague, who was a friend of mine, quite close to. And she very quickly put wheels in motion for me to meet with my then line manager, and sort of take it from there really. (Matthew)*

Managers also discussed how the experience of mental health issues at work can be mixed.

Angela's whole team experienced mental health issues:

*all 3 of my staff who report to me have experience mental health issues in different ways through different reasons. I can't identify one member of the wider team who has not experienced some form of mental health issue or problem during this last year. I think where there was underlying mental health issues they've certainly increased. (Angela)*

William described his extensive experience of supporting people with mental health issues and what he has put in place to help them, including changing job roles, counselling, and signposting to professional services:

*So, within every restaurant or cafe that I run, there have been people with diagnoses, and more importantly, undiagnosed mental health issues. And that has ranged from managing people into the right position to facilitate them to manage their stability and their wellbeing [...] So moving them out of high stress environments, to put them into sort of lower stress to facilitate [...] I've had managers who have shown signs of addiction, sort of either bipolar or manic tendencies, and put them into either professional treatment, advise them to, to seek help and give them avenues to do so. But also, I've been a, literally a counsellor for pretty much every, every person, every manager that I've, I've come into contact with over the last 20 years and being somebody to listen to, but also use my own personal experiences. And my successes and failures within that. To give acceptance, validity, and comfort in. (William)*

Unlike the individuals with mental health issues narratives which focus was upon surviving, managers narratives focus was on how they tried to support individuals to flourish. The

managers in these interviews self-selected and appear to be people management minded and so may have a desire to support individuals to flourish at work. Some of the managers were saddened when they were not able to support individuals to stay and enjoy work. For example, Charles said:

*Just disappointed and frustrated that he couldn't, he had a lot of potential a lot to give [...] and the struggle he was having [...] was holding him back. (Charles)*

Through recording the lived experience of individuals with mental health issues and managers significant issues and factors developed through the data generation and reflexive thematic analysis. These issues and factors were grouped into 11 themes as listed in table six.

Relevant supportive quotes from individuals and managers interviews are used to illustrate the issues and factors and literature is added to further the narrative. Next, is an exploration of the effects that mental health issues can have on work, encompassing both advantageous and negative effects.

## 4.2 Individual cluster of analysis

The individual cluster brings together themes A to D and includes the impact of mental health issues, attitudes, and perceptions, disclosing and diagnosis. See figure five for a visual representation of this cluster.

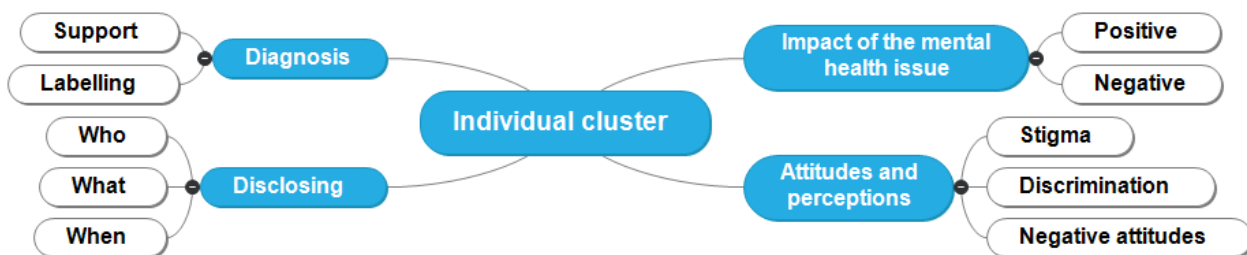


Figure 5: Visual representation of the cluster of the analysis of the individual analysis. Source: Authors own.

These themes will be analysed and contextualised with literature drawn from the narrative review and more recent literature.

#### **4.2.1 Theme A: perceived positive and negative impacts that mental health issues can have on work**

The individuals with mental health issues discussed both positive and negative impacts of their mental health issues on their experiences of work. For example, Grace found that the anxiety she experienced helped her dedication to her job and has aided her career:

*I'm really dedicated in my job, and really dedicated to the kids I work with, and because I know that they're relying on me, my team's relying on me, my staffing team, umm, it almost holds me in check with myself [...] The anxiety almost has aided me in going as far as I have, because it's just that ongoing little, sometimes a kick up the backside, you know? (Grace)*

Similarly, Juliet felt that her experiences with mental health issues made her more passionate about her job:

*Maybe If I hadn't had my past experience, I wouldn't be so passionate about standing up for things [...] It's positive in the sense that I can relate to people better (Juliet)*

Other research also suggests that mental health issues can be beneficial (Hennekam, Follmer and Beatty, 2021b), for example, mental health issues such as schizophrenia and bipolar disorder are associated with holding jobs in the creative professions (Kyaga *et al.*, 2011).

There has also been a link between anxiety and being detail-oriented and hypervigilant, characteristics which are useful in some professions (Bradley *et al.*, 1999). Bipolar disorder has been associated with empathy and realism (Galvez, Thommi and Ghaemi, 2011).

Hennekam, Follmer and Beatty (2021b) conducted qualitative in-depth surveys and interviews with employees who had mental health issues and found 83% of the participants reported positive aspects of their mental health issues. This included being perfectionistic, organised,

having an eye for detail, a tendency to overdeliver, making them high-achieving valuable employees and being empathetic and understanding, which helped them relate to others (Hennekam, Follmer and Beatty, 2021b). It is estimated that one in six workers have symptoms of mental health issues (Lelliott *et al.*, 2008; McManus *et al.*, 2016), and an estimated 1.5 million individuals with diagnosed mental health issues are in work (Stevenson and Farmer, 2017). Further research could look at what parts of the experience of mental health issues can help keep people in work, such as dedication and passion as discussed by Grace and Sue and the strengths found in other research.

For other individuals, their mental health issues had a negative impact on work, especially regarding focus and productivity. Sean stated:

*I find when I get depressed, can't focus as much. I am not as productive. (Sean)*

Sally stated that:

*And I just, in the end, I just kind of gave up. When I went to work, I was just a zombie. I just went to work, did everything on automated pilot. (Sally)*

Lisa discussed that her patience and ability to remain calm were impacted when she was overworked, and this led her to feel more stressed which impacted her mental health issue:

*I think my patience was very affected. Umm, and my ability to remain calm with people [...] And I think, when you're not feeling particularly level-headed yourself, it's difficult to remain calm and listen to someone shout at you and not react. Umm, and I would certainly get more stressed, it's quite common for us to be quite short staffed and overworked, and I would find that very stressful. (Lisa)*

Other impacts of mental health issues included the ability to cope with problems and being forgetful:

*From the very small things like I would have an employee cry on me and I would have to burst into tears in the toilets because I just couldn't just cope with their problems as well as my problem [...] I would be really forgetful, I would not, little things I wouldn't remember to do or, just, like normal things like I would normally remember or would normally be like and it's just really blurry time if you like. (Charlotte)*

The negative impacts of mental health issues reported by the interviewees are consistent with other research. For example, Steadman & Taskila (2015) found a strong association between depression symptoms and performance issues such as cognitive dysfunction, insomnia, emotional distress, and fatigue. Haslam *et al.*, (2005) also found that individuals with mental health issues reported cognitive dysfunctions in concentration, decision making and patience. Recent research has also found individuals with mental health issues reporting trouble concentrating, being sensitive to stress, having difficulties controlling their emotions, and finding it hard to communicate and socialise with colleagues (Thisted *et al.*, 2018).

Previous research has primarily focused on anxiety and depression symptoms, however, some of the individuals interviewed had other mental health issues, such as obsessive-compulsive disorder, post-traumatic stress disorder and bipolar disorder. These can be grouped under the umbrella term of severe mental health issues which also includes schizophrenia and bipolar disorder (OECD, 2012, 2015). Evidence suggests that individuals with severe mental health issues are widely excluded from work at a higher rate than those with anxiety and depression (Mueser *et al.*, 2004; Kilian and Becker, 2007; OECD, 2012; Hakulinen *et al.*, 2020; Gühne *et al.*, 2021). Little is known about the experience of people in work with severe mental health issues. One piece of case study research by Chang (2015), however, has recorded two individuals with severe mental health issues, as discussed in 2.4. Further research is needed though to look at the impact that severe mental health issues

have on individuals' experiences of work and whether they are different from the experience of individuals with anxiety and depression.

For some individuals the workplace was a setting where their mental health issues had little impact. Katie stated:

*it doesn't really have an impact at work because I'm so busy at work. I'm more focused on my patients and my team, and the people around me. I don't really think of myself very much. And it's when I'm not at work that things tend to spiral because I haven't got that focus. (Katie)*

This suggests that work can be a place where individuals do not think about their mental health issues, a place to be busy and get out of one's own head. This may be a reason that employment for people with mental health issues is associated with recovery (Warr, 1987; Llana-Nozal, 2009; Leamy *et al.*, 2011; Doroud, Fossey and Fortune, 2015; Barnay, 2016; Nardodkar *et al.*, 2016). Research has found that employment provides connectedness; hope and optimism about the future; identity; meaning in life; and empowerment (Leamy *et al.*, 2011; Doroud, Fossey and Fortune, 2015). Further research is needed to see whether focusing on work can support individuals' recovery. It may be dependent, though, on the type of work and working conditions, as considered in 2.2 (further discussed in theme K).

In summary, in recording the lived experience of individuals with mental health issues, positive, negative, and possibly little effect of their mental health issues has on work surfaced. These have been uncovered as significant issues for individuals but the association between mental health issues, productivity and performance may not always be negative, contrary to what most literature suggests. Further research is needed, but this implies there is a tension between positive and negative impacts of mental health issues.

#### 4.2.2 Theme B: attitudes and perceptions of individuals with mental health issues at work

The individuals interviewed who had mental health issues discussed the perceptions of mental health issues at work and the fear of stigma and discrimination. The fear is seen in the recruitment process, Margaret said:

*I think really, it's because I, whether imagined or not, I think there is a stigma attached to mental health issues. I think it can be seen in quite a negative manner. And I set myself in the position, as you know, that I've only recently moved, I wouldn't want to be discriminated against on a job application, for example. Sort of negative way. (Margaret)*

Similarly, Rosie stated:

*It just feels like you're going to be judged and you really want the job and if someone comes in who doesn't have mental health problems, not that I don't know who doesn't, but you know, if someone didn't and then looked at me and went um, they would discriminate without a shadow of a doubt they would discriminate because they would go well we can take someone who's a bit of a risk or we could take this person who is just as good and no risk. (Rosie)*

Elijah discussed how, as a senior leader he would like people to disclose mental health issues at recruitment, but is aware that the stigma attached to mental health issues would make that challenging:

*People may be reluctant to declare anything that might prevent them from getting a job, it may change but because there is a stigma on mental health, I suspect people would try to hide it, especially if it was mild Mental health issues. (Elijah)*

Russinova *et al.*, (2011) qualitative analysis of surveys found that employees with serious mental health issues experienced discrimination throughout hiring processes, which is one of the reasons why there is low employment rates for people with mental health issues (Smith and Twomey, 2002; Coutts, 2007; Perkins, Farmer and Litchfield, 2009; Evans-Lacko, Henderson and Thornicroft, 2013; Steadman and Taskila, 2015; Bhugra, Ventriglio and



Pathare, 2016; Stevenson and Farmer, 2017; TUC, 2017). Other research has found that personnel directors and managers are reluctant to hire someone with mental health issues (Manning and White, 1995; Corrigan, Larson and Kuwabara, 2007). Interviews with employers in Sweden, also report that even though they felt that disclosure at recruitment was important most employers would not hire someone who declared having mental health issues during the application process (Porter, Lexén and Bejerholm, 2019), thereby highlighting that the fear of discrimination during recruitment reported by the individuals interviewed is discrimination that they could face.

Individuals also expressed fear about being seen as inadequate and lacking the competence to perform their job effectively. For example, Olivia stated:

*I have always had a major fear of discussing these things with people in the workplace. It relates back a bit to how I think people will perceive me and whether or not that will impact my ability to work and have a career or have enough income to do what I need to do etc. And I've always very much afraid of the stigma that is associated with mental health issues being a problem in my life. (Olivia)*

When sickness absence was discussed in the interviews, a common response was fear to take time off sick. Jasmine stated:

*No, I'm too scared to [...] But I don't think I would have it in me to be able to call down and say "I'm feeling really anxious today, I can't come in" [...] In the back of my head, I know it's no different from calling in with a physical problem [...] I know it's not the case, but I just feel like deficit as an employee [...] It's weird. I have a worry that someone might say "oh, you're not mentally well enough to be at work then". I know that wouldn't happen, but I have a fear of that happening, as well. (Jasmine)*

Another fear reported was being seen as weak:

*I didn't want anyone at work to think that bad of me, that I can be that weak. I know it's not weak but other people don't [...] I don't want, oh has had a fucking breakdown and a wobble, can we fucking trust him? (Liam)*

Katie feared losing her job:

*But as I said, for the whole sickness thing, where you have an episode, and then you have another episode, another episode, another episode, and then you have formal meetings [...] Puts on a lot more pressure and that's the way it makes you feel. But it doesn't do any good for your depression or your anxiety, it just makes it a million times worse because you've got that pressure, that "what's gonna happen?". Are you gonna lose your job? (Katie)*

The stigma and discrimination faced by people in the workplace may, in part, be due to the assumption that people with mental health issues lack both task and social competencies for work (Krupa *et al.*, 2009). Russinova *et al.*, (2011) research supports this. They found that employees with serious mental health issues faced their professional competence being discredited when they disclosed their mental health issues. Perceptions of competence can be influenced by what diagnosed mental health issue is disclosed; individuals with depression and bipolar disorder can be perceived as low in competence and warmth, while employees with anxiety were perceived as low in competence (Follmer and Jones, 2017).

Feeling that mental health issues are not taken as seriously as physical illness and that they can be perceived as not real was also discussed. Alex stated:

*Initially, I held a lot back, because, again, I just felt really embarrassed by it. Like, I never wanted to say that I was like, I had depression. I think it just because, again, at that time, I mean, even now, like, it's still not, I personally don't think it's looked at as seriously as if someone had a broken arm. You know, you can see that it's like, that's the injury, where it's when it's mental its difficult. (Alex)*

Tilly, a manager, also agreed that there is a perception that mental health issues are different from physical illnesses and physical illnesses can be easier to manage:

*I do think that people just find that [physical illnesses] a lot easier to process than hidden disabilities. (Tilly)*

Charlotte also discussed the worry that mental health issues can be viewed as not real:

*It doesn't necessarily manifest itself in the same way so I still think there's still quite a lot of education that is needed for everyone, I don't think it's just managers possibilities, but I think it is changing but like I said the attitudes can still be quite difficult sometimes and people don't always recognise the effect that mental health actually has and the fact that it is a real thing as well. (Charlotte)*

This supports qualitative research that found employees felt that organisations were ignorant about mental health issues including being less accepting and knowledgeable about mental health issues and more sceptical compared to physical health problems (Adams and Oldfield, 2012). This belief is also seen in the wider society, as although mental health issues can be serious psychological conditions they are often perceived as less legitimate than physical conditions (Follmer and Jones, 2018). This may be due to a lack of understanding about mental health issues, how they can present and how people can be affected differently even with the same diagnosis:

*I guess like pretty much everyone like, well a lot of people are affected by mental health issues and like everyone has a different kind of problem as well, it's not like one blanket thing like stress and need to work less [...] I want people to know, I dunno everyone is different, it's not one blanket term and everybody needs. (Juliet)*

The idea that the same mental health issue does not affect everyone the same can contradict the underlying assumptions made by a biomedical approach to mental health issues as it suggests that people's mental health symptoms fit within set criteria and categories that are either present or absent (Widiger and Samuel, 2005; Whooley, 2016), see chapter 2.1 for further discussion on different models of mental health issues. Alternative approaches to diagnosis suggest that mental health issues should be conceptualised as a dimensional, dynamic construct rather than as a discrete diagnostic entity (Hankin *et al.*, 2005; Slade, 2007; Kendler, 2012) as mental health issues are complex and variable (Clark *et al.*, 2017).

This approach could help develop understanding of the complexities and variabilities that individuals with mental health issues experience.

Some managers interviewed were aware of the variability between individuals with mental health issues. For example, Tilly stated:

*I think that obviously, the biggest thing that stands out is that they're all very different. Like I can't summarise the experiences effectively, because it kind of doesn't do justice to the individuals [...] And I think because it's so varied, but I suppose like any aspect of anything to do with any people [...] And that's what makes all the experiences challenging, but also rewarding at the same time. (Tilly)*

Similarly, Amelia stated:

*I think there is so much you need to learn about people to manage them individually because you may have two people with exactly the same mental health condition, but they are managed in different ways because what works for one doesn't work for another. (Amelia)*

Furthermore, Sophie discussed how mental health issues can be less tangible than physical illness and that even for the same individual, symptoms and impact can vary over time:

*I think, certainly, when we're talking about mental health, it's a little bit trickier, because it's less tangible [...] And they might vary from time to time, depending on how people are, are coping with things that are going on for them personally, professionally. And that might vary. (Sophie)*

Jansson & Gunnarsson (2018) interviews with employers also found that mental health issues were perceived as intangible and are seldom explicitly expressed, which makes managing them challenging. Manager's perceptions of mental health issues are important as they can shape workers experience of work due to their involvement in workplace culture and communications, allocating and managing job duties, team development and ensuring that the organisations production/ service goals are met (Kirsh, Krupa and Luong, 2018).

Perceptions can also influence how managers handle processes, especially negative

attitudes, as they can create barriers for individuals seeking and accessing support (Martin, 2010).

A few of the managers were aware of the stigma that individuals with mental health issues can face and recognised it as a significant issue. Gemma said:

*And I think particularly in this sector the biggest challenge we've got is still around stigma.*  
(Gemma)

John discussed how people with mental health issues can be perceived in other areas/departments of his organisation:

*In those sorts of places if you've got a mental health issue then it's oh what a twat, there's a stigma attached to it, whereas up here, we are well versed in how to deal with it.* (John)

Stigma, discrimination, and negative attitudes were discussed by both individuals and managers and surfaced as significant issues for them. Organisational culture can also play a significant role as it can signal what should be done, how work should be carried out and how it can define what managers consider are a problem and what an appropriate response would be (Franklin and Pagan, 2006). An organisation's culture can help managers interpret and initiate organisational policy and procedure and guide their behaviour (Murphy, Cooke and Lopez, 2013). From recording the lived experience of managers and individuals it was clear that an organisational culture that aims to have a culture of care, support, and no blame should be developed. Also discussed was the importance of an individual with mental health issues being respected, being in the organisation for a long time and being a good fit to the organisation

Elijah discussed that looking after people is important to his company:

*Because you want to look after people and we strive to be an employer of choice so it's important to enable that person to get back to work [...] So from a culture point of view it's important that you look after individual people well because if you don't then it undermines the whole culture. (Elijah)*

Adrian discussed having an open culture at work with no blame:

*I think we are fairly open. I'm definitely happy that this is a no blame culture, you know, so yeah, something's gone wrong. You know, but actually, let's look at how we don't let it happen again. Rather than that was your fault. (Adrian)*

Similarly, Oliver said that his workplace has an open culture but acknowledged that not everyone may feel that way:

*Yeah, I think, as an organisation, we're kind of pretty open. But again, it's down to kind of what our core business is. And having said that [...] Can I guarantee all staff would be wanting to come and express everything. Possibly not. (Oliver)*

Even though organisational cultures may be open, accepting and wanting to support employees, Elijah acknowledged that there needs to be further cultural shifts to help make talking about mental health issues a normal thing:

*We are trying to make mental health a normal thing to talk about, that will require a culture shift. (Elijah)*

Tim agreed:

*It has changed for the better, but I still think there's a long way to go.*

Some of the individuals with mental health issues also acknowledged that there were cultural changes about mental health issues at work.

*I think there is a wider acknowledgement that mental health is a big part of life and society nowadays, well forever, but now it's recognised. (Charlotte)*

A few of the managers discussed that how an individual fitted in an organisation can influence what support they get and how flexible organisations are with them. For example, Ben stated:

*I think that organisations exist to support and develop the people who fit in the organisation. I've seen it time and time again. So, people who are not naturally part of the organisation end up being round pegs in square holes. They're made to do things against their will, they're just trapped in a job. (Ben)*

Similarly, some of the individuals with mental health issues interviewed discussed how the type of person you are, was also an important factor. For example, Charlotte stated:

*I think of who you are as person, I think if I hadn't of been so open and honest and engaging I wouldn't have got all of the support I got, if I had come in and been like, or not come in and just been avoiding engagement I think I would, they would have treated me much more firmly and taking me down the absence management route earlier. (Charlotte)*

Ben and Charlotte discussed how being a certain type of person, that fits an organisation can influence the support that is provided. How an individual fits into an organisation may be influenced by the idea of a standard, ideal worker which is a representation of a worker, as described in 2.2.4. An ideal worker is a devoted employee, without outside responsibilities impinging their job, is always ready, willing and able to work, often male, able-bodied with a resilient body, which can conform to the demands of an employer (Acker, 1992; Foster and Wass, 2013; Jammaers, Zanoni and Hardonk, 2016; Randle and Hardy, 2016). Research looked at disabled individuals and the concept of the ideal worker and suggests that organisations focusing on productivity, efficiency and what behaviour makes an individual an 'ideal worker' can exclude people with impairments (Foster and Wass, 2013). This can provide an explanation of the stigma and discrimination by organisations that disabled

individuals face (Foster and Wass, 2013; Vedeler, 2014). Further research is needed to explore the concept of an ideal worker in relation to the experience of work for people with mental health issues.

Another factor discussed is the respect that individuals had within the workplace. Respect was built from how long people had worked in their organisation and how good they were at their jobs. For example, Matthew stated:

*You know, I think, being a bit more mercenary about it, I think had I just been a temporary member of staff, manning phones or emptying the bins every day, I don't really think there would have been as much investment in me, because the turnaround would have been that much faster, you know what I mean? Because of the type of work that it would have been. Whereas, because I'd been at the organisation for a while, I was well known within the office, umm, I'm very good at what I do [...] I think I was more of a valuable resource, than say anyone would be. (Matthew)*

Similarly, Lisa stated:

*the fact that I've been there for 12 years, and I think I can safely say now that I am respected at work, and umm, that I'm a valued member of the department. (Lisa)*

Recording individuals with mental health issues stories of work suggested that fear of stigma and discrimination is a significant issue. This is supported from the managers' perspective. Stigma, discrimination, and negative attitudes appear to be in many areas of work for people with mental health issues: recruitment, being judged, being seen as weak, being less capable, sickness absence, and not being taken seriously. Other research into stigma, discrimination, and negative attitudes support these findings. Managers interviewed in this research also identified negative attitudes and stigma and discrimination faced by individuals. This is similar to other research such as Porter, Lexen and Bejernholm (2019), Jansson & Gunnarsson (2018), and Krupa *et al.*, (2009). Also discussed was the importance of organisational culture and the influence that individuals being seen as fitting an organisation can have. Further



research is needed that investigates organisational culture the influence it has on stigma and discrimination for employees with mental health issues.

#### **4.2.3 Theme C: the experience of disclosure of mental health issues at work for both individuals with mental health issues and managers**

Disclosure can be defined as the deliberate informing of someone in the workplace (Ellison *et al.*, 2003). Many people do not disclose mental health issues to their workplace due to fear of, or prior experience of stigma, discrimination, or harassment (Dalgin and Gilbride, 2003; Gioia and Brekke, 2003; Auerbach and Richardson, 2005; Michalak *et al.*, 2007; Irvine, 2008; Brohan *et al.*, 2012; Lassman *et al.*, 2015; Mental Health Foundation and Unum, 2016; Stevenson and Farmer, 2017; Waugh *et al.*, 2017; Dewa *et al.*, 2020; Barth and Wessel, 2022), as discussed in 2.4.5. The majority of individuals (15 out of 20) interviewed, however, stated that they had disclosed mental health issues at their workplace, their experiences of disclosure, however, were wide ranging. This is a higher rate than previous research that estimated people who felt comfortable to disclose was between 40 to 60% (The Health and Social Care Information Centre, 2011; CIPD, 2016; Mental Health Foundation and Unum, 2016). Recently, a survey of 8,000 UK adults as part of Nuffield Health's Healthier Nation Index report found that 66% of people would not share their mental health issues with their employer (Nuffield Health, 2022). This research potentially observed an increased rate of individuals openly discussing their mental health issues with employers, as they seemed comfortable sharing their experiences. It should be noted that the participants were volunteers who self-selected to participate in the research.

To disclose, or not, is complex and often difficult for individuals with mental health issues (Goldberg, Killeen and Day, 2005; Hatchard, 2008; Wheat *et al.*, 2010; Irvine, 2011; Moll *et al.*, 2013; Lassman *et al.*, 2015; Mental Health Foundation and Unum, 2016; Waugh *et al.*,

2017; Dewa *et al.*, 2020). Legally, disclosing mental health issues can help individuals negotiate for reasonable adjustments and make a claim if they are treated unfairly (Lassman *et al.*, 2015). Research has found reasons to disclose include: being role models, to gain adjustments, and to obtain emotional support. Reasons to not disclose include fear of not being hired, fear of losing credibility in the eyes of others, and fear of rejection (Brohan *et al.*, 2012). Even when people do disclose, research has found that individuals often selectively chose when, who and what they share at work (Irvine, 2011; Moll *et al.*, 2013; Lassman *et al.*, 2015; Mental Health Foundation and Unum, 2016).

For Sean and Liam disclosing at work was important for them:

*Well I just talk about it really, I talk about it at interviews. The reason I am such an attractive employee in this sphere is that I don't see the world in the way everyone else does. I have no innate sense of whether people are happy or not I can only rely on what I see and what they say. That makes me a fabulous social researcher because I essentially do it all the time anyway. So I talk about it as a strength at interview [...] it's a super power. (Sean)*

Liam stated:

*All of them, because I think it is important for people to understand mental health. (Liam)*

Both Sean and Liam's disclosure was part of advocating for individuals with mental health issues in the workplace, with Liam arguing that it is important for people to understand mental health. Moll *et al.*, (2013) institutional ethnographic study found participants discussed the importance of disclosing their experiences of mental health issues at work to challenge the stigma surrounding them. Similarly, a systematic literature review found that being role models for others was provided as a reason to disclose (Brohan *et al.*, 2012). Moll *et al.*, (2013), however, found that for some individuals this type of disclosure was hard work and they did not always feel up to the challenge. In contrast, Brohan *et al.*, (2012) reported that individuals can find concealing their mental health issues stressful. Previous research,

combined with this research, suggests that choosing to disclose mental health issues for individuals can be complex. For example, other individuals reported that they felt their mental health issues were private and did not want to disclose at work:

*And it's quite a private thing, it really is opening yourself up to almost any work colleagues and they're just colleagues, they're not friends. Almost strangers, really. And that is not something that I would feel comfortable doing. Unless it was absolutely necessary. (Margaret)*

James also prefers to keep his mental health issues private as he feels that you do not really know what people think about mental health issues:

*Generally, I kind of operate off a policy of keeping it to myself. I have a particular amount of trust with somebody, because although people are a lot more forgiving now you still don't really know what people think. Whether they go to church, or talk about, spread in a way that you're not happy with. So genuinely I keep it private to be honest. (James)*

Mental health issues being seen as private, none of an employer's business or too intimate to share at work has also been found by earlier research (Brohan *et al.*, 2012; Mental Health Foundation and Unum, 2016). Survey research by the Mental Health Foundation and Unum (2016) reported that even though fear of stigma and discrimination was the most frequently selected reason for not disclosing to work (46%), the second highest was 'because it is none of my employer's business' (45%). This research combined with the interviews of individuals with mental health issues suggests that privacy maybe a significant factor in choosing to disclose or not.

When individuals chose to disclose, it seems that they made choices regarding the details they share, the recipients they share with, and the timing of the disclosure. For example, Lucas discussed the selective disclosure of specific diagnoses, as he held the belief that certain diagnoses may not be appropriately managed:

*I don't believe it is something that would be dealt with or respected or handled correctly. I think it would give an opportunity to be utilised against me. Because of the environment I work in. I work in an incredibly competitive, aggressive work environment therefore even the alcoholism that is something that is prominent in my industry, it is referenced, it is aware of it but it is definitely seen as a weakness rather than something that is to be managed and looked after. (Lucas)*

This is similar with research findings from Moll *et al.*, (2013) where individuals selectively disclose information to be strategic about what content is disclosed. Brohan *et al.*, (2012) systematic literature review called this type of disclosure partial disclosure, and it is when individuals disclosed either selective information e.g., disclosing that they have a mental health issue but not the specific diagnosis and choosing to disclose specific diagnosis like depression rather than schizophrenia. Partial disclosure also includes disclosing only a physical illness when there are mental health issues present as well (Brohan *et al.*, 2012)

Moll *et al.*, (2013) report that one of their participants were less likely to disclose an addiction as they felt it would have a greater risk on their reputation. Whereas Lucas felt that in his industry- hospitality- addiction, especially alcoholism was prominent and therefore was strategic in disclosing addiction rather than disclosing his diagnosis of manic depression which he felt would not be respected or handled well.

Another decision some individuals with mental health issues make is to whom they inform.

For Olivia she informed her line manager:

*Informal one to one with my official line manager just as a sort of closed office door conversation. (Olivia)*

Dewa *et al.*, (2020) survey research completed by Dutch workers found that almost 75% of workers would disclose a mental health issue to their manager largely because of the relationship with their manager. This research also found the relationship to be important in

the decision to disclose (Dewa *et al.*, 2020). Previous research and this current piece of research suggests that the relationship individuals with mental health issues have with their manager can play an important role in the decision to disclose.

Five individuals discussed talking to colleagues at work about their mental health issues. For Rosie and Matthew, they first disclosed to colleagues and then after to their managers. Rosie stated:

*I disclosed to a colleague initially after the event had happened and then to my line manager sometime down the line. (Rosie)*

Matthew had a similar experience:

*eventually did start talking to a couple of people at work about it. Initially just a colleague, who was a friend of mine, quite close to. And she very quickly put wheels in motion for me to meet with my then line manager, and sort of take it from there really. (Matthew)*

This research has found that individuals had positive experiences disclosing to colleagues, however, Moll *et al* (2013) observed that participants received explicit messages from colleagues about the unacceptability of disclosure. These messages were warnings not to disclose personal experiences of mental health issues (Moll *et al.*, 2013). Similarly, Irvine (2008) report that there was also a general sense that colleagues were uncomfortable with discussing matters of mental health, in part, due to a lack of understanding or negative perceptions of mental health issues. Collaborative case study research also found that colleagues were uncomfortable when an individual started to talk about their mental health issues and recommended that they not talk to other staff members (Bergmans *et al.*, 2009). The differences between previous research and this research, in part, may be due to different methodological choices as Moll *et al.*, (2013) and Bergmans *et al.*, (2009) both utilised a case

study approach. As discussed in 3.1, a case study approach to this thesis was not taken as the focus of the research was the individual and their experiences.

Four individuals described other people at work that they disclosed to. For example, Juliet:

*I think I have, to occupational health but not directly to my kind of line manager or anyone in my clinical team. (Juliet)*

Grace, disclosed to a nurse whom they had access to through their workplace employee assistance package:

*So I've had a couple of health check-ups in the last two years with a nurse, and they just do things like, you know, check your bloods, see how you're doing, have a little chat, and it's [...] I've actually found that really helpful [...] And so, she kind of, having access to that person who came into the school, confidentially, anonymously, to kind of just have a little chat, was really helpful. (Grace)*

Selectively choosing whom to disclose to has been reported by other researchers (Irvine, 2008, 2011; Moll *et al.*, 2013). Irvine (2008) found that people with mental health issues partially disclosed in two ways, either through formal ways with HR or Occupational Health departments holding this information on record, but line managers or colleagues were uninformed. On the contrary, there were people who had talked to close colleagues but had not disclosed mental health issues to HR, senior managers, or Occupational Health Services (Irvine, 2008). The first route of partial disclosure can be seen in the interview with Juliet and Lucy who filled out a general health form when she started her job:

*you fill out a form and it gets sent to the nurse and she signs it off [...] It's a general health one which includes various things like when jabs and you then disclose when you have any mental health and that can be followed up with the nurse if she thinks you're a concern. (Lucy)*

In the data generated for this thesis managers, colleagues and occupational health or other health professionals at work were whom the individuals disclosed to.

Many of the individuals interviewed also selectively chose when they disclosed. Elizabeth disclosed to her manager her social anxiety due to grief from bereavement:

*So, when my parent passed away obviously I had to let them know that I got depressions but that was like depression relation with grief. So, I let them know about that and also let them know because of social anxiety. (Elizabeth)*

For others it was part of the sickness absence process, Charlotte stated:

*So, we have a standard sickness absence reporting line at that time, um so when I was formally diagnosed, I was actually off sick from work. So, um we basically have to phone in a number. It's an automated system, so you um like yeh go through a series of questions of answers 1, 2 or 3 um and then um one of those options where it says what's the reason for absence. One of the options is mental health so I clicked on that one and then basically on day four if you're still off sick on day four you have to phone in again and then at that point you're put through to our occupational health department so it's fully confidential and everything your manager just gets a notification to say you're off sick and that it's a mental health condition. (Charlotte)*

For Lucy she disclosed as part of her back to work routine after three weeks of sickness absence:

*A few years ago, when I got diagnosed with the stress-related conditions, having had 3 weeks off as sick leave, I disclosed everything about my own point of how I was feeling, it was a part of my back to work routine. (Lucy)*

Research has found that people selectively time when to disclose (Tse, 2002; Irvine, 2008; Brohan *et al.*, 2012; Moll *et al.*, 2013). Where people had informed new employers, it was often done at the time of interview, through a medical report or questionnaire required at the appointment on the job (Irvine, 2008), like the health questionnaire Lucy described. For people who disclosed during employment in Irvine's (2008) interview research disclosure of mental health issues arose in a variety of circumstances including explaining reasons for absence and voluntary sharing information when experiencing problems. For those who disclosed due to absence they often felt that they had to disclose to their employer and the

information can be provided by the individual themselves or through G.P.'s fit to work notes (Irvine, 2008). In my research both Charlotte and Lucy disclosed their mental health issues as part of their sickness absence and return to work. Other studies report that individuals with mental health issues strategically time disclosure to wait until there is a point at which the individual feels secure in their position with their colleagues before disclosing (Brohan *et al.*, 2012). Similarly, Tse (2002) practical guidelines for people with bipolar disorder suggest that some people may want to wait for a period of time before deciding to disclose in order to have the opportunity to prove themselves first, and to develop social support networks within the workplace.

Individuals who did not disclose provided fear of stigma and discrimination as their reason.

For example, Margaret stated:

*it's because I, whether imagined or not, I think there is a stigma attached to mental health issues. I think it can be seen in quite a negative manner [...] I think people do look at you in a different light somewhat. (Margaret)*

For James it was a fear that disclosing his mental health issues would impact his chances of gaining employment:

*I felt that it would jeopardise my chances of getting a job. (James)*

Fear and or experience of stigma and discrimination have been found in past research to also be a significant reason why people do not disclose (Michalak *et al.*, 2007; Brohan *et al.*, 2012; Martin, Woods and Dawkins, 2015; Elraz, 2017; Waugh *et al.*, 2017; Dewa *et al.*, 2020). As discussed in section 2.4.5. Research that explored the impact of bipolar disorder upon work function found that people chose not to disclose due to previous experiences of stigma and discrimination including some narratives that people lost their jobs following disclosure (Michalak *et al.*, 2007). Brohan *et al.*, (2012) reported that there were six key reasons why



people did not disclose: fear that they would not be hired if disclosed, fear of unfair treatment in the workplace, worry that they would lose credibility in the eyes of others, worry that anti-discrimination legislation is either irrelevant or unsuccessful in preventing discrimination, fear of gossip and being rejected or ostracised due to a person's mental health issues. Similarly, Dalgin and Gilbride's (2003) focus group research found that individuals with mental health issues described concerns about the way disclosing to an employer could result in a change in supervision, isolation from co-workers, termination, not being hired, lack of opportunities for promotion and a need to work harder than others to prove one's worth. Deloitte (2020) report that one in ten of individuals who disclosed a mental health issue were dismissed, demoted, or disciplined, suggesting that people's fears of stigma and discrimination can be correct. This previous research and the current research project highlight that fear and or experience of stigma and discrimination are reasons for not disclosing at work.

Deciding to disclose at work can be challenging for individuals with mental health issues due to several factors as discussed. Managers can be the first point of contact for employees and for some, the person they disclose to. The managers interviewed talked about their experiences of individuals disclosing mental health issues to them. Natalie stated:

*It's a very challenging thing to see and hear when you can empathise so much but at the same time have little to no power to provide more formalised support. (Natalie)*

Sue also found some experiences of being disclosed to difficult but, also has feelings of pride knowing that she was part of someone's recovery journey:

*Sometimes it's fine, and it's okay [...] And other times it's really difficult, and I've finished meeting with someone, and I've gone to the toilets and I've cried about it. Cos it's hard, it's hard. I do sometimes carry a lot of, people offload onto me and they walk away feeling like they've released a little bit and it's better, and I'm like "ooh, am I carrying this all of a sudden" [...]. On that side of things. I've had a situation where someone's said they needed to talk to me, and then said that they had attempted, or considered suicide. Which was the most*

*difficult one that I've ever had, which led to the toilet crying scenario. But at the same time, some super pride feelings, I guess, after it all, that I'd been able to be part of someone's journey to recovering from that really difficult moment. (Sue)*

Elijah discussed the need for disclosure to happen at recruitment to check that the job role is right for the individual and to be able to put in support from the start of the job.

*So ok you've got mental health issues, but you didn't tell us before you started so that made it difficult for us because we couldn't check that it was the right job for her. (Elijah)*

Elijah goes on to say that he thinks that disclosing at recruitment may be hard due to possible stigma so he suggested induction may be a time when people can disclose a mental health issue:

*I'm not sure how effective it would be if we did because people may be reluctant to declare anything that might prevent them from getting a job, it may change but because there is a stigma on mental health, I suspect people would try to hide it, especially if it was mild Mental health issues. So, it's good to create an open culture to talk about it but I'm not sure a specific question at an interview panel would be effective, they might think this is not a question from a caring employer and it might prevent me from getting the job. I can't think how you would include it in recruitment, it's probably more for induction and that might feel less threatening. (Elijah)*

Not discussed in the narrative literature review but Pettersen and Fugletveit (2015) also found that business leaders wanted more openness in the hiring process in relation to any mental health issues job seekers had, however they were also unsure whether job seekers would state that they have or have had mental health issues. Employers need to consider that under the Equality Act 2010, job candidates are not required to disclose a mental health issue to their prospective employer, and it is also unlawful to ask applicants questions about health during recruitment, except in very limited circumstances (CIPD, 2022). Disclosing at recruitment for individuals can be risky as applicants with mental health issues were rated as less employable by employers than either a candidate with a physical disability or a candidate

with no disability (Glozier, 1998; Gouvier, Sytsma-Jordan and Mayville, 2003; Corrigan, Larson and Kuwabara, 2007; Brohan *et al.*, 2012; Follmer and Jones, 2018).

Other research has also found that managers not only become aware of mental health issues through disclosure but also through performance issues, changes in behaviour, and difficulties with social relations (Martin, Woods and Dawkins, 2015; Jansson and Gunnarsson, 2018; Kirsh, Krupa and Luong, 2018). The interviews with the managers for this thesis did not explore when managers became aware, apart from through disclosure. Further research could explore how managers react and behave to different ways of becoming aware of mental health issues.

Managers discussed ways that they tried to support individuals when they had disclosed. For both Charles and Natalie, they tried to support with analysing the situation and providing practical suggestions for the individual:

*I'm quite analytical so I was like right, this is what's going on in a situation. (Charles)*

Natalie also tried to create a safe space:

*I would most often try to provide a safe space for people to talk, and then suggest practical things that could happen to help at that time. Like time off for appointments, time off for rest, removal of duties that might be anxiety inducing for example public speaking etc. (Natalie)*

Recent research discussed what supportive and unsupportive behaviours individuals with mental health issues report (Barth and Wessel, 2022). Supportive behaviours included: emotional and appraisal support, informational support, and instrumental support whereas, unsupportive behaviours identified were: being unsupportive, denial of symptoms and assistance, avoiding, or behaving negatively in the future (Barth and Wessel, 2022). It appears from the interviews with managers that they did react to disclosure with supportive

behaviours. Further research is needed looking at behaviours that can be supportive and unsupportive for individuals who disclose mental health issues and how managers perceive their reaction.

To summarise, in recording the lived experience of individuals with mental health issues, deciding to disclose or not is an important issue but disclosure appears to not be an all-or-nothing process. People can disclose selectively and strategically by deciding what they say, when they say it and to whom. What is said, when it is said and to whom are influenced by multiple factors. It has also been found that reasons to disclose include wanting to be a role model, to gain adjustments, and to obtain emotional support. Reasons to not disclose, however, include fear of stigma, discrimination, and negative perceptions in recruitment, treatment at work and being fired. There is a tension between disclosing and not disclosing to protect from stigma and discrimination. This tension may be managed by individuals by selectively and strategically deciding what, when and whom to disclose to. This strategy demonstrates an attempt to balance disclosure being helpful and the fear of stigma and discrimination when disclosing. This is an example of a both-and response to managing tensions by adjusting where different elements can be seen as important and accommodation of the elements are pursued (Jarzabkowski, Lê and van de Ven, 2013; Suter, Irvine and Howorth, 2022).

For managers, individuals disclosing to them can be challenging as it can be very upsetting but can also lead to feelings of pride knowing that they were part of peoples' recovery journeys. There also appears to be a tension in that managers wish individuals would disclose at recruitment to ensure that the job is right for them, and support then can be put in place but that employers rate candidates with mental health issues as less employable. This research, though, did not explore further into how managers and employers manage this tension.

#### **4.2.4 Theme D: Diagnosis/ labelling of mental health issues can be a significant issue for individuals and managers**

A range of mental health issues were described by the individuals interviewed, from anxiety, depression to post traumatic stress disorder and borderline personality disorder (see table four in the methodology chapter). The individuals had been diagnosed by either a G.P. or a psychiatrist, this was an attempt to have boundaries with the research conducted but it does situate part of the thesis in the biomedical model approach to mental health issues. The biomedical model currently dominates how mental health issues are diagnosed (Crossley and Crossley, 2001; Widiger and Samuel, 2005; Deacon, 2013) and is based upon a categorial understanding of mental health issues that are present or absent (Wichers, 2014; Whooley, 2016). See section 2.1.2 for further discussion on the biomedical model.

For some of the individuals with mental health issues interviewed having a diagnosed mental health issue helped them with seeking help and having better support from work. For example, Elizabeth stated:

*Yes, I mean I know that I I'm not the only one, the experiences I personally have been good, I know it's not the same thing for everyone, but personally I know that they will support me with those issues. I think generally the support is better received if I have like actual proof that I have problems [...] I think if I was to go in there and say I have some issues with social anxiety disorder and here is an actual piece of paper saying on it I think that's when they kind of click a lot more. (Elizabeth)*

For Sally diagnosis was a relief for her as it made her feel more normal:

*It was actually a huge relief. Because I had a diagnosis. I had, you know, I said "the doctor said that I need to try and keep my life normal", but I just said "it feels good to actually know that I'm not going absolutely crazy". It's normal. Like, I'm not, you know, just [...] Umm, you know, I'm not just making it up, it's not in my [...] Although it's in my head, it's out, it's totally normal. It's, you know, the doctor was really helpful. (Sally)*

Sean stated that he had experienced less bullying or harassment after diagnosis:

*I think I experienced more of that before my diagnosis and before I was overtly public about having a disability. In fact I think I got a get out of jail free card which I've never had to play but it does feel that people treat me differently when they know I have a non-visible disability, by differently, I mean better. (Sean)*

Unlike the critique of the biomedical model in section 2.1.2, labelling of mental health issues can help some individuals orient themselves, like Elizabeth, Sally, and Sean as it can provide better understanding of the problems people face, better knowledge of what support they can access and what needs to be done to help with recovery (Angermeyer and Matschinger, 2003). Research has also found that diagnosis can be empowering for some individuals as they have a recognised illness, which can be used to gain access to possible resources (Yanos, Roe and Lysaker, 2010). Role theory points to these positive effects of labelling but also that if mental health issues are seen as an illness, it can help individuals be seen as a patient in need of help and reduces the responsibility the individual has on their illness and so should result in more acceptance of those with mental health issues (Angermeyer and Matschinger, 2003). Labelling individuals with mental health issues, however, can have negative effects as it can trigger the negative stereotypes and attitudes of mental health issues (Angermeyer and Matschinger, 2003). As discussed in 2.1.2 these can be ideas of deficit, dysfunction, danger, and incompetence (Beresford, 2002; Perkins and Rinaldi, 2002; Angermeyer and Matschinger, 2003; Corrigan, Kerr and Knudsen, 2005; Wakefield, 2007; Follmer and Jones, 2017, 2018). This view that mental health issues are a negative phenomenon and are tragic for the individual experiencing them and for those around them is a pervasive perception in society which therefore percolates into the workplace (Chadwick, 1997). For many individuals interviewed, though, diagnosis was helpful. This difference could be due to individuals self-selecting to be part of this research and appeared to be happy talking about their experiences and diagnosis of mental health issues. This implies that there

is a tension between diagnosis and the labelling of mental health issues being helpful in accessing resources and feeling more normal, and on the other hand, negative attitudes and perceptions of mental health issues being rife in society and work.

For some of the other individuals interviewed, though, they did not like their diagnosis of mental health issues defining them, such as Matthew:

*Yeah. And you know, apart from anything else, like, in my own experience at least, I don't. As I sort of eluded to before, I don't like being defined by that. (Matthew)*

Similarly, Jasmine stated:

*I have a massive fear of it taking over my identity. I always have. I have such a fear of losing my identity to it. (Jasmine)*

Avoiding the label of mental health issues is an important part of how stigma can impact individuals with mental health issues as there is an attempt to avoid the negative consequences of the stigma associated with mental health issues (Stolzenburg *et al.*, 2017). Research has found that many people diagnosed with mental health issues are aware and concerned about others' stigma and expect to be discriminated against (Thornicroft *et al.*, 2009; Krajewski, Burazeri and Brand, 2013). There are possibly three ways in which awareness of stigma can impact on an individual's self-concept and depends on the degree to which the individual believes the negative perceptions and stereotypes of mental health issues and how much the person identifies with the label of mental health issues (Corrigan and Watson, 2002). The three ways are: indifference, righteous anger, and self-stigma. The first two are unlikely to affect the self-esteem of an individual, self-stigma is likely to impact self-esteem (Yanos, Roe and Lysaker, 2010; Corrigan and Matthews, 2015; Yanos *et al.*, 2020, 2021). Self-stigma is consistently reported by many people with mental health issues

(Brohan *et al.*, 2010, 2012; Yanos, Roe and Lysaker, 2010; Evans-Lacko *et al.*, 2012). The illness identity model conceptualises how self-stigma can impact individuals with mental health issues as it theorises that self-stigma can damage a person's identity, reduce hope and self-esteem and can lead an individual to believe that there is no possibility for recovery (Yanos, Roe and Lysaker, 2010; Yanos *et al.*, 2020, 2021). This can lead to reduced engagement with help and support, increase risks of suicide and suicidal ideation and poorer social and occupational functioning (Yanos *et al.*, 2020, 2021). Further research is needed to look at individuals with mental health issues in work self-stigma and the impact it has on them. Even though both Matthew and Jasmine did not want their diagnoses to define them they both had sought support at work and engaged with services offered.

Sally stated that the doctor she saw when she was diagnosed was very helpful. This was the case for others, including Margaret who said:

*I sort of noticed it myself, to start off with. And then I approached my university to sort of talk through what I might be feeling. And then they recommended that I go to my GP, which I then did, and got the help I need. (Margaret)*

For many individuals, though, there was a lack of support. For example, Grace stated that accessing support was challenging for her due to lack of support and being taken seriously by her G.P:

*and I have these problems, but I'm not actually going to be taken seriously. (Grace)*

Similarly, Alex stated:

*And I'd gone to the doctor, maybe two weeks prior. The doctor I'd seen she was just like, really like, no, cuz I was like, well, you know, some people have said to me, like, maybe I'm depressed and they were like, you're not depressed. You're not depressed, you just lack control in your life. And that sucks. (Alex)*



Long waiting lists for support through the NHS were also discussed as significant issues for individuals. Lisa described the long waiting lists:

*I didn't have the best experience with that [laughs]. Very, very long waiting list for what I needed. Umm, and then they stopped, the person that I was seeing stopped working for them, so [...] Wasn't the best. (Lisa)*

Mary stated that she had been on a waiting list for two years for support with her borderline personality disorder diagnosis:

*A lot of that is because I'm not, I haven't received any professional help for borderline personality disorder yet, so even I don't understand it majorly. [...] I've been on the waiting list for two years. [...] It's more just like, "oh you're still struggling, you're still on those meds, carry on waiting". I'm on a waiting list for dialectal behavioural therapy, which is apparently the main thing for BPD. (Mary)*

There have been years of underinvestment and austerity related cuts to mental health services and provisions (Turner *et al.*, 2015) that has led to longer and longer waiting lists (Almond, Horton and James, 2022). Seeking help and support for mental health issues can be beneficial (Mental Health Foundation and Unum, 2016) but there can be structural challenges in accessing services for individuals with mental health issues (Almond, Horton and James, 2022). A tension was identified between seeking help and support for people with mental health issues and the difficulty in accessing services. Further research is needed to explore this tension for people in work, the impact it can have and how people are managing the tensions.

Interviewed managers discussed how supporting individuals with a diagnosed mental health issue can be easier than supporting an employee without a diagnosis as, for Ben, it can create an audit trail and for Angela it can change the way she manages.

Ben stated that having a diagnosis can help manage individuals:

*The issue for me is the people who have an undiagnosed mental health issue are the real problem because once it's diagnosed there is some sort of audit trail about what is the best way to deal with a situation. (Ben)*

Angela discussed how someone having a mental health issue changes her managing behaviour:

*I'm always mindful of what I ask of people. I try to make sure they are motivated and have meaningful work but when it comes to mental health it takes you in a different direction, so it's is there something I can do to help, to take the pressure off, will it be helpful if I takes this task away. You start to see the bigger picture. You instinctively go, right, what's the problem, what can be done about it, which angle can I actually help with. And, yes, I do think you suddenly go to another level of caring, trying to help fix the problem in the area that you can. (Angela)*

Similarly, Sue stated:

*I guess, a formal diagnosis is [...] I wanna say helpful, but I don't mean helpful. [...] The diagnosis is helpful. An ongoing, ongoing absence without a diagnosis, but somebody saying it's depression or anxiety can be more difficult, because, you know, you'll say then about "have you been to your GP? What support are you getting?", and then if somebody's not getting support for that, like, "I'm just managing it by having a duvet day", for example, I know we do hear those examples, don't we? Umm, and it becomes more, I dunno. Not that I'm an advocate of everyone getting a diagnosis, for goodness sake [...] There is a difference for me, in my mind, about how those things would be managed. (Sue)*

Further research is needed to look at how managers manage individuals who are having challenges and symptoms of mental health issues but do not have a diagnosis, compared to those with a diagnosis. From this current research it would suggest that there is a difference, but why there is a difference needs to further research.

Tim discussed how he struggled with telling the difference between when a person was struggling with their mental health and when a person was using that diagnosis as an excuse:

*And I think that my own observations, and I'm not at all an expert, is that where's the line between, where's the support, or where's the help, or the guidance for the line between this is a person struggling with a mental health problem, and this is a person using a mental health diagnosis as an excuse [...] And that's where I struggle. Because I've often felt like I've been*

*on that line, and with that particular individual, as an example, and struggled with it, because I don't know what to do with it. (Tim)*

Further research is needed to look at this possible challenge that Tim discussed, looking at manager perceptions of mental health issues and attitudes towards people with and without a diagnosis.

During the recording of the lived experience of individuals and managers the diagnosis and labelling of mental health issues was identified as a significant issue. For individuals with mental health issues, it can be helpful as it helps them feel more normal, access support and receive less bullying and harassment. Diagnosis, however, can lead to stigma, discrimination, and self-stigma. This suggested that there is a tension between diagnosis and the labelling of mental health issues being helpful and on the other hand negative attitudes and perceptions of mental health issues rife in society and work. Some individuals also discussed how the G.P. and the NHS can be a source of support but for others they discussed long waiting lists. For managers, employees having their mental health issues diagnosed can be helpful and for some change how they manage that individual but further research is needed.

### **4.3 Social/ relational cluster of analysis**

The social/ relational cluster of analysis includes themes E to G and so comprises managers experiences, managers behaviour and characteristics and colleagues. See figure six for a visual representation of this cluster.

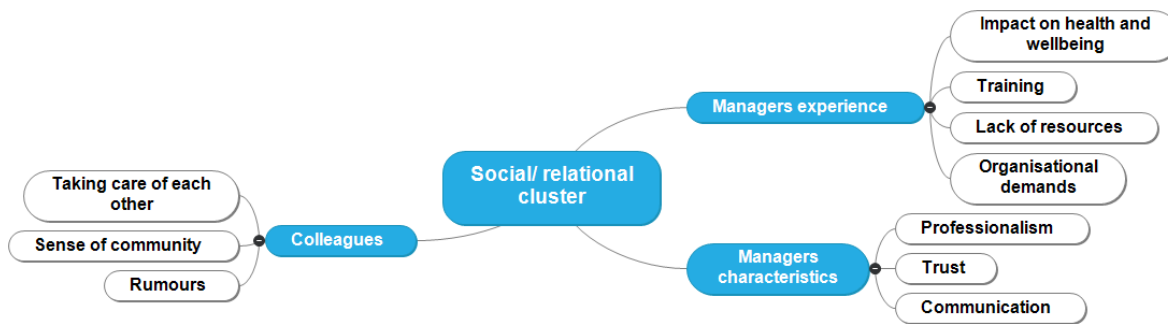


Figure 6: Visual representation of the social/relational cluster of analysis. Source: Authors own.

### 4.3.1 Theme E: Enabling and challenging factors managers experience when managing individuals with mental health issues

During the interviews with managers, many discussed their experiences and what challenges they encountered, including the emotional impact it had on themselves, no training, lack of resources, lack of authority and needing to balance the demands of the organisation and team with the needs of the individual. A few managers also discussed the factors that helped them when supporting employees with mental health issues, including support from their own manager, HR and effective training.

Managers reported a range of experiences of managing people with mental health issues with some having a lot of experience like Sue:

*I've done it a lot, I've got a lot of experience, so I am a Wellbeing Champion, as well as a manager. So, yeah. I have a lot of experience of that, and sometimes it's fine, and it's okay.*  
(Sue)

Others have been in a management role for a short period of time but have already experienced challenging situations e.g., Susan:

*in my less than a year, I've had some quite interesting situations. So, within my first. My first week [...] I had, what my line managers said was probably the trickiest situation he's ever had to deal with. (Susan)*

No matter what experience managers had, the challenges of managing individuals with mental health issues was consistently discussed. These included: negative impacts on the managers themselves, little specific training, no power to support, lack of resources, business demands and managing the impact on the rest of the team.

Sue talked about the impact having conversations with individuals about their mental health can impact her:

*Cos it's hard, it's hard. I do sometimes carry a lot of, people offload onto me and they walk away feeling like they've released a little bit and it's better, and I'm like "ooh, am I carrying this all of a sudden" [...] I've had a situation where someone's said they needed to talk to me, and then said that they had attempted, or considered suicide. Which was the most difficult one. (Sue)*

Worry about the impact of their own behaviour and words were discussed by some of the managers. John stated:

*I just know that my worst fear is that if the individual goes off and does the unthinkable, I'm going to spend the next couple of weeks wondering if it was something I said that pushed him over, so I'm trying not to push too hard, but at the same time I don't want to be seen to be doing nothing more than what are we supposed to do. (John)*

Tilly said:

*And I remember the first time that I had a sales assistant, telling me that she wanted to kill herself, and that she didn't think that she deserved to live, and because of a series of very difficult situations that she'd experienced. And I was trying to reassure her and tell her that that stuff is okay [...] I was just so worried that I might have said the wrong thing. And I said, I sent her home because I knew that she couldn't work. But then I was worried that she might do something stupid when she was at home. (Tilly)*

A few of the managers also talked about how they took the worry and stress home with them at the end of the working day. Tim said:

*And I would often then go home myself and worry about it, stress about it, how am I gonna deal with this? [...] And, you know, you start thinking about, what else could I have done? What else could I have said? And you know, so, it bugs me that I wasn't able, I don't even feel like I made any impact. None at all. And, you know, it was, and over time, you know, you then, it then starts impacting me. (Tim)*

Sophie discussed that fear of legislation can be a barrier for managers:

*Because mental health particularly has legislation attached to it, and people are scared, I think, to, you know, to cross any barriers and think, oh, what if I do that, and I get in trouble, or, you know, you can't possibly call them. (Sophie)*

There was little discussion of legislation by managers except in the discussion of reasonable adjustments, see section 2.3.2. Further research is needed to develop an understanding of managers' awareness of legislation associated with mental health issues at work and how they feel about legislation. Sophie may have a higher level of awareness of legislation as she a HR consultant.

For Emma, a challenge was an increase in her workload:

*This one in particular was making work difficult for her and for her colleagues who were then coming to me and my workload shot up as it became very apparent that they weren't coping very well. That's ok for a little while but when you are working in an intense job role anyway with children with complex needs then the effects become a lot more, what's the word, compounded and things get more fraught. (Emma)*

These worries and the impact of managing individuals with mental health issues may be reasons for why research found that managers find it challenging to provide support to the individual and manage their own personal health and wellbeing (Kirsh, Krupa and Luong , 2018; Martin, Woods and Dawkins, 2018). Interview research by Kirsh, Krupa and Luong

(2018) found that managers can pay an emotional price when supporting individuals with mental health issues. Successfully supporting an employee to regain their function at work, though, can bring a sense of satisfaction and pride for managers (Mizzoni & Kirsh, 2006; Peterson, Gordon and Neale, 2017; Jansson & Gunnarsson, 2018; Martin, Woods and Dawkins, 2018) and can even enhance a manager's skills, competencies, and confidence (Martin, Woods and Dawkins, 2018; Suter, Irvine and Howorth, 2022).

There are, however, many other challenges that managers' report impact their ability to manage individuals with mental health issues. Many of these challenges lead managers to attempt to balance the needs of the individual, other employees needs and organisational demands. This supports recent research by Suter, Irvine and Howorth (2022) that found similar tensions for managers in small and micro businesses.

Many managers reported that they had no specific training on mental health issues. For example, Natalie stated:

*Like I have not had any training on managing people let alone mental health, mental health issues. (Natalie)*

Thomas said:

*We've never had any proper training at all. (Thomas)*

This supports research by Shankar *et al.*, (2014) that found interviewed employers in Canada were not trained to manage people with mental health issues. They also found that employers felt that their job was not to recognise warning signs as they were not mental health professionals even though the majority of those interviewed had previous experience of managing people with mental health issues (Shankar *et al.*, 2014).

For other managers, even when there was training, it was not helpful for them. For John, this was due to the training being delivered through an online format:

*The organisation put us on a mental health awareness course but unfortunately it was an online thing and you just answered questions at the end [...] To be honest I've forgotten all that because I don't learn that way. (John)*

William found the training to be ineffective because its underlying emphasis was on learning strategies to evade consequences for certain actions.:

*Our training is about how to, how to prejudice without prejudice. Getting away without getting caught [...] How do you discriminate against somebody with a disability by not referencing their disability [...] It's not as blatant as that, but it is as clear as that, like. (William)*

William is the only manager who discussed this idea of 'getting away without being caught', but it may be an important and significant issue for managers. By the very nature of the message, though, the true scale is unlikely ever to be known due to the difficulty in researching it and measuring it. William may be the only person who mentioned this as the industry he works within has a notoriously high turnover- an estimated 30%, double that of the UK average (UK Hospitality, 2022).

A lack of resources including support from senior managers and HR and time were also reported as significant challenges for many interviewed managers. Amelia stated that she had no support from those in roles senior to her but had amazing support from her team:

*For me personally I have such a supportive team, we are all pretty amazing and look after each other but not those above us. (Amelia)*

Natalie stated that a lack of HR support, guidance and policies led to mistakes being made:

*So it was a small organisation so I was effectively HR in my role and there wasn't any further support there. There was no guidance and no policies or anything like that. Management was very informal but that also meant that a lot of mistakes were made. (Natalie)*



Another challenge reported by some of the managers was a lack of power to support individuals:

*But I would say that there are instances where you feel that you can't support them. And I think that's, that's obviously the harder the hardest situations. (Tilly)*

Angela discussed a period at work where she had no support and no power to make decisions and the severe impact it had on her own physical and mental health:

*I've gone through a period of time where there was nothing. I sat as a manager with all the responsibility but none of the authority. I took everybody's moans, groans and problems on myself and I had nowhere to go with it. I shouldered it all for the best part of a year and it broke me. I ended up off work for over a month. Completely broken as a person, mentally, physically, emotionally, there was nothing left of me. It has me a while to bring myself back up [...] But it absolutely destroyed me, no two ways about it. (Angela)*

Lack of time to give to people management was another challenge discussed by many of the managers interviewed. For example, Thomas stated:

*And we cannot sadly spend as much time on the wellbeing or upkeep of the staff that we used to [...] But obviously, now, our attention is so strung out that we haven't got time, as much as we need to, we know we need to, and we want to. (Thomas)*

Furthermore, Gemma stated:

*It takes a lot of hours out of the day but because our resources are being stripped thinner, we are told on the non-clinical side we don't have time to do to quote loosely, we don't have time to do the nice to have anymore. Just do what is business critical. (Gemma)*

Lack of time for managers was perceived to be driven by organisational demands which were often placed as more important than people management by organisations. Sue stated:

*Cos at the end of the day, when you are a manager, you're, you've got the two [...] You know, the two hats on, haven't you? You have the organisation, it's my responsibility to manage a budget, manage outcomes, you know, and whatever reason it's for, absence, equals impacting on both those things. (Sue)*

John also acknowledged the demands placed on him by the needs of the operational side of the organisation:

*It's mainly, yes, operational demands. (John)*

This tension was reported by all the senior leaders interviewed as the support offered to employees had to be balanced with the demands of the job role, colleagues, and organisational demands. Adrian stated:

*What can I do then to help? The role is still the role, though, I can't adapt it, as I said, so far that it is no longer looking after children with severe learning difficulties, because that's what the job is. (Adrian)*

Similarly, Oliver stated:

*But it is a balance between, you know, looking after the interests of the person and what makes it easier for me, it's not just the interest of the institution, there are children, they are the most most important thing. Whereas if I was in a different business, you know, doing something in the interests of a client over there. They can lump it, the kids are more important than that. (Oliver)*

For Elijah it is about being fair to everyone and the company:

*So we often talk about, ok, we are a considerate company but it's not just being considerate to one person it is also to the whole company, the team, the finance so using the value overtly what does that mean for that one person and for it to be fair for the whole company. (Elijah)*

The tension between organisational demands and employee needs and wanting to support the individual has also been reported by other researchers. For example, Suter, Irvine and Howorth (2022) research on small and micro businesses found that managers reported tensions between the individual with mental health issues and the needs of the organisation. These tensions can lead to managers feeling like they must perform a balancing act in which the needs of the employee, co-workers, organisational demands and manager's own personal

views and feelings are all weighed against each other (Bramwell, Sanders and Rogers, 2016; Kirsh, Krupa and Luong, 2018; Martin, Woods and Dawkins, 2018; Ladegaard *et al.*, 2019; Suter, Irvine and Howorth, 2022).

The balancing act was reported by all the senior leaders and only some of the managers suggesting that there may be differences in experiences dependent on the level of the manager. Further research is needed that considers the heterogenous roles of managers and the impact that those differences have on the experience of managing individuals with mental health issues.

Balancing the impact on colleagues and the rest of the team was another challenge that managers discussed. For example, Charles stated that some of the difficulty was due to the disruption to other people within the team:

*I think it's more it's not so much productivity as the time and the energy that it takes to cope with somebody who is generating quite a bit of work because they don't fit in or work with colleagues in a smooth way. So it's not that they're actually not doing the work, it's more of the disruptive factor for other people. (Charles)*

Similarly, Tim stated:

*I think there's been situations where we've looked at umm, changing hours, but again, sometimes it's about getting the balance right [...] but it also might have other implications, in terms of the team. (Tim)*

John discussed the impact that needing to spend more time with certain people in his team can have:

*I've got a team of 42 people, when I came here it was 56. I've got 2 people with bipolar, 1 with schizophrenia, 1 with Asperger's and 3 with anxiety issues. That's a lot to deal with. You spend a lot of time with those people, sometimes to the detriment of everybody else and they see you spending your time with these people [...] I can't be focussing on just 5 or 6 people all the time, I've got 42 people in the team. (John)*

Side note- Asperger syndrome is no longer a recognised clinical diagnosis with autism spectrum disorder (ASD) being used instead and it is not a mental health issue. ASD is now often grouped under the umbrella term neurodiversity which can include ADHD (Baumer and Frueh, 2021).

Managers have also demonstrated awareness of the impact on co-workers and has suggested that issues of increased workload and time consumed in supporting the unwell employee can affect overall productivity of the organisation (Porter, Lexén and Bejerholm 2019).

For Charles being a small business director increased his awareness of the possible impacts on the team:

*It's harder in the team here, because there is more at stake for me when doing that. And there is more. There is a big impact from somebody who is struggling, being within a very small team. (Charles)*

Further research is needed looking at the specific challenges and difficulties that small businesses face when managing individuals with mental health issues as most of the research, like this one, homogenises business size. Suter, Irvine and Howorth (2022) recent research found that managers experience tensions as found in other sized organisations but the intensity of these tensions, and the interpersonal effects differentiate managers in small businesses experiences. Managers in small businesses may be constrained as they are within smaller teams, less managerial structures, less resources, and opportunities to spread the pressures (Suter, Irvine and Howorth, 2022).

Through recording managers lived experiences several challenging factors were discussed including lack of time, lack of support from line managers, lack of training, and trying to balance the individual's needs, colleagues, and organisational demands. Other interview-

based research also found that these challenges can influence managers decision- making (Shankar *et al.*, 2014). Research has found that the complex and demanding task of managing the challenges and the balancing act can impact managers mental wellbeing (Kirsh, Krupa and Luong, 2018; Martin, Woods and Dawkins, 2018; Ladegaard *et al.*, 2019)

In contrast, enabling factors were also discussed by the managers interviewed. For some, when there was support from their managers it could be extremely helpful. For example,

Angela stated:

*I have a manager who is very accessible, who is consistently checking in with me and is available 24/7. I don't have any qualms about asking for 5 mins of her time, ten minutes, 2 hours, to talk things over. She is there all the time trying to help me through these staff issues or whatever and beyond that I've got welfare advisors I can go to. In the absence of my manager there are several very senior approachable staff so now I have a great network around me. (Angela)*

The support received from HR can also be helpful, for example Sue said:

*I actually rely on HR colleagues, this is their bread and butter, it's not mine. So, advice, you know, to bounce off ideas from them, supportive arrangements, anything like that is really difficult, uh, really helpful. (Sue)*

Susan stated:

*I think HR can be great. But you have to go to HR for them to be great. They're not psychic. Same with occupational health when you can when you can get through to them. In my experience's they've been fantastic. (Susan)*

Angela had training that she found useful, and it helped to get the support needed quickly and effectively:

*Thankfully I've had some thorough and quality training, so I knew instinctively what to do and how to do it when the alarm bells went off and I recognised the signs. You need to deal with it quickly and decisively and you put thing in place, get that person and put them in front of a safeguarding manager and get them signposted to the correct help. (Angela)*

Previous research of managers experiences of employees with mental health issues have mainly reported the challenges and issues that they face, however, the data generated in this research suggests that there can be enabling factors at work which can support managers. These can include support from HR, managers, and effective training. Further research is needed, though, to explore potential factors that can help managers with managing individuals with mental health issues.

In summary, a range of significant issues and enabling factors for managers have been identified from the data generated. Also discussed were tensions in how they managed people with mental health issues and having to perform a balancing act to manage these tensions. The tensions revealed are managers wanting to support individuals versus the impact it has on the health and wellbeing of managers and individual needs versus the collective demands including organisational and the pressures on the team. Managers' report a balancing act between these tensions. Utilising paradox theory with a tension lens suggests that managers can deal with these tensions in a constructive way by emphasising a 'both-and' approach to these complex situations (Suter, Irvine and Howorth, 2022). The 'both-and' approach allows for managers to actively engage with the tensions of individual needs, their own wellbeing, collective demands, and the pressures on the team by recognising that these phenomena can occur simultaneously and helps managers to work through the tensions in a proactive and constructive way (Jarzabkowski, Lê and van de Ven, 2013; Poole & van de Ven, 1989; Smith & Lewis, 2011). The data generated from the interviews suggests that managers take an adjusting approach to 'both-and' approach to managing tension, meaning that they recognise both elements of the tension are important and attempt to accommodate both, for example, finding an approach that balances the needs of an individual and the needs

of co-workers (Jarzabkowski, Lê and van de Ven, 2013). Further research is needed, though, to identify strategies managers use to manage the tensions.

#### **4.3.2 Theme F: Important characteristics of manager behaviour when managing individuals with mental health issues**

In recording the lived experiences of individuals and managers there was focus on how managers behaved, what were the important characteristics that enabled individuals to feel supported (or not) and how managers preferred to behave. In all twenty interviews conducted with individuals experiencing mental health issues, the behaviour of line managers emerged as a crucial aspect influencing their work experience. Factors such as professionalism, trust-building, and effective communication by managers were highlighted and discussed.

Professionalism and confidentiality by managers were significant issues for many of the individuals interviewed. Grace described the professionalism and the importance of that from her senior manager:

*He's just incredibly professional. There's nothing you could say to him that would phase him. Like, professionally. And the other thing is that he will always, always, always, even if he disagrees with you, publicly, he will always defend you because you are an employee. You know? So, he will always have your back, even if you're having a really crap time. (Grace)*

In contrast, Sally discussed the perceived unprofessionalism from her manager:

*She'd come in and she'd be like "oh", if it was like a Sunday morning and we were at work, she'd be like "Thingy's just phoned in sick, bet she's just hungover, bet she went out last night", you know, it was just little things like that, and it's just like, it's so unprofessional. (Sally)*

For numerous individuals, the absence of professionalism displayed by managers was evident through the prevalence of gossip and the breach of confidentiality. This lack of discretion and respect for privacy was a noteworthy aspect that significantly impacted their

perception of managers. For example, Grace when describing her line manager rather than her senior manager stated:

*And it would very quickly be around the school. And I have a certain reputation and I don't like my private life being spread around, and given the fact that on a number of occasions, I've been in situations where they've been having a good old chat about such and such person, and a good old chat about so and so's issues, and a good old chat about the private life of another person, it doesn't exactly fill me with joy about going to them and saying "oh hey I'm really struggling". (Grace)*

The impact of the gossiping and unprofessionalism had on individuals was also discussed.

For Mary, it impacted her mental health and was one of the reasons she left an organisation:

*It's one of the reasons why I actually left [...] It was the unprofessionalism, it was the supervisor, it was the gossip going around. It was umm. You felt a lot like you were treading on eggshells. I had to be really careful in what I said, and be really careful in what I did so that things didn't go spreading around, and things didn't get out of hand. And it was just, that all made me anxious. (Mary)*

For Alex his manager making jokes about mental health issues felt unprofessional and hindered him feeling supported:

*And then my manager was like, basically, he's just a drama queen [...] But he was laughing about it. And then the senior manager was laughing about it. And I was just like, chuckles but then I was like, yeah, well, it's not a laughing matter considering I've just been off for a week [...] Like, I nearly in a grievance against him. Because I was like, okay, you're my manager, you're meant to understand, or even though understand, like, I've just been off with, don't make a joke about it. (Alex)*

Another part of lack of professionalism was how managers behaved when talking about other people. As an illustration, engaging in gossip about others in the presence of these individuals fostered emotions of mistrust, diminished support, and a lack of understanding.

Consequently, this behaviour reduced the inclination of individuals to approach or confide in such managers, seek help, and have confidence in the support offered. Olivia stated:



*But it did not make me feel comfortable and confident that I could go and have a conversation about where I was at and be taken particularly seriously or be given the support that I needed at that time. (Olivia)*

Professionalism and confidentiality of managers were important issues for individuals with mental health issues. Managers gossiping, talking about other people in negative ways and making jokes at the expense of the person was a significant issue for many individuals. Further research is needed to see whether this is an issue for managers as well.

Trust in their line manager was also a significant factor for many individuals. For example, Margaret stated:

*Knowing that you trust somebody makes a massive difference. (Margaret)*

Manager's behaviours of professionalism, maintaining confidentiality, not gossiping, or making negative comments about mental health issues were factors into whether individuals felt that they could trust their manager. Grace expressed her observations regarding her senior manager:

*He would never put someone down or undermine someone's experience publicly. Definitely never ever would he do that. And because of that, for me, I trust him. So, I feel like I could trust him, because he's not gonna be running around making judgey comments about someone that was struggling mentally, you know. (Grace)*

For Lisa trust was built through regular 1-to-1s and catch-up meetings where she felt that she could talk about issues at work and non-work problems:

*we have regular 1:1s, we have regular, just catch-up meetings where we'll go and go away from the office, get a cuppa or whatever, and work but also have those talks when we need them. Umm, I very much feel that I can confide in him if I need to, or if I want to. Even if it's not affecting things work-wise. (Lisa)*

Similarly, Lucy also found having 1-to-1 meetings outside of the office helped build trust in her manager:

*He took me off into a room for a 1 to 1, it was out of the office [...] he is a very supportive person through work anyway and I just felt I could trust him. (Lucy)*

In comparison, some individuals highlighted the absence of trust in their line managers as a significant issue. They expressed concerns about their line managers potentially exploiting their mental health issues as a means of disadvantaging them. For example, Juliet stated:

*So, on the one hand it's a good thing because telling the people that you trust and actually have a better understanding of you is better than telling everyone and your line manager and they might not be trustworthy people and they might use it against you. (Juliet)*

Furthermore, Grace talked about not trusting her line manager and fear that she would not be seen as capable:

*It's the fact that you don't really trust them. You know, if you're gonna start talking about your mental health, there's still so much stigma about mental health issues and such a lack of understanding about what that means and how that comes across, and especially in a role where I am actually in charge of a group of very vulnerable young people, it's very easy for someone to turn around and say "oh well I don't think you're capable", you know? I am very capable. However, I don't trust her to keep. (Grace)*

As seen in the discussion of theme B, individuals with mental health issues experience high levels of negative attitudes leading to stigma and discrimination. One of the negative attitudes is that individuals with mental health issues lack competencies for work tasks (Krupa *et al.*, 2009; Russinova *et al.*, 2011). Individuals' fear of negative attitudes plays a part in developing trust with managers. Trust appears to be built by regular 1-to-1s that are away from the office, how managers behave and talk about other employees and managers being supportive people.

Another important factor for supporting people with mental health issues was managers communication, including listening, being open and honest and informal communications.

For Katie a significant enabling feature of her manager behaviour was their willingness to listen:

*I think it was the willingness to sit down and listen. (Katie)*

Similarly, Sally talked about her senior manager:

*He just [...] Sat there and just listened to me. And I was really upset by that point, and he'd come into the store and I said "can I have a chat with you at some point, like one to one?", I said "I'm really unhappy" [...] He just sat and listened, didn't judge me. (Sally)*

For Liam, he felt that one of his managers was brilliant as they listened:

*You know he's listening, it's not like in one ear and out the other. You know it's sinking in because the engagement in the conversation. (Liam)*

Lilly described how her line manager listened and remembered what had been previously talked about:

*having a discussion with him, he remembers what we've talked about, remembers the principles of what we've talked about, and actions things going forward [...] he does know my history, it's not something he has to look up, it's not something he has to check [...] He's been very understanding of how things have progressed for me. He listens, and it's very clear that he listens. (Lilly)*

In contrast, Elizabeth talked about how her line manager does not listen:

*Her biggest problem is that she doesn't listen, especially when it is general problems with the job like, when I say that we are not getting enough support, or we are being told things that we don't have the tools or stuff to do with. (Elizabeth)*

The managers interviewed also discussed the importance of good communication skills especial listening to individuals. Amelia stated:

*I think it is just communication, people skills, listening and then working together. (Amelia)*

Similarly, John said:

*Absolutely, I think this communication thing is key. (John)*

Listening is a key factor in good management practice and business performance (Cohen *et al.*, 2012; Welch and Mickelson, 2013; Wood and Alford, 2022). Listening that is attentive and respectful can be a powerful technique for managers (Dailmer, 2016; van Quinquereme and Felps, 2018) as it can influence the success of teamwork (Kocoglu *et al.*, 2018), can increase employee creativity and engagement (Castro *et al.*, 2018; Basit, 2019) and can help employees make greater progress towards daily goals and report fewer somatic issues (Scott *et al.*, 2010). Previous research found that active listening serves as a valuable tool for managers to comprehend their employees' emotions (Klein, 2019). Neglecting or underestimating the emotions of employees, on the other hand, has been identified as a costly management approach (Klein, 2019). Furthermore, managers who create an environment that facilitates listening and communication is associated with greater employee attachment to their organisation (Reed, Goolsby and Johnston, 2016). Research by Cohen *et al.*, (2012) investigated managers perceptions on the conversation between themselves and employees in return-to-work discussions following absence and found that managers described carrying out the discussions in a professional manner that included listening more carefully and showing they were listening through active listening. This approach to the discussion was felt to help the employee feel valued and have a sense of participation in the process (Cohen *et al.*, 2012). Even though research highlights the importance of listening,

listening is a skill that is often overlooked and taken for granted in workplaces (Goby and Lewis, 2000; Welch and Mickelson, 2013). Communication, including listening, is an important skill for managers and is an enabling feature for people with mental health issues.

Another important part of communication that many individuals reported was managers having an open-door policy. For example, Charlotte stated:

*So yeah, just kind of having, really open-door policy, just, real basics of how you are doing, or you don't seem yourself today, are you okay, do you want to talk. (Charlotte)*

Katie described the open-door policy and approachability of her manager:

*Umm, she is lovely, and she is approachable, and she always says, you know, she's got an open door policy so if you want to go and speak to her, about things, you can. But you're talking like five minutes. (Katie)*

This implies that managing individuals with mental health issues does not necessarily require a significant amount of time from managers. It can be accomplished in brief, five-minute moments, as what truly matters to individuals is the approach taken by managers. A successful approach is characterised by qualities such as openness, honesty, approachability, active listening, professionalism, and confidentiality. The significance of these brief, five-minute moments in managers' behaviour for individuals is evident in this research. However, further research is needed to explore the specific methods and approaches employed during these moments, determining what is effective and what is not for individuals, as well as understanding the perspectives and experiences of managers regarding these interactions.

Jasmine, though, talked about how even though her workplace purports having an open-door policy, the door quickly closes when she has wanted to talk about mental health:

*Well, they don't even talk to us, you know. They don't talk to us. They get little email messages to send out to us. People have raised questions about sickness and stress there before. The open-door policy suddenly becomes a closed door, depending on what you wanna talk about. (Jasmine)*

Managers also recognised the importance of openly and honestly talking about mental health and mental health issues with their employees. For example, Elijah stated:

*We are openly talking about mental health and making it OK not to be OK and say those sort of things and make it the normal thing to talk about. (Elijah)*

Similarly, Gemma said:

*I think it's just breaking down any false perception or that there is a taboo about talking about stuff like that. So, I'm quite open with her, so if I've had a shit evening, sorry, pants evening, she knows that. When I walk in the office she knows. I think sharing that mutually has really helped her be more open back. (Gemma)*

Other research has also found that open communication between employers and employees was important for employers to manage employees with mental health issues (Mizzoni and Kirsh, 2006; Hauck and Chard, 2009; Thisted *et al.*, 2018). Regular communication between employer and employee has also been found to promote workplace participation for employees with depression (de Vries *et al.*, 2015). Furthermore, research that interviewed pairs of employers and employees with mental health issues found that an open-door policy with clear communication between employers and individuals was a key thing that employers could do (Peterson, Gordon and Neale, 2017). The discussion by individuals and managers is supported by other research, suggesting that open communication and open-door policies may be a significant factor for managing individuals with mental health issues at work.

A recurring narrative in the interviews with individuals was their preference for managers to adopt an informal rather than a formal approach. They expressed a desire for meetings to be

free from standardised forms and structured in a more relaxed manner. The informal chats and catch ups appeared to be an essential part of individuals with mental health issues feeling supported and cared for at work by their managers.

Jasmine stated:

*Because it's more like, a friendly chat and someone looking out for you than a structured thing that you know is coming up and like, if it was formal, I just think it would be more anxiety inducing, and it would feel more like a policy, like oh, we have to do this, whereas when it's informal, it feels more like someone actually cares about your mental health. (Jasmine)*

In comparison, Matthew talked about his experience in previous employment when managers used templates in meetings and the impact they had on him:

*in my old job, there can be a real kinda clinical nature to talking about mental health, and health and wellbeing in general. A real kinda clinical. This is the template, we do not stray from the template, this is the way that corporate deals with this, this is our policy [...] Can really have the very worst. The very opposite effect. It can push people away, you know, I certainly think it did with me in the early stages. (Matthew)*

Many managers also discussed being informal in how and when they communicated. For example, Angela stated:

*They are all informal. It's the nature of how I line manage people, it's always informal, often over a cup of tea or a walk outside and sit at a bench or even at a table with a pen and paper and plan and go through things but it's always at that informal level, nothing is ever that serious, let's just chat it over. (Angela)*

Similarly, Anne said:

*Cos we can just have a chat, so I don't have to sit across the table and say "right, we're going to look at this", you know. You can do that over a cup of tea and go and sit on the soft seats, and have that informal chat, and still get the same outcome, but everybody feels better about it. (Anne)*

Many managers and individuals mentioned cups of tea, getting out of the office, and comfortable seating as part of the open, informal communication. These range of strategies that managers used helped in developing safe spaces where individuals felt they could talk and reach out for support.

Gemma stated:

*It's knowing that they've got someone to talk to in a safe place that can often save things from getting to a point where it gets quite scary. (Gemma)*

There were times, however, that managers recognised that formal meetings and communication that followed the organisation's processes or policies was needed. For example, Angela stated:

*There is a time and a place to be formal and there needs to be that distinct difference that if someone has done something wrong then you've got somewhere to go with it. That's when you can be formal. Day to day I prefer to be informal, approachable, any problem come to me. That's how I like to be in myself, almost like their friend but a friend on the appropriate level. (Angela)*

Suter, Irvine and Howorth (2022) research identified that managers in small and micro businesses experienced a tension between informal and formal responses to supporting individuals with mental health issues. They found that managers reported conflict between formal approaches to managing individuals and the informal nature of employment relationships and organisational culture, between friendly and professional relations and a lack of formal processes in the organisations (Suter, Irvine and Howorth, 2022). Managers appear to favour an informal response but recognise that formal approaches can help to recognise and intervene when issues start to emerge (Suter, Irvine and Howorth, 2022) and provide greater transparency and accountability for managers especially when there are concerns about performance and capability (Martin, Woods and Dawkins, 2018). It appears,



though, that individuals with mental health issues prefer informal approaches to communication and support. Further research is needed to look at when formal approaches may be more suitable for both the individual and manager.

Qualitative research of employers with experience of employees with mental health issues found that employers want to be responsive and communicate to employees through open-minded dialogue, daily monitoring and being responsive and attentive (Jansson & Gunnarsson, 2018). The National Institute for Health Care and Excellence (NICE) recommends that managers need to be equipped with the skills to have conversations around mental health to reduce stigma in the workplace and one key factor to do this is open communication (NICE, 2022). From the data generated in this thesis, managers behaviour, approaches, and ability to have open communication with individuals with mental health issues was shaped by personal experiences. Managers being supportive, kind, compassionate, open, listening, and informal was due to either having personal experience of mental health issues, supporting a loved one or had been through a tough life. For example, Liam stated:

*Her understanding of it all. She was abused when she was younger, so she had a doorway into it all. She would always consider the tone of her voice when talking a sort of comforting tone, chose her words. The manager whose there now, he lost his dad a while back, he's a dad and a general understanding, compassionate person. (Liam)*

Matthew described how his manager had a partner with severe mental health issues that helped their understanding and support of Matthew:

*Fortunately I suppose that's the wrong word here, but, he in his own life, had some experience with those kind of issues, his partner I think had very severe mental issues, so he was almost very good at recognising the symptoms, and he then made it as easy as possible to get me what help I needed. (Matthew)*

Many managers also identified that they drew on their own personal experience of mental health issues or people close to them to help them with managing employees. Amelia stated:

*I guess if you've experienced anything like that yourself then you have an insight to what that person is feeling and what might help. (Amelia)*

Charles said that he drew on his own personal experience of having a breakdown and his learning from that experience to support individuals at work:

*Personal experience more than the professional environment... Yeah, so I had a breakdown 15 years ago and a big part of learned recover from that was learning to pace and to take time out. (Charles)*

Similarly, Susan drew on her own lived experience of being someone with mental health issues:

*I think, just from my experience, and as, as a person with mental health issues, and things that have previously helped me or things that have been offered to me. (Susan)*

Research has also found that managers can rely on previous and personal experience to support employees with mental health issues (Lexén, Emmelin and Bejerholm 2016; Porter, Lexén and Bejerholm, 2019; Shankar *et al.*, 2014). In interviews of employers conducted by Shankar *et al.*, (2014) they found that employers who had positive experiences in hiring and accommodating individuals with mental health issues had some previous experience with people with mental health issues and/or had personal experience with mental health issues or close relatives or friends with issues. Former experience appears to also influence managers hiring decisions (Brohan *et al.*, 2012; Lexén, Emmelin and Bejerholm, 2016). For example, qualitative research looking at employers who have been part of supporting individuals into work through individual placement support (IPS) were more likely to consider individuals with mental health issues if they had prior experience (Lexén, Emmelin and Bejerholm, 2016). This

highlights that managers' previous experiences of managing people with mental health issues and/or personal experience is a significant factor for the management of mental health issues at work. Not everyone, though, will have prior or personal experience, so further research is needed to identify how managers can be kind, compassionate, open, and informal without the experiences.

A further significant factor of why managers behave the way they do is that people management is important to them, and it feels like the right thing to do. Several managers identified this, for example Amelia stated:

*Because it's important isn't it. I might have about 10 emails to write up or other things but supporting the person is more important. (Amelia)*

Charles said:

*Ethically, for me, it's the right thing to do if somebody has a particular need. And by accommodating that they can be effective at work. (Charles)*

Tim provided an analogy for why he prioritised people management:

*For me, it's like a prioritisation, really. I think in the grand scheme of things, I always use the sort of analogy that within IT, we've got the three Ps, which is Process, People and the Products. And I always prioritise the people. And the other stuff, I believe if you get the people stuff right, the other stuff naturally comes. (Tim)*

Interviews conducted by Kirsh, Krupa and Luong (2018) also found that managers perceive that management of mental health issues is a relevant part of their role but managers' report that they often lacked certainty on how to manage employees, how to respond in genuine caring ways and what information they would need to support the individual.

Prioritising people management also led managers to support individuals by treating them as a person. Oliver said:

*But generally, it's that we treat people as individuals, and kind of treat them as professionals, and having high expectations of them, but supporting them to get there. (Oliver)*

Elijah, a senior leader discusses how treating employees as individual's is important to the workplace culture:

*So from a culture point of view it's important that you look after individual people well because if you don't then it undermines the whole culture and people are going to think, ok, he is nice to me now but look at how he treated her and if this happens to me how am I going to be treated? (Elijah)*

Being treated as a person was a significant factor identified by some of the individuals. Lilly stated:

*Treating me like a person and not an employee [...] It shows a conscious level of compassion. (Lilly)*

Similarly, Matthew stated:

*Part of it was a general approach, I think. It was a willingness to. A willingness to sort of engage with me as an individual rather than me as an employee, I guess? Checking in on the person, not the Business Analyst, you know? Or rather the employee [...] in almost all the dealings I had with both of them, there was that attempt to find that human angle, that kinda perception there, you know what I mean? (Matthew)*

Treating employees as unique individuals appears to be a significant factor for individuals and managers in this research. The impact of managers' behaviour cannot be taken lightly with some individuals talking about how they would reorganise their life to stay with their manager.

Lilly stated:

*You know, I'm not alone in saying that if the teams split up and get changed, I will make every effort to change something in my life to allow me to stay on his team, whether it meant changing hours or something like that, I would reorganise my life if it meant keeping him as a manager, not because of the sort of socialised benefits of it, but because I don't have to worry, you know [...] You know, as long as I know I'm doing my very best, he knows the*

*difference between taking the mick and needing space, needing something. And I do think that is a rare quality. (Lilly)*

Similarly, Jasmine stated:

*I don't know, she's just amazing. I don't think I would have stayed there if it wasn't for those two. (Jasmine)*

Some managers highlighted a characteristic of their behaviour that involved reactive firefighting rather than proactive, solution-focused management. They recognised the need to shift their approach from being constantly reactive to actively seeking solutions. For Tim the reactive, firefighting ways of managing were due to how the organisation has been structured:

*I think the way we've been and the way we've structured has been very reactive. (Tim)*

Elijah highlighted that constantly firefighting and not being able to put proactive structures in place could lead to difficulties:

*you are just firefighting and if you haven't got the ability to put structures in place to stop the firefighting it gets really difficult. (Elijah)*

Similarly, Tilly stated that prioritising emergencies could be challenging when there are multiple employees with difficulties:

*And then you have to prioritise the emergencies as they kind of come up in front of you. Yeah. And it's just sometimes it just bites you where, you know, actually, they are bad, they are struggling at the same time. And, you know, we've had that. (Tilly)*

Sophie described possible ways that organisations can be proactive:

*But things like resilience training, or a lot of, a few of the larger organisations that I work with are putting things like mindfulness training on where people can attend the workshops, again, all optional, not something that's compulsory, which is, which is a real benefit to show that they're being proactive, but it's still about self choice, it's still about that option, and they're not*

*sure everybody who might be in positions where they're struggling, realise that maybe that's some of the support that they need at that point. (Sophie)*

A myriad of significant issues and enabling factors of managers' behaviour was discussed by individuals with mental health issues and managers. Enabling factors included managers behaving with professionalism, building trust and managers listening, informal communication and managers being open and honest. Whereas issues with managers behaviours included lack of professionalism and gossiping, not trusting managers, not being listened too and formal communication. For managers listening and informal communication were also enabling features. In contrast, having to firefight problems, manage reactively rather than proactively were significant issues for managers.

#### **4.3.3 Theme G: Colleagues and the part they play in the experience of work for individuals with mental health issues**

The majority of interviewed individuals discussed the important role their colleagues played in their experience of work. Enabling factors included checking-in with each other, having a laugh, loyalty and affection with colleagues leading to a sense of community and taking care of each other. For other individuals, though, difficulty with colleagues, rumours and the social side of work were negative factors.

For Grace, her colleagues provided more support than they had experienced from any mental health services:

*It's real, they care about me as a person, and they know me. Umm, whereas I dunno, I feel a little bit like when you go through mental health services, you're just a bit of a number that they wanna get out of the way really, you know, that's how you feel. (Grace)*

Katie felt that the reason colleagues were able to support her and be there for her was that they were friendly and kind people who openly talked about their own lives:

*I think they talked quite a lot about sort of their own lives as well, and their own feelings, and they were all, again, very open, very friendly, very kind people. Umm, and what made them like that was they always asked how I was, they called me lovely, and there was very much a sense of a community, so you know, if you're making a cup of tea, you're making a cup of tea for the entire ward. And you'd have like, snack days, if it was somebody's birthday, you'd bring in a cake for them, and [...] Umm, if you needed five minutes, somebody would do your drug round for you if you needed to take time out, if you were struggling you could go and sit in the pantry and take five minutes. And somebody would always help. And they were really good, really good. (Katie)*

Olivia discussed developing friendships with colleagues and how they became people who she could talk to without fear of judgement:

*My colleagues were just very good sounding board, I think what I needed most was just people willing to talk and be open and not judgmental. So having just a good discussion and knowing that they would be there to support me if I needed it was a very positive response. And I think that was more of a personal thing than a professional thing. We've developed friendships. (Olivia)*

For some individual's colleagues were instrumental in returning to work, enjoying work, and managing their mental health. For example, Olivia stated:

*Having moments where I could stop, take breaks, have a conversation meant that I'd be a little bit more capable of sitting and working for a little bit. And they were very open to doing that, and very helpful in assisting that. (Olivia)*

Research has also found that colleagues can play an important role in individuals return to work (Tjulin, MacEachen and Ekberg, 2010; Vemer *et al.*, 2013; Dunstan and Maceachen, 2014). Colleagues, though, are often invisible workplace actors in supporting individuals return to work even though they can be critical in individuals returning to work and sustaining their productivity (Tjulin, MacEachen and Ekberg, 2010; Dunstan and Maceachen, 2014).

Lilly, talked about a specific friend at work:

*She would come in every other day, and say, see how I'm doing, so I didn't feel left out, and then, she would explain the people who were sat on the pod, because each pod in there was*

*nine people, you know, nine computers, nine people. She would explain where my seat was assigned, she was assigned next to me, how much they talk, because obviously she'd been sat on that pod for a while, who she was speaking to on a daily basis, what they were like. Umm, until I eventually wanted to come out and continue to talk to her. Umm, I think that's very much an individual basis, she is very understanding, she's had a lot of personal issues herself, completely different to mine, but we have a very good friendship. A very good relationship in that respect. And has been absolutely instrumental with keeping me going.*  
(Lilly)

Grace discussed an experience when a colleague bought in food as she was not eating due to her mental health deteriorating. Whilst this was essential for Grace, her colleague was blasé about it:

*She was very. Umm, blasé about it, like she just didn't even make a thing of it. She was like, "there's your dinner for tonight", and she'd leave it in the fridge in the classroom for me, and err, and that was that. There's a lot of loyalty and affection and almost like a family, it's a family community feel. And that's been really helpful. And I think perhaps I value that more because I don't really have that familial thing so much in my personal life.* (Grace)

These did not need to be big gestures but can be, as Jasmine described:

*Or some people just catch me in the corridor, they'd be like "you alright?".* (Jasmine)

The social support provided by co-workers can be a significant enabling factor for people with mental health issues to return to work, stay in work and be productive (Stansfeld *et al.*, 1999; Glozier *et al.*, 2006; Mizzoni and Kirsh, 2006; Raderstorf and Kurtz, 2006; Rollins *et al.*, 2011; Vemer *et al.*, 2013; Hjarsbech *et al.*, 2015; Mental Health Foundation and Unum, 2016; Thisted *et al.*, 2018). Research from the employees' perspective showed that social support from co-workers can result in less time returning to work after sickness absence (Vemer *et al.*, 2013). From the co-workers' perspective, qualitative research found that open-mindedness, adjustments for employees' needs and consideration of employees' experiences were perceived to promote work participation of employees with mental health issues (Corbière *et al.*, 2015). Previous research revealed that fostering open communication among employees,



co-workers, and employers played a pivotal role in providing support to individuals with depression (Hauck and Chard, 2009). Employers also acknowledge the important role that co-workers can play in the support of people with mental health issues (Mizzoni and Kirsh, 2006). Employer interviews uncovered that the awareness of co-workers regarding mental health issues can significantly influence the working environment and the support offered (Mizzoni and Kirsh, 2006). In workplaces where co-workers were aware of an employee's mental health condition, or when such awareness arose, the overall atmosphere tended to be more supportive and conducive to providing assistance (Mizzoni and Kirsh, 2006).

Interpersonal relationships are important for people with mental health issues, especially individuals with severe mental health issues as they can experience difficulties with social skills (Bellack, Morrison and Mueser, 1989) that can impact their ability to obtain support from co-workers (Rollins *et al.*, 2011). For example, it has been found that people with schizophrenia can struggle with friendly communication skills, understanding the behaviours of co-workers, and perceiving how their own behaviour can impact co-workers (Lysaker *et al.*, 1993). Research by Rollins *et al.*, (2011) found that individuals with severe mental health issues reported feeling supported by their social network and high levels of satisfaction with workplace relationships. It appears that social networks and the support of colleagues can be a significant enabling factor for people with mental health issues. For some individuals, however, their colleagues could also negatively impact their experience of work. Elizabeth talked about how her colleagues were family and provide a lot of support, however, the talking can lead to rumours and sharing of misinformation:

*My colleagues are one hundred per cent family. The people I work with are amazing, I have a lot of support, when my dad died, they really helped me out a lot. We all just talk...As much as it is a good thing it can also be a curse because that's where you also hear the rumours, that's where also hear the, oh but she said this you going behind her back. So, it's good and bad. (Elizabeth)*

Lilly also emphasised the struggle faced by colleagues in balancing a sense of community and camaraderie with the prevalence of gossiping within the workplace:

*There is very much a family sort of nature in all the positives and the negatives, you know, I mean there's a lot of in-talking, just like there is anywhere else, you know, and Chinese whispers, and this, that and the other. But ultimately, especially with our team, it's very much looking after each other, you know, it's [...] We're all there for the long haul, as it were. (Lilly)*

Other individuals reported that some of their colleagues only hinder their experience of work, for example Jasmine stated:

*There was one person who was incessantly saying so many things behind my back, like she'd tell the friends I do have there that I bitch about them and I don't actually like them, and she tried saying I had drugs in my bag. Oh my god, honestly! [laughs] It gets interesting! [...] Umm[...] Okay, when it first started, I wanted to quit and I was, this was when I was crying in the toilets, almost daily. [...] Yeah, this is really serious stuff that's being said. But everyone was just like, there became like a culture of "oh, just don't be sensitive, be careful what you say around them", I was like "no, that's not the case at all". (Jasmine)*

Lucy found that her colleagues could be judgemental and inconsiderate:

*very quick to judge and very quick to take the mickey and not understand the seriousness behind some of them issues [...] It is partially my team being inconsiderate, but as the workplace in general, we have a big stigma around mental health anyway, for both staff and students. (Lucy)*

Perceived lack of support from co-workers can lead people with mental health issues to feel isolated and undervalued (Raderstorf and Kurtz, 2006). Deterioration of social support from colleagues can be a factor in people taking sickness absence (Eriksson, Starrin and Janson, 2008). Lack of colleague support is also associated with increased risk of mental health issues (Stansfeld *et al.*, 1999). Further research is needed to develop an understanding of the consequences of negative experiences with co-workers for employees with mental health issues.

The importance of colleagues' behaviour for individuals with mental health issues suggests that social factors play a key role in the experience of work and so shifts underlying assumptions of mental health issues away from a biomedical model of mental health issues to a social model as social factors have been highlighted as key in shaping individuals' experiences of work. As discussed previously in 2.1.2, the biomedical model seeks to explain mental health issues by medicalising individuals experiencing them and reduces psychological phenomena, such as thoughts and feelings, to a biological cause (Szaz, 1977, 2011; Pemberton and Wainwright, 2014) and so leaves no room for social, psychological and behavioural dimensions of mental health issues (Engel, 1977; France, Lysaker and Robinson, 2007; Deacon and Lickel, 2009; Deacon, 2013; Robles *et al.*, 2014; Timimi, 2014). In contrast, social models are concerned with the influence of life events, inter-personal dynamics, belief systems, thinking styles on mental health and how society reacts to individuals with mental health issues (McCulloch, 2006). By drawing on a social model of mental health issues, organisations and research could focus on the dynamic inter-personal relationships individuals with mental health issues have at work, the impact they have and strategies to manage them. Looking at colleagues supportive, enabling behaviour and the interaction individuals have with them may provide insights into how employees could be managed within the dynamic, social world of work.

In summary, from recording individuals with mental health issues experience of work colleagues appeared to play a significant role. Colleagues could be important factors by providing support, being friendly and open, and supporting returning to work, however, they could also be significant issues by gossiping and being judgemental and inconsiderate. These behaviours of colleagues would benefit from further research to explore the impact of colleagues' behaviour on individuals with mental health issues and how colleagues respond

to individuals. A tension between colleagues' support and negative colleagues' behaviour has become apparent in this research. Further research is needed to explore how individuals with mental health issues manage this tension.

#### 4.4 Organisational cluster of analysis

The organisational cluster of analysis draws together themes H to K and so includes workplace resources, workplace policies and processes, reasonable adjustments, and work design. See figure seven for a visual representation of this cluster.

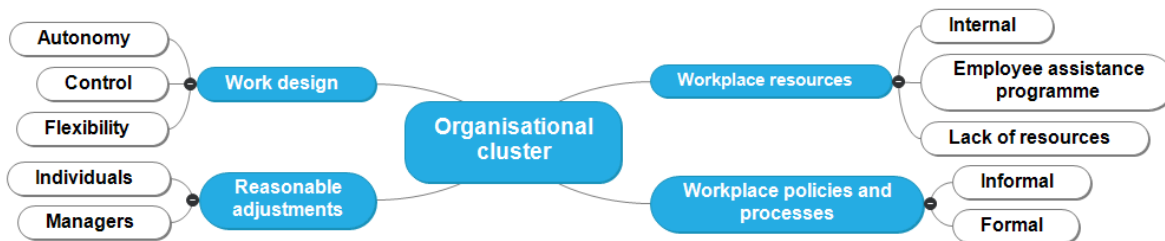


Figure 7: Visual representation of the organisational cluster of analysis.

Source: Authors own.

##### 4.4.1 Theme H: workplace resources of support and help for mental health issues

Workplace resources to support employees with mental health issues were discussed by both individuals and line managers. Individuals described a wide range of workplace offers of possible support and help including counselling, appraisals, and occupational health, see table seven. Both individuals and managers reported issues with these resources, even though workplace resources can be enabling factors.

Table 7: Range of services individuals with mental health issues had accessed. Source: Authors own.

What individuals have accessed	Supporting quote
Occupational health	<i>occupational health will contact you either on day four or shortly after to discuss the likely return date (Charlotte)</i>
Counselling	<i>We provide access to a counselling service. (Lucas)</i>
Employee Assistance Programme	<i>the university has umm, an Employee Assistance Program. (Lisa)</i>
Appraisals/ performance reviews	<i>It's a questionnaire, it covers whether we have a work-life balance, targets from your previous year, setting product targets for the next year, whether there is any training which you wish to acquire. (Lucy)</i>
Mental health first aiders	<i>we introduced mental health first aid. (Charlotte)</i>
Human Resource	<i>I spoke to my HR department. (Elizabeth)</i>

Managers discussed what services they had referred employees with mental health issues to, see table eight.

Table 8: Resources that line managers have discussed in their interviews which they may have referred individuals with mental health issues to or suggested that they access. Source: Authors own.

Resource/ service	Supporting quote
Employee Assistance Programme	<i>Employee Assistance programmes, we're also able to use the retail trust, who's like charity (Tilly)</i>
Counselling service	<i>Also, to be able to signpost her to help, signpost her to counselling, which was an absolute success (Abigail)</i>
Occupational health	<i>I would have done the referrals for Occupational Health, getting advice through there, umm, adjustments within the workplace. (Tim)</i>
HR	<i>I guess I would always involve HR if there was a trigger regardless. (Sue)</i>

As can be seen in tables seven and eight, the resources individuals accessed, and managers signposted employees to, were very similar. This suggests that many organisations have

access to occupational health, counselling services, employee assistance programme and HR. Individuals, though, also discussed appraisals and performance reviews as a possible resource as they can provide an opportunity for individuals to talk through challenges and goals with their manager. But the appraisal system for Lucy was not a place for discussing her mental health:

*doesn't go into the ins and out of stuff like that. (Lucy)*

Three individuals talked about their organisation having mental health first aiders. Charlotte stated:

*we introduced mental health first aid, so the official company, or whatever they are, company, organization, so we introduced their training so our well-being coordinator, she ran that training, so we got a number of mental health first aiders in the organisation. (Charlotte)*

However, Lucy expressed her lack of trust in the mental health first aiders within her organisation:

*because they are very new and I don't know any of them personally so I don't feel like I could actually trust them straight off, if I had an issue. (Lucy)*

Mental Health First Aid (MHFA) offer training to equip people with skills to support their own and others wellbeing (MHFA England, 2022). Kitchener & Jorm (2006) found the benefits of the training include: improved helping behaviour, greater confidence in providing help to others and decreased social distance from people with mental health issues. A systematic review and meta-analysis of randomised controlled trials of MHFA programs found that the training led to improved mental health first aid knowledge, recognition of mental health issues, beliefs about effective treatment post training up to six months later, but the effects twelve months later were unclear (Morgan, Ross and Reavley, 2018). The evaluation of MHFA

training has primarily centred on assessing its impact on the trainees themselves, while limited research has explored the effects it has on individuals who may seek support from those who have undergone the training. There has been little research on the impact it has on those with mental health issues and so further research is needed.

During the interviews with the individuals with mental health issues there was mention of what an organisation could offer internally, drawing on their own resources of staff such as mental health first aiders and wellbeing officers and services which were externally provided. For example, Charlotte was able to access a wide range of support and help within the organisation:

*So I met with an occupational health nurse and a wellbeing manager, basically to talk through what I was going through, what the situation was um and they well sort of wellbeing managers were a trained CBT therapist and counsellor so she basically talks through things with me, um she listens so I think I can't remember exactly but I had either weekly or like a session with her um and then the occupational health nurse they saw me once a month. (Charlotte)*

Drawing on the work forces own skills and knowledge appeared to be a common feature of many of the organisations the individuals' interviewed worked for. Lisa discussed the different networks in her organisation and that knowing about them helped her feel like she was supported:

*the women's network, and the LGBT+ network, I think there's a disabilities network. Umm, I know they're not directly related to wellbeing, but I think knowing that things like that are available, that does certainly contribute to my wellbeing, I think [...] knowing that there is support there, even if it's just from each other, and not necessarily a formal thing [...] I think knowing that things like that are available, that does certainly contribute to my wellbeing. (Lisa)*

In contrast, other organisations bought in external services to support people, for example Grace stated:

*the school buys into an insurance kind of thing, an insurance thing. Like a health insurance type thing. (Grace)*

This insurance thing discussed by Grace is an employee assistance programme (EAP), a few other individuals discussed them. For example, Elizabeth stated:

*It's literally just an employee assistance programme and it's just a phone number and a little bit of information that tells you what the phone number is about, but it doesn't tell you what HR can do for you. (Elizabeth)*

Lisa also acknowledged her workplace had an EAP and had more knowledge of what it was able to offer than Elizabeth.

*Umm, which is basically a website where you can go and have online counselling, telephone counselling, or they can refer you to have in person counselling. Umm, there is a lot of other stuff, like cycle to work schemes, umm, there's like a [...] bicycle user group for the university, called BUG, which I think is quite sweet. (Lisa)*

Some managers also discussed EAPs offered by their organisation. Susan stated:

*We have an Employee Assistance programme. I'm not 100% sure what's offered as part of that anymore. But there's various things like we have online counselling and telephone counselling. (Susan)*

Many employers choose to offer an EAP to support their employees' health, safety, and wellbeing (Hall, 2020). EAPs can include a range of services including: short term counselling, critical incident support, and management coaching, which can be used to support a variety of personal and professional issues (Daniels, Teems and Carroll, 2005; Joseph, Walker and Fuller-Tyszkiewicz, 2018). EAPs can offer employees a way of accessing professional support to communicate, process and work through issues and worries (Joseph, Walker and Fuller-Tyszkiewicz, 2018). There appears to be an increase in the number of employees seeking support from their organisation's EAP, with Zurich UK (a leading provider



of EAPs) reporting a 50 percent increase in 2022 compared to 2021 with anxiety being the most common reason for seeking help (Cholteeva, 2022). A systematic literature review evaluating the effectiveness of EAPs found that generally they enhanced individual and organisational outcomes, especially in the reduction of presenteeism rates and improvements in levels of functioning at work and at home (Joseph, Walker and Fuller-Tyszkiewicz, 2018). Research by Hastuti & Timming (2022) also report that EAPs are significantly associated with the reduction in suicidal ideation. Furthermore, employees who used EAPs showed improvements in depression, anxiety and alcohol abuse symptoms five months after accessing the EAPs (Richmond *et al.*, 2016). EAPs, however, are not sufficient as the sole support for individuals with mental health issues as they offer limited counselling and employees must disclose to access support (Hall, 2020). EAPs can be seen as a way for organisations to portray compassion to employees but they can also promote ignorance by managers and colleagues as there can be a lack of knowledge of who is accessing the support and why (Quinane, Bardoel and Pervan, 2021).

Both individuals and managers described challenges with the workplace resources offered, accessing, and signposting. Issues included not knowing what was available, inability to access, a push for services to be online and reduced resources due to financial constraints.

For Jasmine, knowing what was available for her was challenging:

*my line manager. She was like “you can access counselling through here” and she did offer it as an option, but if it hadn’t been for her, you would never have seen it advertised, or anything. (Jasmine)*

Grace, was unable to access it due to the counselling opening hours:

*Monday to Friday. So, I’d just like to point out that I’m at work! I start work at half past 7 in the morning. The kids are at school from quarter past 9, and they finish at half past 3. When the hell do I access that service? I can’t! I can’t access it. (Grace)*

As services are being stretched there was a push for them to be online:

*They want to make everything online; they want to give everyone CBT because they can do it online. (Rosie)*

A systematic literature review found that online therapy can increase access to therapy services as it can increase availability and flexibility, can be convenient, can help meet the increased demand and there are economic advantages (Stoll, Müller and Trachsel, 2020). There are, however, concerns about privacy, confidentiality, security issues and a need for the therapist to have specialist training so they can manage communication difficulties (Stoll, Müller and Trachsel, 2020). Rosie suggested that there may be a reluctance to engage with online services, but further research is needed.

Another challenge identified was that even when well-being resources were made available, individuals were often too busy to access them. Juliet said:

*They have, you know, wellbeing mornings where they do mindfulness in certain places in the hospital, but I guarantee that nobody ever gets to go to them because everyone is too busy, and it's not seen as something that is vital. (Juliet)*

Some of the individuals interviewed discussed seeking support from Human Resource (HR) within their organisation. Elizabeth, for example, stated:

*I spoke to my HR department [...] But I did manage to speak to them, and they were really supportive and [...] they've at least given me information on how to deal with it and they have told me what I can do if I were to release the information. (Elizabeth)*

For others, though, they experienced issues when dealing with HR. For example, Lisa found the HR person involved difficult and not supportive:

*She was not my favourite person in the world. She was incredibly condescending [...] Not supportive in the slightest [...] There was no “how are you, how are you doing? Are you improving? Is there anything we can do for you?”, which I did have from my boss. But from a HR point of view, there was none of that. (Lisa)*

Lucas also had a negative experience with a HR personnel:

*he started to utilise it against me, in the initial stages he would pass comments, like at events he would come up to me and say like I can't imagine how hard this is for you with your condition and all that kind of stuff and then it got to the point where it started to come back to me through other people. Even down to the point of once having a meeting with him where he made reference to me that how fortunate I was that the company was willing to accept me even with this ticking time bomb as he referred to it. (Lucas)*

HR, due to its multifunctional nature, can engage in a variety of activities that can impact the experience of work for employees with mental health issues (Hennekam, Follmer and Beatty, 2021a). Little research though has looked at employees with mental health issues experience of engaging with HR and the influence that may have on their experience. Under researched, also, is HR professional's views, attitudes, and approaches towards employees with mental health issues.

Another challenge discussed by many of the managers was how the resources they had had access to were being reduced. Gemma stated:

*the problem we've got is that our resources are being stripped thinner and thinner [...] And there's all these things that you have to try and manage and support [...] But sometimes you feel like you're having to pick and choose which one to support, when and how. (Gemma)*

The reduction was not just seen in what was offered but also if resources, such as occupational health were available, accessing them was an issue. Susan stated:

*So, we have occupational health, but again, there's a lot of changes going on there at the moment with various restructures in the organisation. So, at the moment, it's very challenging to get through to someone. I have an ongoing physical health issue with one of my team*

*members, and the referrals and everything that's taking months, and months, and months, it's very difficult. (Susan)*

This reduction in resources was suggested to be due to financial constraints and a lack of corporate rationale for providing support. William stated:

*But there's no corporate reason for that. There's no financial reason. So why would a business in a million years invest in a project that's just hard work, dangerous, and really, in their opinion, will not have a monetary gain. (William)*

For Elijah and Charles who are senior leaders of small businesses, the financial constraints of being a small business impacted what they were able to offer:

*So, what I am trying to explain is the difference between larger companies where it is easier to be lenient with policies because there is more money available than if you are running a small company, especially a small company that is struggling financially so you are more likely to stick with what you have to do legally even though it's really hard. (Elijah)*

An international systematic review of workplace mental health guidelines found that the recommendations often made for managing mental health issues at work are not suitable for small and medium businesses as they may not have the time or financial and personnel resources to implement them (Memish *et al.*, 2017). Further research is needed to explore the impact of employees with mental health issues in small and medium businesses and what resources are available for both individuals and managers to help provide support.

A range of workplace support resources were discussed by the individuals and line managers, for some of the individuals these resources could be helpful. There were, however, many issues identified including inability to access, reduction in services, services being stretched and unsupportive HR professionals. This suggests that workplace support resources may not be enabling factors for individuals and managers. In further discussions though, it became apparent that one of the key issues for individuals with mental health

issues was not about what was done, but how it was approached, so the next section discusses important characteristics of managers behaviour.

#### **4.4.2 Theme I: The experience of workplace policies and processes for individuals and managers**

According to the CIPD (2022), policies provide guidance on how a wide range of issues should be managed within an organisation. They describe the rights and responsibilities of the organisation, managers, and employees and can play a role in the organisation supporting fairness and consistency across an organisation (CIPD, 2022). Through the recording of the lived experiences of individuals with mental health issues and managers it became apparent that how workplace policies and procedures were implemented by managers could be a significant issue. For both individuals and managers, there was a preference for applying policies and procedures flexibly and informally, but some managers said the formal processes helped their management of individuals with mental health issues.

Many of the individuals identified the importance of managers flexibly applying workplace policies to them. For example, Lisa stated:

*I think I have been very lucky in that my line manager applies them well. Umm, he doesn't take it all as black and white, it's not follow this completely step by step, and if you have a day sick, you're not going to lose your job, that kinda thing. (Lisa)*

Lilly gave specific examples of where her manager flexibly applied and used the workplace policies to support her so that work worked for her:

*And, on other occasions, where I haven't actually had the TOIL to use, he has been flexible in allowing me to potentially earn it later and use it. Umm, which, in some counts has been against policy. (Lilly)*

TOIL stands for Time Off In Lieu.

Similarly, many of the managers discussed how they preferred to use policy and processes informally and flexibly when managing individuals with mental health issues. For example, Thomas stated:

*But we usually try to deal with it as informally as possible. (Thomas)*

Reducing anxiety for the individual involved was provided as a reason for not using the policies and processes formally by Charles:

*We don't use a formal procedural approach because that increases anxiety, as the behaviours become more extreme. (Charles)*

Gemma discussed how the policy is there to ensure managers are following legal requirements but that there are grey areas and room for flexibility in applying policies and procedures:

*So, you have your policy which is the backbone and your ultimate line of don't breach that because you'll be breaking the law and anywhere between that is a grey area that you just muddle your way through and work out what's best for that one person. (Gemma)*

Oliver also identified that there is room for flexibility in applying policies and processes:

*So, where there is wriggle room, which we say, or the kind of shades of grey? [...] That will be ultimately an interpretation. (Oliver)*

Research has found that there is a difference between the espoused policies and procedures that organisations state they have for supporting individuals with mental health issues and what happens in practice (Cunningham, James and Dibben, 2004; Fairclough *et al.*, 2013).

Part of the difference between espoused and enacted policies and procedures may be due to the apparent discretionary power managers have with how policies and procedures are and are not enacted in the workplace (Edwards and Whiston, 1989; Dunn and Wilkinson, 2002;

Purcell and Hutchinson, 2007). This is not just seen in policies about mental health issues, ill health, and disability but in other people management policies as well (Legge, 1995; Whittaker and Marchington, 2003; Khilji and Wang, 2006; Purcell and Hutchinson, 2007; McCarthy, Darcy and Grady, 2010).

For some of the managers formal processes can be useful, it can provide a framework for how to approach managing employees. Tim, though also discussed that policies were tools that can be used flexibly:

*Like I said, a framework then of how to approach things, how to deal with things. Again, I use it as a tool, that's it. That's it, a tool. And if I need to step out of that process, I will. As long as it's appropriate. (Tim)*

Angela discussed that the sickness absence log in her organisation prompts her to ask questions which she has found helpful:

*Yes. It's a good prompt sheet. I think, because this is done when they return, if it was a mental health issue then I would have already gone through lots of processes. I would have a given additional support before we were at the point of documenting return to work. (Angela)*

Sophie went further and suggested that managers can be more confident when there is a step-by-step process to follow rather than being flexible and informal with their approach:

*I think people are much more confident around things like capability because there is a step-by-step process at most, and it's much more tangible, because it's about skills and outcomes and achievement and it's measurable, I guess, is the, the difference. (Sophie)*

Sue stated that it can be difficult to be flexible:

*I guess I've said it was difficult applying the policy and the flexibility because there isn't an end point. (Sue)*

Thomas says that being flexible can be trial and error:

*it is generally trial or error. Frankly, thankfully, there's been no error. But yeah, the majority of these situations came about, and you're generally left to work through the resources and use your discretion. (Thomas)*

Amelia, in comparison found policies and procedures unhelpful:

*Not anything of use, no [...] it's like putting everyone in a box, this is the policy that will work for everybody, but mental health is not a one size fits all, it's so individual. (Amelia)*

Similarly, Sophie mentioned that sometimes policies and processes could be a tick box exercise:

*What I do see sometimes is a lot of tick box exercises. And that's not exactly using good practice. But I think that's because of time and sometimes because of that confidence. (Sophie)*

In addition, Gemma talked about the devolution of HR to line managers and the stress it puts on them, as managers can feel inadequate to do what HR are asking them to do:

*HR can play a really good role in it and the sadness is the way that HR as a profession has had to evolved to become more strategic and devolve out to line manages. It puts a lot more stress on the line managers because they feel inadequate to do what you are asking them to do. (Gemma)*

Case study research by Earnshaw, Marchington and Goodman (2000) found that formal processes and procedures have been recognised by managers as important and that when they were done right it helped avoid employment tribunal appearances and lost cases. It does seem, however, that at the beginning of an issue arising, informal methods were still preferred (Goodman *et al.*, 1998). Suter, Irvine and Howorth (2022) found that informal responses were preferred at the initial onset of issues by managers. They also found that a formal structured approach was sometimes helpful. Many managers also highlighted that they might be quicker to take up more formal approaches in the future as they can help employers to recognise and



provide support earlier on (Suter, Irvine and Howorth, 2022). More formal approaches can also help managers be more transparent and accountable (Martin, Woods and Dawkins, 2018).

Some of the managers discussed that their organisations had no specific policies or processes to support managers managing employees with mental health issues.

Natalie found it challenging that her organisation lacked not only mental health policies but also comprehensive managing people policies in general:

*The lack of organisational support through guidance, policies, processes etc was often challenging in my role [...] In an ideal world there would be very open, flexible policies and procedures to safeguard those with mental health issues and a way to ensure that all people involved were nurtured [...] without any policy in place it was very difficult. It was really difficult as there was mostly one of a lack of tolerance from higher up the management chain.*  
(Natalie)

Research has also found that organisations have limited effective workplace policies for prevention and support of employees with mental health issues (Fairclough *et al.*, 2013; Henderson *et al.*, 2013; OECD, 2015). There does, however, appear to be an increase in organisations reporting formal policies on stress and mental health and employees feeling that the policies were well understood and effective in helping people (Henderson *et al.*, 2013). In contrast, research by CIPD (2016) found that only 46% of respondents felt that their organisation supports people with mental health issues well and that 20% of respondents said that their organisation did not support those employees well. For some of the individuals interviewed in this research managers formally applying workplace policies were seen as putting more pressure on people and the pressure led to feelings of fear of taking time off and losing their job, see theme B for further discussion on fears. For example, Katie discussed:

*But as I said, for the whole sickness thing, where you have an episode, and then you have another episode, another episode, another episode, and then you have formal meetings,*

*which is [...] Puts on a lot more pressure. And I remember when my depression was really bad, when I initially worked there in my early 20s, and going for these meetings, and it was awful. It was awful and they say “do you want to bring a union rep with you?”, and it’s like, “are you gonna sack me?”, and that’s the way it makes you feel. But it doesn’t do any good for your depression or your anxiety, it just makes it a million times worse because you’ve got that pressure, that “what’s gonna happen?” Are you gonna lose your job? (Katie)*

Similarly, Matthew discussed the return-to-work process being more formal in his old job and found that it became a barrier for him:

*return to works, which were much more formal in my old job than they are here, [...] the process very much became a wall between me and the organization, and then because of where my mind was, my line manager. Because my line manager has to represent the views of the organisation and look out for the organisation in the same way that, you know, he has to try and look out for me. But at the end of the day, it reinforces that point that if it’s you or them pal, it’s you. (Matthew)*

Whereas, if managers apply the policies flexibly, they can help some individuals return to work quicker. Lilly stated:

*the work policy is to stay in touch on a weekly basis, to phone. Umm, I have a serious issue with phone conversations. He’s aware of this, so I’m able to communicate with him via Facebook, and if I’m going, if I’m off for anxiety reasons, he will leave it to me to contact when I’m ready over a given period of time. And therefore, not exacerbate my issue by constantly calling up and asking when I’m gonna be back at work, which makes a difference. I tend to return to work quicker when I’m able to do so in my own time, and not being, “encouraged” back to work. And again, flexibility of the hours, there is a healthy balance between what work needs from me, what requirements there are on a very fundamental level, and what he’s able to be flexible with. (Lilly)*

But many individuals reported returning to work too quickly after absence due to mental health issues and needing to take more time off. Lisa stated:

*Came back to work on the Monday and went off again straight away. Umm, it was too soon to come back, I pushed myself too hard and I couldn’t cope with it. (Lisa)*

Charlotte discussed not having any phased return and needing to take time off:

*I just came back in, really without any kind of phased return [...] So, I kind of came back basically all my colleagues said you shouldn’t be here, go home, and then I sort of realised*

*that I was like I couldn't do anything back there. So, I just went I kind of can't do this anymore, so went back off again. (Charlotte)*

This study has revealed concerns regarding workplace policies for both individuals and managers. Whilst there is a desire for policies and procedures to be implemented flexibly, some managers have emphasised the benefits of formal processes and policies in guiding their actions and ensuring compliance with organisational requirements. This tension, between informal and formal use of policies was also seen in research conducted by Suter, Irvine and Howorth (2022). This thesis research highlights the existence of a tension between informal and formal processes experienced by individuals. The preference among individuals is for managers to apply policies in an informal and flexible manner, as the strict enforcement of formal procedures can induce feelings of pressure, worry, and stress.

#### **4.4.3 Theme J: Individuals and managers experience of reasonable adjustments**

Organisations are legally required to make reasonable adjustments under the Equality Act 2010 to ensure that individuals with a protected characteristic, such as a disability, have the same access as people without a disability (Bell and Heitmueller, 2009; Geo, 2010; HM Government, 2010, 2011; Department of Health, 2011; Lawson, 2011; Bell, 2015; Department for Work and Pensions, 2017). For people with mental health issues, reasonable adjustments can reduce symptoms (Brenninkmeijer, Houtman and Blonk, 2008), prevent job termination (Mak, Tsang and Cheung, 2006), reduce the risk of a mood or anxiety disorder (Bolo *et al.*, 2013) and can help people return to work quicker (Cullen *et al.*, 2018). Research, however, has found few people received work accommodations (Wang *et al.*, 2011). Twelve of the individuals interviewed reported having workplace adjustments made for them, a much higher percentage than the 30% found by Wang *et al.*, (2011). This difference may be due to their

research focusing on individuals with anxiety and depression whereas this research included people with severe mental health issues such as bipolar disorder. Another distinction may be that several individuals interviewed did not perceive the accommodations they received as reasonable adjustments; instead, they often viewed them as flexible working arrangements or as part of the process of returning to work following an absence. For example, Matthew stated:

*No other than the umm, other than the phased return, then no. It's just I've been fortunate enough at both the previous employer and here, we employ a flexible. Time off in lieu policy I think we call it here, a flexible working policy at the previous organisation. I think the previous organisation, funnily enough, was more flexible. Particularly in my job, there were no core business hours, as it were, you could quite legitimately, so long as you made up your 37 hours a week, you could work pretty much whenever you wanted to. But again, that was mainly because my job was an analytical data and internal customer type role. (Matthew)*

This could be a reflection that individuals with mental health issues often have a limited knowledge of reasonable adjustments and what they are entitled to (Goldberg, Killeen and Day, 2005).

When adjustments are made, previous research has found that flexible scheduling/reduced hours, modified training and supervision, and modified job duties/descriptions were commonly made and that physical modifications to the workplace were the least common (Mcdowell and Fossey, 2015), as discussed in 2.4.3. During recording the lived experience of individuals with mental health issues different types of reasonable adjustments were discussed including changing working hours, adjustments to work equipment, taking breaks and working in different rooms. See table nine for examples of those discussed. The individuals interviewed experienced various physical adjustments, as evident from Lilly's hardware modifications and Margaret's relocation to a different work setting. The difference between the findings of this research and previous research could be due to differences in methodologies as Mcdowell

and Fossey (2015) research was a scoping review of literature published between 1993 and June 2013.

*Table 9: Examples of the reasonable adjustments that the individuals with mental health issues had. Source: Authors own.*

Reasonable adjustment made	Supporting quote
Specific hardware	<i>the keyboard for the small difference of moving from the keys to the mouse, which is required quite often for different types of images that we're working with, that stress has been reduced by simply buying a new keyboard. (Lilly)</i>
Change in where working	<i>Just moved temporarily to a different location. (Margaret)</i>
Phased return	<i>look it's like 1 o'clock now so you need to go home because its, you're on phased return, and I would be like, yeh alright I will just finish this, and they would be like can you leave it until tomorrow. (Charlotte)</i>
Having own desk when the rest of the company hot desks	<i>I don't mind sitting in someone else's desk, but I really dislike it when someone sits in mine. If I come back on a Monday morning because I work at home on Fridays, and things have been moved round on my desk and stuff has been left or things unplugged that really irritates me and so there's a big notice on my desk saying leave the autistic bloke's stuff alone. (Sean)</i>
Changes in hours work	<i>and I've been given my own individual hours, where I now work five hours Monday, Tuesday, Thursday and Friday, but I have Wednesday, Saturday and Sunday off. (Lilly)</i>
More supervision	<i>we decided that I needed regular supervision. (Rosie)</i>

Individuals discussed reasonable adjustments with their line managers. Lilly described her line manager and his ability to support her with adjustments to her work:

*Other managers basically run the argument "oh, we can't treat you any differently to anybody else", whereas my line manager is clearly of the mindset that it's not about treating me any differently, it's that I am different in certain aspects, and he's given me the equal opportunity that everybody else gets. And it's understanding that there is significant difference with that. He understands that it's not I'm getting extra sort of help, why not give me the extra day off when people with childcare needs need it, but it is an actual necessity based on my mental health, to allow me to maintain a decent working standard and a decent level of health. (Lilly)*

Similarly, Rosie talked about discussing with her line manager what she needed to stay in work:

*With my line manager. Stuff that was going on with my anxieties, I was having counselling at the time where obviously a lot of things were being talked about so it was only you know like hopefully it was going to have an impact on me at work so I said to my line manager that I was having real struggles coming into work because with the job that I do, I can't focus with my patients. She said she wants to work with me to keep me here [...] So we just talked about ways in which it would be better and easier for me. (Rosie)*

Research has also found that line managers are likely to be the person whom individuals with mental health issues discuss reasonable adjustments (Cunningham, James and Dibben, 2004; Foster, 2007; Foster and Fosh, 2010). Negotiations for reasonable adjustments may not be easy (Foster, 2007) and many people with mental health issues do not receive any accommodations (Wang *et al.*, 2011). For example, Elizabeth stated:

*You don't know what will help and sometimes my manager is in a position where she doesn't know what to suggest. I think when there is a list of things that she can pull from like, reduced hours, reduced physical activity, easier ways of getting around the location but when that runs dry, I think she's stuck, she doesn't know what else she can provide. (Elizabeth)*

In-depth interviews by Foster (2007) found that the negotiation for reasonable adjustments had been turned into a lottery based upon the goodwill of line managers and employers rather than a legal obligation, as discussed in 2.4.3. This research, though, looked at the experience for disabled people, it was not focused on people with mental health issues. The level of goodwill among managers could be influenced by their understanding of mental health matters. However, various studies have revealed that managers generally lack knowledge about mental health issues and the skills needed to provide support to their employees (Cunningham, James and Dibben, 2004; Waugh *et al.*, 2017; Hogg *et al.*, 2022; Olsen, 2022), as discussed in 2.3.2. This implies that when individuals negotiate for reasonable accommodations, they may encounter difficulties and tensions. Managers are the primary

stakeholder in these negotiations, yet they often lack the necessary knowledge and skills to effectively support individuals through the process.

Some individuals voiced during interviews that they refrained from requesting reasonable adjustments due to their reluctance to explain the reasons behind their need for them. For example, Juliet stated that due to previous experience of being in an awkward position when people asked her why she had accommodations she feared people asking:

*I think it's probably from a fear of people asking why you have those things [...] Umm, yes, I have and then that leaves you in quite an awkward position if you don't want to talk about it.*  
(Juliet)

How colleagues react to other people who have reasonable adjustments needs further research and how individuals with mental health issues feel about colleagues knowing about it. As highlighted in themes B and G, individuals may encounter negative attitudes from their colleagues. These attitudes can act as barriers, preventing individuals from disclosing their mental health issues to their co-workers which consequently, may also contribute to hesitation in discussing or seeking reasonable adjustments.

Even though previous research has discussed limitations of managers knowledge of mental health issues and reasonable adjustments being down to managers goodwill (Hogg and Turner, 1987; Cunningham, James and Dibben, 2004; Foster, 2007; Waugh *et al.*, 2017; Olsen, 2022) many of the managers interviewed had applied reasonable adjustments when managing people with mental health issues. Table ten provides a summary of what managers discussed. These are very similar to those that individuals discussed in table nine, but managers also mentioned change in job role as a reasonable adjustment. Research has found that such changes to an employee's job can be challenging as they can disrupt the day-

to-day work, operations, and structure (Pinder, 1995; Harlan and Robert, 1998; Saint-Arnaud, Saint-Jean and Damasse, 2006; Gewurtz and Kirsh, 2009).

*Table 10: Summary of reasonable adjustments managers discussed. Source: Authors own.*

Reasonable adjustment	Supporting quote
Desk set up	<i>the other thing that we would talk about is somebody's desk and the way it's set up. (Sue)</i>
Flexibility in the working environment	<i>But it would more be about flexibility in the working environment. (Sue)</i>
Reducing work hours	<i>For instance, an example was reducing her work hours. (Amelia)</i>
Flexible working hours	<i>just take that time and do what you need to do. (Gemma)</i>
Phased return	<i>return to work phase. (Adrian)</i>
Change in job role	<i>Managing people into the right position to facilitate them to manage their stability and their wellbeing. So, taking people out too often, often people serving is a high stress. So, moving them out of high stress environments. (William)</i>

Many of the managers talked about the importance of reasonable adjustments being specific to the individual's needs. For example, Abigail stated:

*So, I think it's a case by case. You know, let's have a look at it and see. (Abigail)*

Oliver discussed that the support given needs to be bespoke and specific to the individual needs:

*And it's kind of it's also what support can kind of go in. It's, it's that it's got to be bespoke, isn't it. Down to kind of what their individual needs and what those are. (Oliver)*

Even though managers discussed the need for reasonable adjustments to be focused on an individual's needs, Tilly found that many of the employees she supported did not know what could be done so did not know what would help them:

*I would say that they're very much led by me, which makes me feel uncomfortable, because I want them to be employee-led, but most of my employees don't understand what is*



*reasonable to ask to be adjusted...and we get to the section, where we're asking what we can adjust for them to make it better. Most of them are too scared today [...] And, and that's where I'll explore with them being, oh, well, you know, you know, this is reasonable [...] Sometimes I know, because now with various experiences and knowing different types of medication, I might know to say are you really struggling to get out of bed in the morning? Shall we just do shifts after 12pm, for example? And then they'll be, Oh, my God. Yeah, that's like a really good idea. It just depends on the individual. (Tilly)*

Reasonable adjustments are an individualised approach to removing disadvantage and discrimination in the workplace that ideally involves both the worker and employer working collaboratively to identify the barriers the individual faces and to create solutions (Almond, Horton and James, 2022). This is the approach favoured by some of the managers interviewed in this research. However, individuals with mental health issues appear to have limited knowledge of reasonable adjustments and what they may be entitled to (Goldberg, Killeen and Day, 2005) and so the collaborative process between individual and employer can be challenging, as discussed by Tilly. There also appears to be a lack of confidence and understanding by employers and individuals about what an adjustment could look like for someone with a mental health issue (Lockwood, Henderson and Thornicroft, 2014). This suggests that there exists a tension between the need for individualised reasonable adjustments and the limited knowledge and understanding that individuals and managers possess regarding the potential forms of accommodations.

Managers also discussed how they approached the negotiation of reasonable adjustments. In certain cases, informal methods were employed, such as John's experience, where he discovered that many adjustments could be easily implemented without formal processes:

*Quite easy. If somebody has to have any workplace adjustments we can do a few things informally. (John)*

John, though, also acknowledged that at times the negotiation had to be done more formally, especially when occupational health became involved:

*Obviously, some things we can't do for people, especially if it affects the operation and if it's more severe, then we do bring in OH and we get a recommendation from them, and then we decide whether or not we can do it. Most of the time we can. (John)*

As discussed in theme E and F there was a preference by both individuals and managers to communicate and apply workplace policies informally and flexibly. John's discussion though, implies that there are different times for using informal and formal approaches to managing individuals with mental health issues.

Consideration of operational needs was also reported by some of the managers, especially senior leaders. For example, Adrian stated:

*You know, because the kids that we work with are so vulnerable, there isn't adaptations I can make in the end. Yeah, we've got really complex kids who are really difficult to work with. If that's part of your problem, I can't change that. And there isn't another job that you can just do something quiet for two weeks. That doesn't exist. So that's quite difficult. (Adrian)*

Similarly, Oliver stated:

*But there's the, it's a difficult one, reasonable adjustments, we're just getting that balance of you can make a reasonable adjustment. But equally, if someone has, for example, a specific role. So, in teaching is TLR, teaching learning responsibility. If keeping on top of that means that they'll know, while we want to kind of mitigate things that job still needs to be done. (Oliver)*

Sophie acknowledged that both the individual and organisations perspective needs to be considered with reasonable adjustments:

*we deal with things like reasonable adjustments, mental working, and look at it from a business and an individual's perspective to try and make wherever possible, it works. (Sophie)*

For managers, especially senior leaders, they must consider that the job still needs to be done and they only have a finite number of resources. According to Bell (2015) reasonable adjustments can reconcile individual needs and organisational demands, but it appeared from the interviews with managers that this is more complex and needs further research. There is a tension between supporting the individual and operational demands which some of the managers found difficult. It appears that managers respond to this tension with a both/and response as they recognise that both individual needs and organisational demands are important and try to balance both (Smith and Lewis, 2011).

Both Adrian and Oliver as headteachers, said that the nature of the education sector may significantly influence the reasonable adjustments they can provide. Given the limited alternative job options, individuals who are teachers may have fewer adjustment options. This suggests that the organisational context can shape what reasonable adjustments are offered but further research is needed.

To summarise, reasonable adjustments can be a significant factor for individuals with mental health issues and a range of accommodations were identified. Managers were the person that individuals discussed reasonable adjustment with, but they also experienced tensions when negotiating with reasonable adjustments as managers can lack the knowledge and the skills necessary to support individuals through reasonable adjustments. The managers interviewed also identified a range of reasonable adjustments but also the tensions that they can face including balancing operational demands and supporting the individual.

#### 4.4.4 Theme K: Work design and workload are significant issues for individuals with mental health issues

Work design can be defined as the content and structure of an individual's work tasks, activities, relationships, and responsibilities (Parker, 2014). Work design emerged from the interviews as a significant issue for individuals with mental health issues. Individuals discussed the way work was structured, how workloads were managed (or not), the control and autonomy individuals had and flexibility at work; not just working from home but choice over what tasks were done and when, were important factors.

Workload appeared to be a significant issue for many of the individuals interviewed. Grace stated:

*At the end of the day, you can give as much support as you could possibly want, the sheer workload kills you. Because it kills your personal life, and it kills your time to recover and rest, and do the things that are really important to you. (Grace)*

Similarly, Margaret discussed the challenges she encountered while coping with her mental health issues at work, particularly when faced with heightened pressure and increased workload:

*Yeah, I think most of the time, when everything's on an even keel, it's fairly easy to do that. The difficulty comes when there is a lot of pressure from work that you know, the amount of work. (Margaret)*

Recent exploratory research by Hennekam, Follmer and Beatty (2021b) found that 65% of their participants felt that their mental health issues affected their capacity to deal with stress and high workloads and it can be detrimental to their mental health.

For both Grace and Margaret, it did not matter how many employee assistance programmes, mindfulness, supportive elements were offered to them if the workload was too high.

*I mean, that this is, the thing about that type of stuff is, what people actually want is enough staff and to do the work. And the flexibility to not have to stay late every single night. But employers seem to think that, okay, we want you to deal with mindfulness and all the rest of it, but what they actually will provide us with yoga class or something, or we need to introduce these sorts of small techniques. But what people actually want and said before, is just enough staff to do what they need to do, that is more helpful, a lot of times than trying to sort of say, oh, well, you know, we'll, we'll pay for someone to come in and teach you about something else. That's not, that's not what people need. (Margaret)*

Likewise, Grace stated:

*And you can put in as many supportive things, but if I'm working a 60-hour week, I can't go to the social function, which is all 'hooray, yeah let's go and do this', you know, because I can't physically get through my work to do it, and if I don't finish my work, you know, I'm then not doing my job. So, you can put in as many initiatives as you want, but if I can't access it, what the hell's the point?! (Grace)*

Individuals with mental health issues struggles at work cannot be solely answered by workplace health and wellbeing initiatives even though workplace wellness initiatives are becoming more and more popular (Hall, 2020; Braun, 2021). Organisations relying on workplace resources of support, such as those discussed in theme H, may ignore the importance of work design and its impact on mental health issues. There is a body of research that demonstrates a clear link between psychosocial work factors and mental health (Karasek, 1979; Llana-Nozal, 2009; LaMontagne *et al.*, 2014; Leka and Nicholson, 2019; Woods *et al.*, 2019), as discussed in 2.2.2. Two approaches to this link are the job demand-control model and the effort-reward model (Karasek, 1979; Llana-Nozal, 2009). Research has found that low job control, high job strain and demands, and low social support were associated with an increased risk of common mental health issues (Stansfeld and Candy, 2006). Other research has found a significant association between low job control and high job strain and the development of depression (Clumeck *et al.*, 2009; Inoue *et al.*, 2010). This

further supports the need for organisations to look at work design, including job strain, job control and social support when managing people with mental health issues.

There is a balance with workload though, as many individuals interviewed said that keeping busy was important for them, for example Katie said:

*Umm, it doesn't really have an impact at work because I'm so busy at work. I'm more focused on my patients and my team, and the people around me. I don't really think of myself very much. And it's when I'm not at work that things tend to spiral because I haven't got that focus.*

(Katie)

For Liam, keeping busy at work and interacting with customers allowed him to push his mental health issues aside and focus on the job rather than his own problems:

*When I'm with customers, I don't have to be me, it's like having a small vacation in a way because I'm dealing with the problem in front of me so I'm not having time to think about anything that is not directly in front of me so I get to have a break. (Liam)*

This analysis suggests that individuals with mental health issues experience tension between keeping busy and workloads being too high. Keeping busy can help maintain their mental health and manage their mental health issues, whereas too much demand from workload can negatively impact their mental health and mental health issues.

Another enabling factor discussed by individuals was control and flexibility over what tasks they do and when. For many doing basic, menial, low brain power tasks when they were having difficult days could be helpful. For example, Lisa stated:

*I actually find, sort of, the workload easier to manage now, even though I've got more work, because I can do it in my own time, and at my own pace, and I can prioritise it myself, I find that that helps...if I'm having a day where I don't feel amazing, I can work on the sort of, more menial tasks, and things that aren't massively important, or things that aren't particularly taxing. (Lisa)*

Margaret also discussed using easier, repetitive tasks to give her brain a break at work which helped her manage her mental health issue:

*I think I just busy myself with tasks that don't involve interacting. You know, just doing mundane tasks, reorder sorts of tasks that you don't really sort of speak to anybody about [...] just to give my brain a break. (Margaret)*

Lucas discussed having control over when he did work and the flexibility to change tasks when he needed to, helped him manage his mental health issues:

*I'm in the fortunate position because of the job I do I control probably about 90% of my time, of my diary. So, it's quite easy for me to excuse, you know I have a workload that I can work at 5 o'clock in the morning or 2 o'clock, I have few set meetings. So, I can relatively be in control [...] I can take myself out of it, that's the thing. Even though my job is all consuming I can create windows or space. I can also control my environment quite a lot. (Lucas)*

For Matthew using audio books and listening to music were coping mechanisms he used:

*Being able to work at my own pace is quite a good one. I spend a lot of time, when obviously not in meetings or actually talking to colleagues, listening to music, audio books, err, vlogs, podcasts, that kind of stuff. (Matthew)*

Not only is control over tasks important for the individuals interviewed, for some flexibility in working hours and how work was done was also important. For example, Charlotte stated:

*so, I have told them that I suffer with seasonal affective disorder, so come October that's a really bad time for me. So actually, I am generally in a bit later. We've got flexible working so were really lucky [...] And they're like do you know what as long as you're ok with it and you deliver, or if you're struggling to deliver, you talk to me about it, that's absolutely fine. (Charlotte)*

Lisa highlighted the importance in autonomy and control as people will not be able to work 100% all the time:

*Yeah. Yeah, definitely, and I think it's, it's unreasonable to expect everyone to be at 100% all of the time. Umm, and I think I used to put a lot of pressure on myself to constantly be up there and performing at 110% all the time. Umm, but no one can do that all the time, you know? It's unmanageable. Everyone needs some down time and some days where you [...]*

*even if you're sort of doing half the workload you would do other days, you're still there and you're still achieving, you're still doing something. Umm, autonomy, I think, is really important.*  
(Lisa)

Research has also found an association between job control and flexibility and mental health issues. For example, research that looked at men in manufacturing jobs found that high levels of job control were associated with a lower risk of long-term sickness absence due to depressive disorders (Inoue *et al.*, 2010). It also appears that control and flexibility can help individuals manage their mental health issues as Michalak *et al.*, (2007) interviews with people with bipolar disorder found that some people valued the ability to retain flexibility in their work schedule to help manage fluctuations in their mood.

How work is designed, how workloads are managed are important as work can be a safe space for individuals, it can be part of their recovery and management of mental health issues. For example, Lilly stated:

*it's my second safe space. I only [...] I feel safe at home, where I have CCTV everywhere for my comfort, and I feel safe at work, because of the managers I've got there. I don't go anywhere else, so it's, to say that work is one of my safe spaces.* (Lilly)

Work can be important for people's recovery and management of mental health issues (Michalak *et al.*, 2007; Llana-Nozal, 2009; Leamy *et al.*, 2011; Doroud, Fossey and Fortune, 2015; Barnay, 2016; Nardodkar *et al.*, 2016) as employment can offer connectedness, hope, optimism about the future, be part of an identity, empowerment (Leamy *et al.*, 2011; Doroud, Fossey and Fortune, 2015) and can provide structure and routine (Michalak *et al.*, 2007). Research by the Mental Health Foundation and Unum (2016) found that the majority of people report that being in work and their job is important to them to protect and maintain their mental health. Furthermore, this thesis research has shown that work can also be a safe space. This, though, needs further exploration as people with mental health issues can face



high levels of stigma, discrimination and negative attitudes at work (Smith and Twomey, 2002; Coutts, 2007; Perkins, Farmer and Litchfield, 2009; Russinova *et al.*, 2011; Evans-Lacko, Henderson and Thornicroft, 2013; Martin, Woods and Dawkins, 2015; Steadman and Taskila, 2015; Bhugra, Ventriglio and Pathare, 2016; Follmer and Jones, 2017, 2018; Stevenson and Farmer, 2017; TUC, 2017; Hennekam, Follmer and Beatty, 2021b), as discussed in theme B and sections 2.1.6, 2.2.5 and 2.4.4 in the literature review. There appears to be a tension for some individuals that work can be a safe space and important for their management of their mental health issue but can also impair them due to the stigma, discrimination, and negative perceptions.

Social motivations can also be an important part of work design (Parker, Morgeson and Johns, 2017; Allan *et al.*, 2018). For some of the individuals interviewed, it could be an enabling feature of work for individuals with mental health issues. For Grace:

*I'm really dedicated in my job, and really dedicated to the kids I work with, and because I know that they're relying on me, my team's relying on me, my staffing team, umm, it almost holds me in check with myself [...] I have to be self-aware. And I have to manage it. Because if I don't, I'm letting, I'm letting people down. (Grace)*

Work exists in a social context and can have an impact on individuals. Research has shown that employee's motivation can be increased if they relate to the prosocial benefits of their work (Grant, 2008; Parker, Morgeson and Johns, 2017). Grace works as a teacher in a special needs school and feels very dedicated to her job, the children she teaches and her team. Meaningful work is associated with better mental health (Steger, Dik and Duffy, 2012; Allan *et al.*, 2018) and can be defined as work that is important, facilitates personal growth and adds to the greater good (Steger, Dik and Duffy, 2012; Allan *et al.*, 2018). Other research has found that meaningful work is linked to greater life satisfaction, and lower anxiety and depression (Arnold *et al.*, 2007; Steger, Dik and Duffy, 2012; Allan *et al.*, 2018). Further

research is needed to look at meaningful work and its impact on employees with mental health issues.

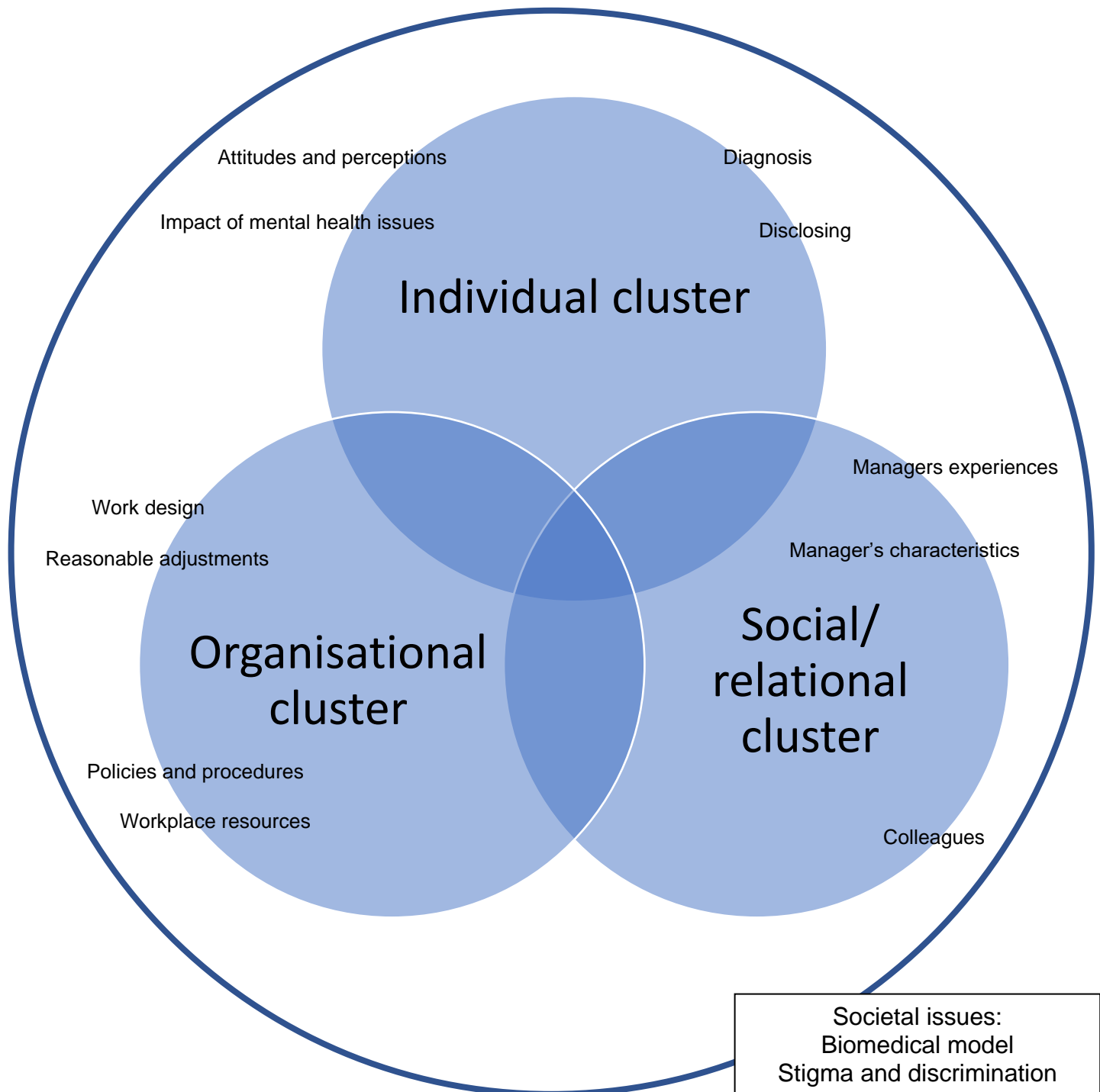
In summary, work design including the way work is structured, how workloads are managed (or not), control and autonomy work and flexibility at work, were significant factors in the experience of individuals with mental health issues. A high workload could negatively impact individuals and make it more challenging to manage their mental health issues but also, in tension, being busy at work could help individuals manage their mental health issues. Having control, choice and flexibility over what work is done and when was also an important feature of work design reported by individuals. The job demand-control model may provide an understanding of the underlying mechanisms of the impact control and demand have on individuals with research showing an association between low job control and high job demand and risk of mental health issues (Stansfeld and Candy, 2006; Clumeck *et al.*, 2009; Inoue *et al.*, 2010). Further research, though, is needed to look at the impact for people in work with mental health issues. Work can be an important part of how individuals with mental health issues manage their issues and recovery, however, there is a tension as work is also a place of stigma, discrimination, and negative attitudes. Further research is needed to explore this tension further and how individuals manage to resolve it.

#### **4.5 Concluding remarks**

The aim of this thesis was to surface and explore significant issues faced by individuals with diagnosed mental health issues in the workplace, as seen through the eyes of both individuals and managers. By taking into account the economic, legal, social, and medical aspects, the thesis sought to document personal experiences of individuals and managers and identify key issues affecting them. The analysis of the data generated for this thesis

reveals that this was a challenging endeavour due to the multifaceted nature of mental health issues and the unique experiences of individuals. From recording the lived experience of individuals with diagnosed mental health issues and managers, a range of significant issues and enabling features have been identified which have been presented in eleven themes, as can be seen in table six.

The themes can be grouped together into three clusters: individual, social/relational, and organisational. Within the individual cluster the factors include the impact of mental health issues, attitudes and perceptions, diagnosis and disclosing. The social/relational cluster contains managers' experiences and characteristics and colleagues. The organisational cluster encompasses work design, reasonable adjustments, policies and procedures and workplace resources. Figure eight provides a visual representation of these clusters and factors. These clusters also interact and influence each other as, for example, attitudes and perceptions of individuals can influence managers behaviours. Underpinning these clusters is societal issues which include the biomedical model and the stigma and discrimination of people with mental health issues. See figure eight for a visual representation of these clusters and underpinning issues.



*Figure 8: Visual representation of the clusters of analysis and significant issues. Source: Authors own.*

The themes generated, analysis of the data and literature together provide a starting point of the jigsaw puzzle of the day-to-day experience of work for people with mental health issues.

These include the positives and the negative aspects of work, the enabling factors, and

significant issues for individuals with mental health issues. Figure eight is an illustration of this jigsaw puzzle. To continue with the metaphor of a jigsaw puzzle, figure eight provides the outside pieces of the jigsaw- the societal issues and clusters and then some of the inside pieces which are the significant factors and issues such as work design, managers experience and disclosing. These inside jigsaw pieces align with previous research as discussed throughout this analysis. This research, though, has gone further and started to explore the outside pieces of the jigsaw. Thus, highlighting the importance and shaping influence of societal issues such as narrative, models and assumptions of mental health issues and stigma and discrimination. Knowing what the jigsaw puzzle pieces are from the perspective of individuals with mental health issues is important as they are the experts of their experiences. This now means that any future research can be based upon the individual's experiences and their voices and not the voices of professionals. This is important as the field of mental health issues and work has been dominated by professional voices and not the people living with mental health issues, as discussed in 2.1.1 and 2.1.2.

The theoretical framework of paradox theory and tension lens (Lewis, 2000; Smith and Lewis, 2011; Miron-Spektor et al., 2018; Quinane, Bardoel and Pervan, 2021; Suter, Irvine and Howorth, 2022) has been used to frame the analysis and has revealed more details of the jigsaw puzzle of the significant issues at work for people with diagnosed mental health issues, from the perspective of individuals and line managers by highlighting a range of tensions experienced. These tensions are:

- Positive versus negative impacts of mental health issues,
- Disclosing versus not disclosing to protect from stigma and discrimination,
- Diagnosis is helpful versus negative attitudes and perceptions of the label,
- Seeking help and support versus the difficulty in accessing services,

- Needs of the individual versus needs of the collective,
- Managers supporting individuals versus the impact it has on their own mental health and wellbeing,
- Managers wanting to support versus the demands and pressures of their role,
- Informal versus formal,
- Colleagues being supportive versus colleagues' negative behaviour,
- Managers are first contact versus managers lack knowledge and skills,
- Keeping busy versus workloads too high,
- Work can be a safe space versus stigma, discrimination, and negative perceptions.

Even though the focus of the research was not to find out how the tensions were managed, when they have been responded to the approach was a both/and response. The reactions to the tensions were to recognise both elements were important and to accommodate both (Poole and van de Ven, 1989; Jarzabkowski, Lê and van de Ven, 2013; Schad *et al.*, 2016; Suter, Irvine and Howorth, 2022). This suggests that the jigsaw puzzle of mental health issues at work is dynamic and often there are not complete solutions for individuals or managers. Rather a balancing act between needs, demands, safety, and support. These findings align with other research in the mental health issues at work field suggesting that the jigsaw puzzle is not static but is a dynamic one made of factors, issues, tensions and balancing acts.

Building on the analysis, the concluding chapter seeks to draw together the jigsaw puzzle of experiences factors, issues and tensions to provide a future research agenda for the field of mental health issues. To ensure that this is based on quality research there is an overview of the story of the thesis, critique of the research conducted, and an attempt to develop a model of themes and tensions.

## **5 Conclusion and further research agenda**

This thesis set out to explore the significant issues at work for people with a diagnosed mental health issue from the perspective of individuals and line managers, by focusing upon the economic, legal, social, and medical context, the lived experience of individuals and line managers, the significant issues for individuals and line managers and enabling features for individuals and line managers. It was also intended to develop a research agenda for further research into significant issues at work for people with mental health issues. The journey to accomplish the aim and objectives has been challenging: choosing what to focus the research on within the broad field of mental health issues at work, the complex, discrete nature of the existing body of literature, deciding upon a methodology that allowed for in-depth exploration but was also robust and defensible, analysing the rich, in-depth data generated in a meaningful way and writing about the topic as a whole whilst at the same time analysing the interconnectedness of its component parts. This journey has been tempered by my own personal travel through ill-health, chronic illnesses and learning how to manage my body and its needs.

This chapter will focus on addressing what the story of the thesis is, what the quality of the story is, using Tracy's (2010) eight criteria of quality qualitative research as a guide, what contribution the thesis makes to theory and practice and what further research needs to be done, with the development of a future research agenda.

### **5.1 Story of the thesis**

I came to the PhD journey with a wealth of experience of supporting people with mental health issues and listening to stories of their challenges and difficulties. Their stories about work were centred on surviving the day. I found this concerning as I have innate values of

fairness and belief in people being all that they can be. The stories I heard were not just the personal struggles of people but also structural challenges at work which prevented flourishing and at times seemed unfair. I was curious to find out whether this was a common experience, what could help people with mental health issues flourish at work and what could shape and impact their survival.

Searching the literature provided some knowledge on what specific aspects of work can be like for people with mental health issues and some of the shaping factors e.g., reasonable adjustments, disclosure, and the importance of the line manager. The common message was that work can be a negative experience for individuals with mental health issues due to the stigma, discrimination, and negative perceptions. It failed to offer a comprehensive depiction of the experience of work for people with mental health issues including the supportive elements present and the factors that affect them. There were many options which could have formed the basis of the PhD research including: focusing on the experience of stigma and discrimination at work by individuals, identifying the process of reasonable adjustment negotiation or disclosure, effectiveness of the support services, the health and wellbeing agenda for people with mental health issues and the value of the training on mental health issues. These options though were not taken as the focus on any of these specific elements would not enable the exploration of the breadth of the issues that had been discussed in the conversations I had with people with mental health issues. The route I took was to look more holistically at the experience of work and to explore the positive and negative aspects. This led to the research aim: to surface and explore the significant issues at work for people with a diagnosed mental health issue, from the perspective of individuals and line managers. The objectives were to:

1. Recognise the economic, legal, social, and medical context,



2. Record the lived experience of individuals and line managers,
3. Uncover the significant issues for individuals and line managers,
4. Explore enabling features for individuals and line managers,
5. Develop a research agenda for further research into significant issues at work for people with mental health issues.

This thesis has been driven by a spirit of exploration and curiosity which originated from an interest in the insights gained from conversations with individuals about their personal experiences. There was a strong desire to delve deeper into these experiences and to investigate what was happening in work for people with mental health issues. Exploration led me to a wide range of literature, but I found it lacking in answering my curiosities regarding the daily work experiences of individuals with mental health issues and the factors that shape and influence their experiences. This limited knowledge from the literature led to exploratory research being undertaken. Exploratory research can be valuable in gaining insights and seeking clarity about what is happening within a topic (Saunders, Lewis and Thornhill, 2019) but can be fraught with struggles and surprises (Casula, Rangarajan and Shields, 2021). This exploratory approach to the research has been challenging due to the complexity of the topic but given the incomplete nature of the literature it was a valid route and has rendered an informed basis upon which to build an agenda for future research.

Exploring individuals and managers experiences was an important aspect of this research. The decision was made to examine both perspectives, considering that the most significant relationship in the workplace for individuals with mental health issues is typically with their line manager. Consequently, it was probable that the line manager plays a pivotal role in shaping the individual's work experience. Little is known about this relationship and what influences

and shapes the managers experience of managing individuals with mental health issues and consequently how this experience in turn shapes the experience of the individuals.

Researching both perspectives has been challenging, but the rich, complex data generated through the interviews has made this approach worthwhile. Looking at the managers' experiences was done to shed light on the experiences of individuals with mental health issue, the focus was not the managers' experience.

During the interviews a myriad of stories were collected, which were dynamic and rich. These findings illustrated that people's experiences can vary significantly from one day to another, each individual's experience was unique and the narratives of managers were diverse.

However, there were also shared factors that consistently emerge throughout the stories, indicating common threads that connect these experiences. For managers a reoccurring narrative was a people management approach to their managing style, but this was impeded by organisational demands. A common thread running through the individuals with mental health issues interviews was the experience of stigma, discrimination, and negative attitudes in their working careers. Another thread was the importance of the manager to their experience and how that can be shaped by the manager's communication skills, their knowledge, and previous experience. The importance of work design was a further common thread, with many individuals discussing workload, access to resources for support and policies and procedures. The prevalence of the underlying assumptions of the biomedical model in the interviews was common throughout all the interviews. The biomedical model influenced narratives as much of the focus is upon making individuals fit within the constraints of an organisation rather than recovery and enabling factors.

Looking at the whole experience of work for individuals with mental health issues was difficult as it is made up of multiple elements. My research, though, identified some of these: impact

of mental health issues, perceived positive and negative impacts that mental health issues can have on work, attitudes and perceptions of individuals with mental health issues at work, the experience of disclosure of mental health issues, diagnosis/ labelling of mental health issues as a significant issue for individuals and managers, enabling and challenging factors managers experience when managing individuals with mental health issues, characteristics of managers' behaviour when managing individuals with mental health issues, colleagues and the part they play in the experience of work, workplace resources of support and help for mental health issues, workplace policies and processes, reasonable adjustments and work design. These factors have also been found to be interlinked, informing, and shaping each other, see figure eight on page 230. The precise nature of this interconnectedness requires further research.

The literature discussed in chapter two often presented a limited and fragmented view. For instance, it tended to concentrate solely on either the negative aspects of work experienced by individuals with mental health issues, such as stigma and discrimination, or solely on the positive aspects, such as the role of employment in their recovery. This one-sided approach oversimplified the complex reality of work experience, creating an unrealistic portrayal that does not align with the actual lived experiences of individuals in the workplace, as my research has discovered. At the beginning of many of the interviews, individuals recounted only the negative aspects of their experience, it took some probing in the conversation to reveal that there were positive aspects of their experience. Unlike the literature, this research has demonstrated how complex and multidimensional the field is. It also found that there are many tensions and that these tensions significantly impact the experience that individuals have.

The field of mental health issues at work is vast. It includes: the high costs to organisations, organisational and workplace conditions that can impact on mental health, stigma and discrimination, workplace policies, managers' attitudes, reasonable adjustments, and disclosure. Literature can be found in multiple disciplines including psychiatry, rehabilitation, occupational health, law, and psychology (Follmer and Jones, 2018; Woods *et al.*, 2019). This has led to mental health issues at work to be researched from multiple approaches and perspectives with little cohesion between them. I attempted to seek clarity on the potential direction that the research field could take by exploring the lived experiences of individuals and managers. There is little previous research that has looked at the day-to-day lived experiences. What there is has focused on the lived experience of returning to work, supported employment, IPS and long-term sick. By taking an approach that has explored the day-to-day overall experience it has enabled a detailed future research agenda to be developed, see table eleven on page 258. I have contributed to theory by surfacing significant issues and factors at work for individuals with mental health issues and managers. Using paradox theory and tension lens has reinforced the picture that these issues and factors are multi-dimensional. This has also led to a contribution to practice.

### **5.1.1 Contribution to theory**

Due to the exploratory, qualitative nature of this research project an inductive approach was taken. This does not lend itself to a priori theory development and testing as it is often not based upon previous research (Bryman, 2012; Reiter, 2013; Casula, Rangarajan and Shields, 2021). Furthermore, even though there is a wide range of literature discussed in the literature review, there is a limited amount on the specific area of what is work like for people with mental health issues and what significant issues and factors shape their experience. This meant that there was insufficient literature to provide an underpinning theory to this research

project. Consequently, the PhD did not set out to identify a theory, develop a theory or to test a theory but through the data generation and analysis it became clear that there was the potential to contribute to theory.

One of the challenges I experienced when thinking about theoretical contributions was the definition of theory and what theoretical contribution means. I started the thesis thinking that a theory would be able to explain the why, what, where and when of a phenomenon and predict what can happen thus aligning with Creswell and Creswell (2018) grand theory aspect of their proposed three-level typology of theories. Grand theories refer to abstract and general theoretical perspectives that can influence individuals' thinking about the world, but these theories are too abstract to be tested empirically (Wilkins, Neri and Lean, 2019). Other types of theories include middle range theories and substantive theories (Creswell and Creswell, 2018; Wilkins, Neri and Lean, 2019). Substantive theories are specific to a particular population of people, problem, or research setting (Creswell and Creswell, 2018). The exploratory nature of the research conducted for this thesis has enabled the development of a substantive theory which is a set of interrelated concepts or ideas that explain an aspect of the world (Lee and Lings, 2008).

From the analysis of the data generated it became apparent that there were interrelated ideas that can provide an explanation of the experience of work for individuals with mental health issues and key issues and factors that shape their experience and the experience of managers, as can be seen in figure eight on page 230.

Figure eight, however, omits the tensions that were identified in the analysis when paradox theory with a tension-lens was used. For many PhD students the theoretical framework they use in their thesis can be identified through the literature review process (Wilkins, Neri and

Lean, 2019), however, as already discussed, the topic area of mental health issues at work lacks theoretical and conceptual underpinnings (Elraz, 2017; Follmer and Jones, 2018; Hennekam, Follmer and Beatty, 2021a, b). The theoretical framework for this thesis became apparent through the analysis process and reading Suter, Irvine and Howorth (2022) and Quinane, Bardoel and Pervan (2021) papers where paradox theory with tension lens approach had been taken to their research. Discussion of paradox theory can be found in chapter 1.5. Utilising the paradox theory and tension lens during the analysis provided an opportunity to look at some of the complexities in the experience of work for individuals with mental health issues and managers' experience. It showed that the experiences are not one dimensional but are complex and can be fluid.

A model that incorporates the themes, clusters and tensions can be seen in figure nine. This shows the significant issues at work for people with mental health issues that has been found in this thesis. This includes the key issues within the three clusters- individual, social/relational, and organisational and that they shape and influence each other as suggested by the arrows. Within the individual cluster the significant factors are impact of mental health issues, attitudes and perceptions, diagnosis, and disclosing. The social/relational cluster is formed from managers experiences, managers characteristics and colleagues. The organisational cluster is comprised of work design, reasonable adjustments, policies and procedures and workplace resources. Within these three clusters are also the tensions that have been found in those clusters. For a list of the tensions, see 4.1 and 4.5. The tensions are represented by arrows which have been used by other authors such as Suter, Irvine and Howorth (2022) and Quinane, Bardoel and Pervan (2021) to represent tensions. The model, also like figure eight, shows the overarching impact of societal issues. This reflects the consistent assumptions running through many of the interviews that mental

health issues are understood and approached from a biomedical model view and that there are negative perceptions of mental health issues that can create stigma and discrimination for individuals. These negative perceptions are pervasive and affect the experience of work for people with mental health issues.

This model can be seen as a substantive theory as it is specific to people with mental health issues at work and currently is restricted to the participant group of the research (Creswell and Creswell, 2018). The future research agenda, see section 5.3, provides a detailed plan to fill the research gaps identified about the experiences of work, the factors, and issues for the individual and managers and through this research the model can be examined to see if it can provide theoretical understanding.

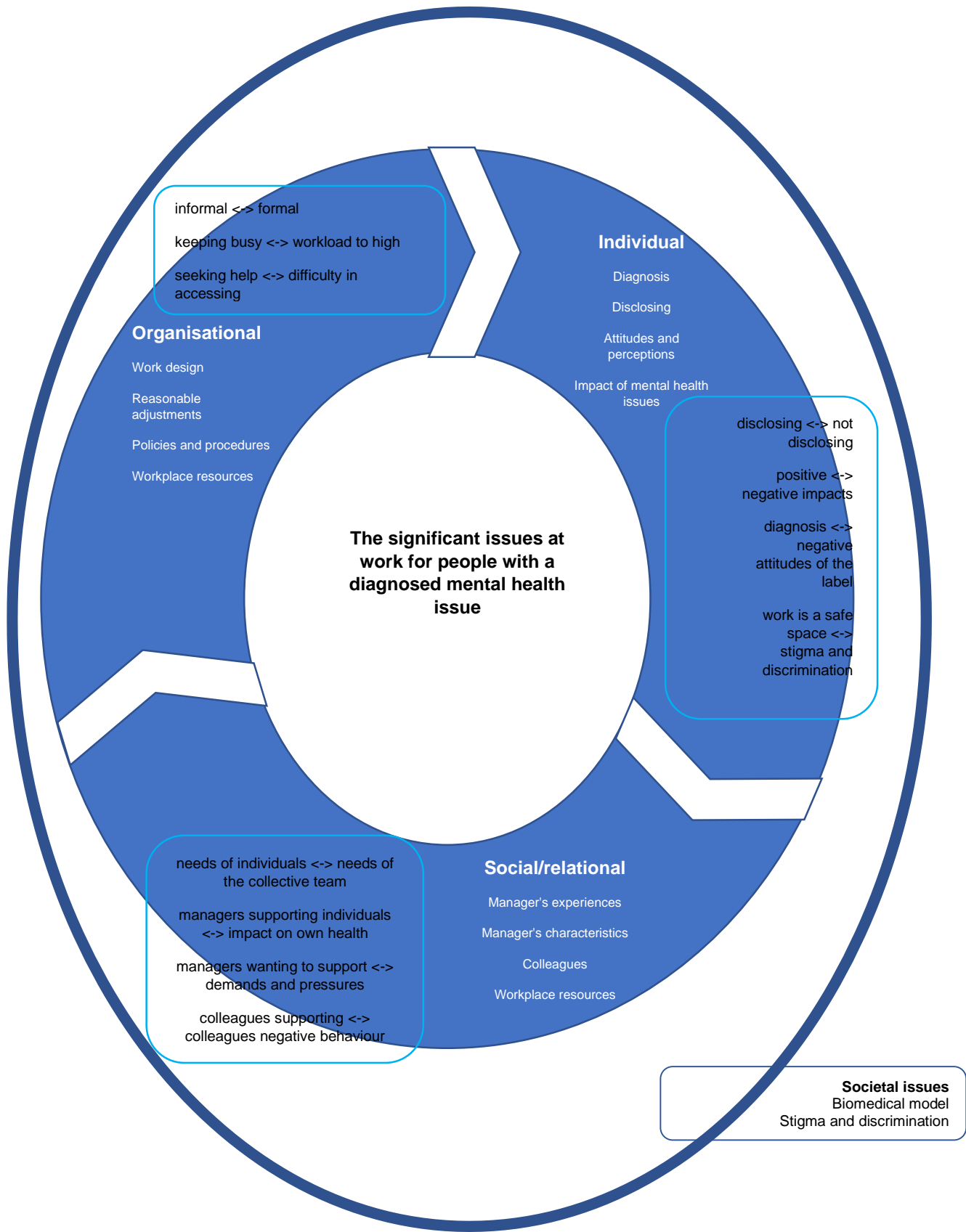


Figure 9: A model that incorporates the themes, clusters and tensions. Source: Authors Own



### **5.1.2 Contribution to practice**

The PhD did not aim to develop knowledge or understanding in order to contribute to practice, it aimed to explore the whole picture and surface potential issues and influences. This has meant that whilst many issues have surfaced, the contribution to practice is not direct but as they have been identified as important their influence on practice can be considered. The key issues identified encompass various aspects: the potential positive impacts of mental health issues at work, the crucial relationship between individuals and their managers, the significance of active listening, the importance of managers possessing appropriate skills, knowledge, and resources, the value of treating individuals with respect and dignity, and the autonomy required by individuals with mental health issues to manage their productivity effectively. Additionally, important considerations for managers include effective communication, fostering informality and flexibility, the availability of supportive resources, and appropriate training. However, it is essential to acknowledge that these factors can be influenced by job roles, organisational demands, and the managers' past experiences, potentially placing constraints on their implementation. The model in figure nine can provide a platform for the future development of training and resources for organisations and managers in managing individuals with mental health issues. It provides a starting point in understanding what the key factors, issues and tensions are at work for managing people with mental health issues.

## **5.2 Quality of the story**

There are several philosophical assumptions that underpin the methodology used in this thesis to create the story. Chapter 3 discusses the ontological position of constructionism (Bryman, 2012; Easterby-Smith, Thorpe and Jackson, 2013; Gray, 2014), an epistemological position of social constructionism (Berger and Luckmann, 1991; Cunliffe, 2008; Andrews,

2012), an inductive approach to the research (Bryman, 2012; Easterby-Smith, Thorpe and Jackson, 2013; Saunders, Lewis and Thornhill, 2019), and following a qualitative research strategy (Bryman, 2012; Creswell, 2016) that have been adopted by this thesis. This approach to research can mean that typical assessments of the quality of research such as reliability, generalisability and validity cannot be applied as they are based upon different research philosophy assumptions (Bryman, 2012; Levitt et al., 2017; Lincoln & Guba, 1985; Lloyd et al., 2006; Smith, 2018; Smith & McGannon, 2018; Tracy, 2010). A range of approaches can be taken to evaluate the quality of qualitative research such as Lincoln & Guba's (1985) two main criteria: trustworthiness and authenticity and, Yardley's (2000) four criteria of: sensitivity to context, commitment and rigour, transparency and coherence, impact and importance. For this thesis Tracy's (2010) eight criteria for quality has been used. It includes worthy topic, rich rigor, sincerity, credibility, resonance, significant contribution, ethics, and meaningful coherence. This has been chosen as the criteria reflects a flexibility in applying a quality criterion to research (Tracy, 2010; Smith and McGannon, 2018) and its application has provided a robust review and critique of the research conducted in this thesis.

Worthy topic refers to the topic of research being relevant, timely, significant, and interesting (Tracy, 2010). As discussed in the introduction and literature review, the high economic and organisational cost of mental health issues in work can be a justification of conducting this research (Sainsbury Centre for Mental Health, 2007; Centre for Mental Health, 2010; Mental Health Foundation and Unum, 2016; McManus *et al.*, 2016; Parsonage and Saini, 2017; Stevenson and Farmer, 2017; Hampson and Jacob, 2020; ONS, 2022) but there is also a human cost with an estimated 1.5 million people in work with a diagnosed mental health issue and 300,00 people with long-term mental health issues losing their jobs every year (Stevenson and Farmer, 2017). Much of the previous research has focused upon these high

costs with the rest of the mental health issues field being researched in disparate, discrete ways which has not provided a deep understanding of the field, including the significant issues for individuals with mental health issues and managers (Follmer and Jones, 2018; Woods *et al.*, 2019; Suter, Irvine and Howorth, 2022). This context suggests that the topic was worthy of research.

The next quality criteria from Tracy (2010) is rich rigour. This describes high quality qualitative research as having a rich, complex abundance of theoretical constructs, data sources, contexts, and samples. Forty semi-structured, in-depth interviews were carried out as part of this research. The shortest interview duration was one hour whereas the longest was three and a half hours, demonstrating the richness, depth and complexity of the data collected. This has generated more than enough data to explore the aim and objectives and provide the backbone of the analysis presented in chapter four. The data was generated over a year and the analysis was conducted from the first interview in 2019 until the write up phase in 2022. The diversity of participant, however, could have been improved by considering different contexts and taking them into consideration in the analysis e.g., mental health issue diagnosis, gender, age, sector, level within an organisation and size of organisation. These were not taken into consideration as the research was exploratory (Woodall *et al.*, 2010). There are challenges with researching individuals with mental health issues and so an opportunistic, snowball sample was utilised (Atkinson and Flint, 2001) taking advantage of my professional network. This can bias the research towards people that I know and exclude other people (Hendricks, Blanken and Adriaans, 1992; Griffiths *et al.*, 1993). An attempt to minimize the bias was made by utilising snowball sampling and asking those already participating in the research to ask their colleagues, managers, and friends to consider participating. On reflection, however, the participant group was adequate to generate the

data, the analysis that has been conducted and the conclusions drawn from it as there are no attempts to generalise, but in future, research in this area will need to consider the contexts of the people interviewed and extend recruitment outside my professional network.

Rich rigour in this thesis has been affected by the participant group who took part in the interviews. As can be seen in table four in the method chapter, only six of the individuals with mental health issues identified as male, fourteen identified as female. Eleven of the managers interviewed identified as female but all the senior leaders identified as male, see table five.

Women are more likely to experience a mental health issue, it is estimated that one in five women compared to one in eight men will have a common mental health issue (McManus *et al.*, 2016) so the individuals with mental health issues participant group being female dominated may reflect society. The managers data set, however, does not reflect society as it is estimated that fewer than half (41%) of management roles in the UK are held by women (Chartered Management Institute, 2022) whereas this data set was 55% female. Also unrepresentative is that all the senior managers in the study were male whereas the figures from the Chartered Management Institute (2022) estimate that 38% of senior managers are women. The predominance of women in the total sample may reflect my professional network. This source of participants, however, had the strong advantage that they were willing to talk to me about their experience and all the managers had some experience of managing individuals with mental health issues. It is likely that the willingness of both individuals and managers to talk about their experience is unrepresentative of the wider population. The range of both positive and challenging experiences discussed by the interviewees, though, suggests that the self-selection may not have influenced the findings detrimentally.

Another issue with the data set is the lack of knowledge about other identities of the participants. Current estimates are that people who identify as LGBTIQ are between two to

three times more likely than heterosexual people to report having a mental health issue in England (Elliott *et al.*, 2015) and an estimated 23% of Black or Black British people will experience a common mental health problem in any given week compared to 17% of White British people (McManus *et al.*, 2016). Future research needs to consider how the data set is put together including gender, race, age, and sexual orientation to develop understanding of what work can be like for people who may have minority identities. A limitation of this research is the lack of diversity in the data set, which can be argued to impact the rigour of this thesis.

The research aimed to recruit individuals and their managers to provide the different viewpoints within the same contexts. This, however, did not happen. To ensure that I was ethically recruiting participants I asked the individuals with mental health issues that I interviewed, if they felt happy to, to pass the research details (see appendix 1) to their managers who could then contact me. I conducted the recruitment this way so that the individuals were in control of who they shared the information with. However, this yielded a limited number of participating managers. This process of recruitment meant that I did not have the contact information of the individuals' managers and so I could not follow up if they were interested or not. This has meant that differences in views about the same organisational contexts have not been recorded. This was the main reason for recruiting managers as well as individuals with mental health issues and this was not achieved. Looking at the same issue, but with individuals and managers from different organisations, as has been done in this research, provided insight and knowledge that would not have been explored if only individuals with mental health issues participated. By including managers, this research has been able to provide rich, complex, in-depth insights into the experience of work for individuals with mental health issues. Future research could focus on researching within the

same organisational context, possibly through case study research such as Moll *et al.*, (2013). They found that silence was pervasive throughout the organisation, including employees with mental health issues and stakeholders, a finding that would not have been possible from my research.

The research methods can also affect the rich rigour criterion. Interviews were selected as the data generation method due to their ability to provide researchers with insights into the experiences and perspectives of others, thus offering a means to understand their world (Qu and Dumay, 2011) and to give voice to individuals and managers. Semi-structured interviews are flexible, accessible, provides an opportunity to research complex and important aspects of human and organisation behaviour and enables interviewees to provide responses in their own terms and language (Qu and Dumay, 2011; Bryman, 2012; Gray, 2014; Coleman, 2019; Saunders, Lewis and Thornhill, 2019). Given the aim and objectives of the research, interviews were a suitable methodology to use. However, according to Saunders, Lewis and Thornhill (2019) semi-structured in-depth interviews have issues related to dependability, forms of bias, generalisability/transferability and validity/credibility. Dependability is concerned with bias and whether other researchers would reveal similar information (Saunders, Lewis and Thornhill, 2019). The interview schedules provided the structure of the interviews, however, reflecting on the interview process for individuals and managers the managers interviews were much more unstructured whereas the individuals' interviews followed the interview structure more closely. This maybe because the individuals interviewed needed more prompting. Some of their stories were challenging for them to talk about and they were more likely to go off on tangents. In comparison, most of the managers interviewed needed little prompting and they gave succinct answers. There are times, though, that I wished I had probed the managers discussion more, for example firefighting vs proactive managing was

mentioned by Tim, Elijah, Thomas, Tilly, and Sophie but I did not delve into what they meant by this and the impact it had on managing people with mental health issues. Another part of the interviews that I wish I had probed more was when interviewees mentioned models, assumptions and attitudes of mental health issues to gain greater understanding of the societal issues impact. Overall, though, the interviews did fulfil the aim of the research by exploring the experience of work for people with mental health issues and surfacing factors and issues.

Another issue of dependability in interviews is interviewer bias where the interviewers' attitudes and beliefs can frame the questions asked and can shape the interpretation of the data generated (Saunders, Lewis and Thornhill, 2019). Attempts were made to manage this in this thesis by using the interview schedules and self-reflexivity. I aimed to maintain reflexivity throughout the research journey by keeping a research diary and engaging in consistent reflection. However, due to my chronic illnesses, I had to suspend my studies multiple times, resulting in intermittent periods of reflexivity. As a consequence, my research diary consisted of fragmented notes on bits of paper and recorded thoughts on my phone. This was disjointed reflexivity and so the transparency of my research process is challenged. In the later parts of the PhD journey, I had used OneNote as a place to gather my thoughts, reflections and make notes. I plan to continue using OneNote in future research projects. The combination of the reflexivity that was done and interview schedules has enabled the research to be reasonably dependable, but future research needs to ensure more consistent reflexivity.

Reflexive TA presents certain limitations including the flexibility in terms of theory and analytic orientation can pose challenges when attempting to formulate interpretative analysis (Braun and Clarke, 2022). Additionally, its interpretive power may be limited if not utilised in conjunction with a specific theoretical framework (Braun and Clarke, 2022). During the

analysis of the data generated I did get lost in the richness and depth of the interviews and it was not until reading Suter, Irvine and Howorth (2022) and researching paradox theory and tension lens that the analysis started to come together, and I was able to interpret the data generated in a more meaningful way.

Another aspect of rich rigour is the care and practice taken in data generation and analysis (Tracy, 2010). Interviews were conducted face-to-face or over the phone on the preference of the interviewee, the interviews were based on an interview schedule, they were recorded, and in-depth interview notes were made during and after the interview. The interviews were transcribed word for word by a third party who provided the transcripts in a timely manner. Using the field notes the analysis was able to start as soon as the first interview was done, with notes being made in my research diary about words, sentences and discussions that stood out and consistencies and differences across the interviews. The analysis journey, though, has been long (three years) as my chronic illnesses meant I have had to have time away from the research. This has led to in-depth thinking of what the data generation said, what stood out and what the consistencies were, but it meant that I approached the analysis from different emotional states, different levels of physical pain and different levels of cognition which were not considered at the time. It is possible that reflexivity would have benefited from being aware of the impact these changes had on the analysis.

The third criterion is sincerity and relates to authenticity and genuineness (Tracy, 2010). This requires honesty and transparency about the researcher's values, biases, and goals and how they played a role in the method (Tracy, 2010). As stated above, the journey to this point has been a challenge for me personally and I have tried to acknowledge the impact that has had on the research process. Also acknowledged in the methodology chapter is my experience of working with people with mental health issues and what my biases are. My past work



experience has meant that I felt confident in creating safe spaces for the interviews for people to talk about themselves, but this would have been influenced by my beliefs about mental health issues – that the social context is as important as the symptoms of mental health issues, that the voices of individuals with mental health issues are important and that we can learn from their experiences. I think though, that my self-reflexivity could have been better. I have been very reluctant to acknowledge the impact that the chronic illnesses have had on me, my perception of myself and my abilities, possibly due to the difficulty I have had in processing and accepting that my life completely changed six months into the PhD journey when I developed chronic illnesses.

The transparency of the research process encompasses an additional aspect of sincerity and it raises questions about various elements, such as how the researcher entered the research context, the practices employed for fieldnotes, and the level of detail maintained in transcription (Tracy, 2010). The transcriptions were completed by a third party who was paid to transcribe the interviews verbatim but as discourse analysis was not conducted pauses and reflections were not transcribed as the focus of the research was not on the language used (Wetherell, Taylor and Yates, 2001). In the research, notes were taken during the interviews, which were used as part of post-interview reflection with further notes added. This practice enabled immersion into the data generated, initial thoughts to be recorded and these are what I went back to after breaks from the PhD due to ill-health. I came to the context of mental health issues at work from my experience with supporting people with mental health issues and listening to stories of their challenges and difficulties with work being a central concern for people. I have made this clear through the PhD journey and so feel that this part of transparency has been managed well.

Credibility is the fourth aspect of the criteria and refers to the trustworthiness and plausibility of the research findings (Tracy, 2010). Credibility can be achieved through thick description, triangulation, and multivocality (Tracy, 2010). Thick description is demonstrated in this thesis by approximately 50% of the analysis being direct quotes and the analysis being situated within previous literature including what was discussed in the narrative review and what had been published since the completion of the literature review. Improvements could have been made by situating the analysis in the circumstances of the people interviewed instead of grouping all the interviewees together. So, differences due to circumstances such as the mental health issues diagnosed, size of organisation, and sector could have been considered. Ensuring that there was a balance of contexts in this research would have been challenging due to the size of the participant group and the method of recruitment. Future research, with larger samples, need to consider the contexts. Triangulation was not conducted as part of this thesis, however, multivocality has been. Triangulation was not conducted due to concerns about how ethically it would be to carry out. The emphasis was placed on capturing the individual's experience, and in some cases, the individuals interviewed had not disclosed their mental health issues at work. Consequently, gathering additional sources would have posed ethical concerns and been ethically questionable. Multivocality research includes the use of multiple and varied voices as part of the analysis and report (Tracy, 2010). All the interviewee's voices have been included in the analysis, their different experiences, different opinions, and attitudes have been referred to. The use of reflexive thematic analysis as the analytical framework ensured that the voices of the interviewees were centred in the analysis. The fifth component is resonance which describes the ability to influence, affect and meaningfully resonate with the readers (Tracy, 2010). This can include the aesthetic merit where the text is presented and written intertwined with the content (Tracy, 2010). This thesis

has tried to tell a story focused on the lived experience of individuals with mental health issues and managers. One way this has been attempted is to have a golden thread running throughout. This has been challenging as the sheer complexity and size of the topic has meant that I got lost and confused about the direction of the thesis. I think I have made a good attempt at drawing together the complex area and rich and in-depth stories. Another element of resonance is generalisability, not in the quantitative definition but rather in terms of transferability to other settings, populations, and circumstances (Smith, 2018; Tracy, 2010). Several links have been made between the findings from this research and previous research that has been conducted in different settings, populations and circumstances suggesting that there is generalisability.

How mental health issues is defined, and the language used can impact transferability. There is no consensus in the literature about terminology and definitions and many different ones are used (Moll *et al.*, 2013). When recruiting participants, I did not define in the recruitment literature what I meant by mental health issues, but I asked the individuals if they had a mental health diagnosis which allowed participants to interpret it in a manner that suited them. This meant that they had been to see a G.P. and had been provided with a diagnosis of a mental health issue which can be classified under a Diagnostic Statistical Manual of Mental Disorders (2013) criteria, thereby utilising the biomedical model of mental health issues. Using a biomedical model approach to diagnosis was difficult for me due to the inherent issues and weaknesses of the model and diagnosis, as discussed in 2.1.2, but I had to have a selection criterion, and this seemed to be one that most people would understand.

Another problem with the transferability of the research is that the data was primarily collected before the pandemic of Covid-19. The research is a snapshot of time (Saunders, Lewis and Thornhill, 2019) and has not considered the impact Covid-19 has had on work, people with

mental health issues and managers. Research has suggested that the pandemic is linked to unemployment, job loss, job change, reduction in hours, working from home (Diab-Bahman and Al-Enzi, 2020; Venkatesh, 2020; Griffiths *et al.*, 2021) and increased anxiety, stress, and depression in the population (Knolle, Ronan and Murray, 2021). These changes may have affected the nature of work and the experience for people with mental health issues.

Significant contribution is the next measure for quality. It judges the contribution to theory, practice, method, and heuristics (Tracy, 2010). Theoretical significance can be seen when the research extends, builds and critiques existing disciplinary knowledge (Tracy, 2010). By looking at both the individual and managers experiences I have been able to develop a rich tapestry of the overall picture of their experiences as seen in figure nine on page 242, which has added to theory. Utilising paradox theory and a tension lens has also led to the research contributing to theory as it provides a level of understanding of experiences that has not been done before. Contribution to practice has been to identify the significant factors and issues for individuals at work with mental health issues and knowledge about the key issues for managers, as discussed in section 5.1.2. The research has not used any new creative methods so has not added to methodological discussions in that way. But it has added to the methodological discussion of researching sensitive topics and recruiting vulnerable individuals. For this research to have heuristic contribution it needed to inspire future research, suggestions for a future research agenda are shown later in this chapter.

The penultimate criterion is that it is ethical, how the research considers procedural, situational, relational, and exiting ethics (Tracy, 2010). In this thesis procedural ethics was managed through following the ethical guides of BPS Code of Human Research Ethics (The British Psychological Society, 2014) and Code of Ethics and Conduct (The British Psychological Society, 2018) with ethical approval granted through the University of Plymouth

ethical procedure (Pellowe, Lucznik and Martin, 2018). Situational ethics refers to ethical issues that may arise in data collection (Ellis, 2007). Some distressing and upsetting stories were shared with me, and many individuals cried during the interviews. This provided in-field ethical challenges that I had to reflect on to ensure I was maintaining the safety of the individual. I drew upon my training and experience of working with people with mental health issues to provide options that would enable interviewees to leave the interviews unharmed. Most of the interviewees took a short break and then continued sharing their stories with me, but all were offered the choice to pause the interview, have a break, or stop. Relational ethics involves a researcher being aware of their actions and the consequences they may have on others (Tracy, 2010). To ensure that there was mutual respect and dignity, the research interviews were set at times and locations chosen by the interviewee, breaks throughout the interview were offered, interviewees were also offered the opportunity to receive the anonymised transcript to ensure that they were happy with it. Interviewees were also offered information, guidance, and contact information for organisations they could access if they felt that they needed further support, see appendices 7 and 8. Ethical issues do not stop once the data is collected but continues throughout the analysis, write up and publication (Tracy, 2010). To manage this all interviews were anonymised (and for those who wished, checked with the interviewee) and pseudonyms have been used to refer to the interviews.

The final component of the quality criteria is meaningful coherence. This is when a study has achieved their stated purpose, used methods and procedures that fit the intended aim and meaningfully connects literature, research focus, findings, and interpretations with each other (Tracy, 2010). The aim of the research was to explore the significant issues at work for people with diagnosed mental health issues and the significant issues for line managers in managing them. Exploration was the key approach and has underpinned every step of the thesis. This

approach has been challenging, each stage of the thesis has been based on curiosity rather than a formal approach and so finding boundaries with what is and is not included has been difficult. For example, the initial analysis of the interviews generated many fascinating themes and narratives, but some had to be omitted to ensure that the aim of the research was met and not digressed from. Even though there have been challenges to get to a place of meaningful coherence in this research I feel this has been achieved. In the literature review this has been done through the use of clusters that group the literature together. The analysis also uses clusters to show how the themes are connected. Another curiosity has been how the factors discussed in the analysis are interconnected and the impact these have. The analysis hints at these interconnections but require further in-depth research to unravel fully.

In summary, I believe that this research has met the eight-point criteria proposed by Tracy (2010) that includes worthy topic, rich rigour, sincerity, credibility, resonance, significant contribution, ethics, and meaningful coherence. There are weaknesses in rich rigour as there has not been much attention paid to the contexts the interviewees were in and the impact that had on the research. The sincerity criteria has been affected by my unwillingness to acknowledge the impact that the chronic illnesses I live with has on my life let alone the impact it has had on the research. Reflecting on these eight criteria I am surprised by how much I have encountered, practiced, and learnt. Qualitative research is not straightforward, it is multifaceted and complex (Tracy, 2010) and choosing the topic of mental health issues at work adds extra layers of complexity due to the nature of mental health issues (Clark *et al.*, 2017). What I have learnt, though, is that my attempts to navigate this complex field have resulted in interesting research, fascinating findings, and a clear research agenda for the future. I have successfully navigated the research through many of the quality criteria and I am proud of that.

### **5.3 What else needs to be done- future research agenda.**

A research agenda can be comprised of a framework that demonstrates how a researcher will approach a topic from multiple perspectives and can provide a map for the researcher (Ertmer and Glazewski, 2014). The development of a research agenda can be important as it can give the researcher purpose and focus (Ertmer and Glazewski, 2014). It is important in this thesis as developing a research agenda for further research into significant issues at work for people with mental health issues is objective five of the thesis and is a natural outcome from exploratory research. It is a significant outcome of the thesis; it provides next steps in the research into the field of mental health issues at work based on reflections on the analysis of the data generated. The data generated provides an in-depth exploration of work for people with mental health issues, how they are managed and what the significant aspects of that experience are. Due to the exploratory nature of this research a wide range of aspects were discussed in the interviews, confirmatory research is now needed to examine those aspects in greater depth. Table eleven is the future research agenda covering topic area and research questions.

The future research agenda was developed from the analysis of the interviews and literature in this thesis. As can be seen throughout chapter 4, there are many research gaps identified that need further research. The research gaps included the positive impacts of mental health issues at work, the concept of an ideal worker, the strategies individuals and managers utilise to manage tensions, HR professionals' views and attitudes, and meaningful work. These are just a few that were detailed in the analysis. As discussed in 4.5, the exploratory research undertaken has started to build the jigsaw puzzle of mental health issues by developing the outside pieces but there are still many inside pieces missing which the future research agenda provides guidance on researching those areas.

Whilst the table of the future research agenda has come from the body of work in this thesis, there are many other areas that are relevant to the topic of mental health issues at work. For example, researching remote workers and their experiences and the experiences for people with undiagnosed mental health issues but have symptoms.

Research methods will most likely be semi-structured interviews and focus groups to develop understanding of people’s experiences but there are topics that would also benefit from quantitative surveys. Future research will also benefit from ensuring that the samples are diverse and consider demographic factors such as gender, age, race, job role, level in organisation and organisational size. Another approach could be to conduct case study research within single organisations.

*Table 11: Future research agenda. Source: Authors own.*

Topic Area	Research Questions
The importance of having a job to manage mental health issues	Is having a job important to mental health? In what way is it important? Is work regarded as a safe place? What influences the decision to stay in work: <ul style="list-style-type: none"> <li>• the individual’s attitude to their mental health issues,</li> <li>• the nature of the work including control, flexibility, and autonomy,</li> <li>• attitudes to the individual at work,</li> <li>• how the individual is treated by their line manager,</li> <li>• how the individual is treated by their colleagues,</li> </ul> Is work regarded as meaningful? How important is it that work is meaningful? Does being in work aid recovery? If so, in what way? What are the benefits of being in work? Are the benefits of work dependent on being collocated with colleagues? Can the benefits of work be realised by working remotely?
What impact does having a mental health issue have on the work of individuals?	What impact does having a mental health issue have on the job? Does it have an impact on attitudes to work? Does it impact psychological needs from work? Is the impact consistent? What does the impact depend on – <ul style="list-style-type: none"> <li>• type of job/sector,</li> </ul>



	<ul style="list-style-type: none"> <li>• level of strain in the job,</li> <li>• amount of pressure perceived by the individual,</li> <li>• workload,</li> <li>• amount of control the individual has over their job,</li> <li>• amount of control exerted by others on the job,</li> <li>• amount of social support,</li> <li>• monetary reward,</li> <li>• intrinsic reward,</li> <li>• job security,</li> <li>• predictability of work,</li> <li>• responsibility for others,</li> <li>• diagnosis,</li> <li>• severity of diagnosis,</li> <li>• the financial dependency on the salary,</li> <li>• previous experience</li> <li>• personal relationships at work</li> <li>• nature of interactions?</li> </ul> <p>What is the impact on the demands of the job?  What is the impact of the resources needed to perform the job well?  What is the impact on productivity?  What is the impact on focus?  What is the impact on problem solving?  What is the impact on dealing with others?  What is the impact on career progression?  What helps with how the individual copes with the impact of mental health issues?  What factors influence employee engagement both positively and negatively?</p>
<p>How much is understood about mental health issues by people at work?</p>	<p>What is the understanding based on?  How is understanding measured?  Has training been given?  What is the nature of the training?  Is the effectiveness of the training reviewed?  What role does HR play?  Does the understanding relate to any of the models of mental health?</p>
<p>The experience of stigma</p>	<p>How stigma manifests?  Who experiences stigma?  Who shapes stigma?  What are the reasons for stigma?  What is the impact of stigma at work?  Has stigma resulted in discrimination?  Is it recognised as discrimination?  What is the impact of stigma on the individual?  Is there a fear of stigma?  What is that fear based on?  Does fear of stigma have an impact?</p>

	Is self-stigma experienced? If so, what is its impact?
Disclosure-experience of individuals	<p>Do people disclose their mental health issues when applying for a job?</p> <p>What influences whether they disclose when applying for a job?</p> <p>Once employed, what does disclosure depend on?</p> <p>Who is disclosure made to?</p> <p>What determines who to disclose to?</p> <p>Does disclosure impact how others treat someone with mental health issues?</p> <p>Does disclosure impact how competence is viewed?</p> <p>Do private conversations on mental health issues remain confidential?</p>
Disclosure-practice and policy	<p>Is there a policy on disclosure?</p> <p>Is it expected that people will disclose? If so, when:</p> <ul style="list-style-type: none"> <li>• during the recruitment and selection process?</li> <li>• once employed?</li> <li>• during any performance issues?</li> <li>• during sickness absence?</li> </ul> <p>Does disclosure of a mental health issue influence the selection decision? If so, what is taken into consideration?</p> <p>Who should people disclose to?</p> <p>How is non-disclosure viewed?</p>
Disclosure-managers experience	<p>Do line managers encourage their staff to disclose mental health issues to them?</p> <p>How do they feel when someone does disclose?</p> <p>Is what has been said discussed with anyone else?</p>
Self-managing mental health issues at work and support available	<p>What do individuals do to help themselves?</p> <p>What helps the most?</p> <p>What support services are available in organisations?</p> <p>What services outside the organisation have been accessed?</p> <p>What was the waiting time for access?</p> <p>What has been the effectiveness of the service(s) used?</p> <p>Have there been any accessibility issues?</p> <p>Is there any stigma about using the services?</p> <p>If no services have been used why is this?</p> <p>Why was a service used?</p> <p>Is the use of a service disclosed?</p> <p>What support is expected from the line manager?</p> <p>Are appraisals considered to be a support resource?</p> <p>Have line managers had any training in mental health issues?</p> <p>Was the training beneficial?</p> <p>Have individuals had support from anyone who has had mental health first aid training?</p> <p>Did the training make any difference to the support given?</p> <p>What support is expected from colleagues?</p> <p>Is support asked for?</p> <p>What needs to be present to ask for support?</p>

	<p>Does the organisation have a policy on supporting people with mental health issues? If so, is it known and enacted?  What is the attitude to its enactment?  Has HR been approached for support? If so, was that helpful?  Are the services online or in person?  How are online services viewed?  What is the most important thing that can be done for individuals at work?  Is the workload manageable?  Is there any control, flexibility, or autonomy over work? Is it important to have?  What are the most important features of work design?</p>
How people with mental health issues are perceived?	<p>What is the perception of people with mental health issues at work?  What is the basis of the perception?  Is that perception fair?  How does the perception manifest in the culture of the organisation?  Does the perception vary by position in the organisation and nature of job?  Does the perception affect attitudes?  Does the perception affect behaviour?  How do people with mental health issues perceive themselves?  What forms the basis for how people with mental health issues are treated?  Are mental health issues perceived as a real issue?  Is there a difference between the perception of mental health issues to a physical health issue or physical problem?</p>
Balancing support and productivity by line managers	<p>What demands are there on time for supporting people with mental health issues?  What support do line managers give?  What constrains what support is given?  How is productivity maximised whilst at the same time demonstrating support?  What do line managers perceive as their priorities?  Is the view on priorities by the line manager the same as the view of senior managers? If there is a difference, does it create tension?  How is that tension managed?  Who are the social actors involved in the tension and how do they perceive it?  How does that tension impact individuals with mental health issues?</p>
Managing people with mental health issues	<p>What challenges are there to managing someone with mental health issues?  Do the challenges vary according to sector, size and nature of the organisation?  Are there benefits to managing someone with mental health issues?</p>

How do line managers learn how to support people with mental health issues?

How do line managers react when it becomes known that someone has mental health issues?

What training have line managers had in recognizing the possibility that someone has mental health issues?

What training have line managers had in managing someone with mental health issues?

What was the value of the training?

Is the training formally evaluated?

Do line managers feel confident in their ability to manage someone with mental health issues?

What impact does managing someone with mental health issues have on line managers?

What do line managers do to enable them to cope?

What support is given to the line manager?

How do senior managers react?

What is the attitude in the organisation to people with mental health issues?

What support is given by HR?

What do line managers do to support someone with mental health issues?

Are informal 1 to 1's practised? If so, what is their value?

Are line managers aware of what support services are available for themselves and their staff?

What support services are people signposted to by the line manager?

What do line managers do to enable access to be feasible?

What do line managers think of the value of support services?

How do they know the value?

Are appraisals a time to discuss mental health issues at work?

What impact do mental health issues have on the career progression of individuals?

If asked to give a reference, do line managers mention the mental health issues?

Is it possible to make any changes at work for individuals with mental health issues, including the nature of the work and the workload?

Is it considered to be fair to make changes?

Are changes made? If changes are made, are they formal or informal?

Are the changes discussed with the team?

What policies and procedures are most helpful?

Is a formal or informal approach to policies and procedures preferred?

What is the value of having formal policies and processes?

When is it appropriate to use formal approaches?

	<p>Do you line managers feel supported in enacting the policies and processes?</p> <p>How are the needs of someone with mental health issues balanced with the needs of the rest of the team?</p> <p>What support is given by the team to the line manager?</p> <p>Can the needs of someone with mental health issues and the business needs align?</p> <p>What impact do line managers think they have as the line manager of someone with mental health issues?</p>
Legislation	<p>What legislation is relevant?</p> <p>Does legislation drive policy and practice?</p> <p>Is the legislation known and understood?</p> <p>How are people informed of the legislation?</p> <p>Do line managers find the legislation helpful?</p> <p>Is the legislation perceived as a challenge to find a way around?</p>
Impact on others at work	<p>Is the time spent on someone with mental health issues perceived as fair?</p> <p>Is there a requirement to work harder because of someone in the team having mental health issues? If so, how is this perceived?</p> <p>Is the team expected to support someone with mental health issues? What is their reaction to doing so?</p> <p>Is any training offered to the team to help with support?</p> <p>What role does the team play in highlighting concerns about a person with mental health issues?</p>
HR role	<p>What role does HR believe they have in managing and supporting people with mental health issues?</p> <p>Whose responsibility do they think it is?</p> <p>Are there written policies? If so, who writes them?</p> <p>Do HR ensure there are services available for people with mental health issues to use?</p> <p>How is the value of the services determined?</p> <p>How are such services budgeted and controlled?</p> <p>During times of financial difficulties are these services protected?</p> <p>What is HR role in reasonable adjustments?</p> <p>Do HR provide training in supporting people with mental health issues?</p> <p>What support is given to individuals with mental health issues?</p> <p>What support do they give line managers in supporting people with mental health issues?</p> <p>When prioritizing work, where would supporting a) individuals with mental health issues and b) line managers managing people with mental health issues come in the list?</p>
Sickness Absence	<p>Is there a sickness absence policy?</p> <p>Is there a recognised procedure?</p> <p>What aspects of the sickness absence policy and procedure are most helpful? most unhelpful? For:</p> <ul style="list-style-type: none"> <li>• individuals with mental health issues</li> <li>• Line managers</li> </ul>

	<ul style="list-style-type: none"> <li>• HR</li> </ul> <p>Is there a perception that the sickness absence policy puts pressure on people not to take sickness absence?</p> <p>Is there a fear of repercussion by individuals if sickness absence is taken?</p> <p>Is absence attributed to mental health issues or is it attributed to something else?</p> <p>Are people with mental health issues sufficiently supported to feel able to say if absence was due to mental health issues?</p> <p>Is sickness absence used as a prompt for discussion?</p> <p>Are staff contacted at home when they are off sick? If so, what is the purpose of doing so?</p> <p>Are individuals asked what contact they would prefer? Is the preference respected?</p> <p>What is the return-to-work practice?</p> <p>How much flexibility can be exercised over return to work?</p> <p>Is the return-to-work process regard as fair and helpful by individuals?</p>
<p>Role of the line manager from the perspective of an individual member of staff with mental health issues</p>	<p>What is expected from the line manager?</p> <p>What is the most important thing that the line manager can do to aid individuals with mental health issues?</p> <p>What is the most important attribute of a line manager?</p> <p>Do individuals trust their line manager?</p> <p>What does trust depend on?</p> <p>Would individuals disclose/confide in their line manager? If not, why not?</p> <p>Does the line manager respect confidentiality?</p> <p>How is professionalism of the line manager defined?</p> <p>Do individuals feel respected by their line manager?</p> <p>Do individuals think that their line manager has any understanding of their mental health issues? If so, what is that understanding based on?</p> <p>How regularly do individuals have 1 to 1s with their line manager?</p> <p>Do individuals have formal meetings with their line manager?</p> <p>Which is preferred - a formal or informal approach?</p> <p>How important are quick 1 to 1s?</p> <p>When are formal meetings preferable?</p> <p>How do individuals think their line manager perceives their mental health issues? Does that perception influence the behaviour of the line manager towards the individual?</p> <p>Does the line manager talk about their own experience of mental health issues?</p> <p>Does the line manager treat their staff as an individual?</p>
<p>Workplace culture</p>	<p>How would you describe the culture?</p> <p>Does the culture influence how mental health issues are treated and talked about?</p> <p>Is there a culture of presenteeism?</p> <p>What are the core values of the organisation?</p>

	How do the core values affect attitudes and support for people with mental health issues?
Policies	<p>What policies does the organisation have which have relevance for mental health issues?</p> <p>Who is the custodian of the policies?</p> <p>How are staff informed of the policies?</p> <p>Are the policies applied? Are they applied rigidly or flexibly?</p> <p>How important is flexibility?</p> <p>Are staff supported in enacting policies?</p> <p>Is the effectiveness of the policies reviewed?</p>
Colleagues	<p>How important is the attitude of colleagues for people with mental health issues?</p> <p>What are the important things that colleagues do?</p> <p>What are the negatives things colleagues do?</p> <p>What impact does the attitudes and behaviour of colleagues have on someone with mental health issues?</p>
Reasonable adjustments- Individuals' perspective	<p>Do individuals know about reasonable adjustments?</p> <p>Do individuals know what is feasible?</p> <p>Did individuals ask for reasonable adjustments? If not, why not?</p> <p>Do individuals suggest reasonable adjustments they would find helpful? If so - helpful in regard to what?</p> <p>Who do individuals discuss them with?</p> <p>What attitude is encountered?</p> <p>What reasonable adjustments are made?</p> <p>Are they effective?</p> <p>How do individuals feel about having reasonable adjustments?</p> <p>How do individuals feel about others knowing they have reasonable adjustments?</p> <p>What attitudes were encountered to having reasonable adjustments?</p>
Reasonable adjustments - line manager's perspective	<p>Does the organisation have a policy regarding reasonable adjustments?</p> <p>Do line managers know the policy?</p> <p>Do line managers consider reasonable adjustments to be an obligation, a right or what should happen?</p> <p>What do line managers consider to be the purpose of reasonable adjustments?</p> <p>Whose responsibility is it to grant reasonable adjustments?</p> <p>Do line managers know what reasonable adjustments are feasible?</p> <p>Do line managers get support in deciding about reasonable adjustments? If so, who from?</p> <p>Can reasonable adjustments be made by an informal arrangement?</p> <p>Do line managers feel it's necessary to tell everyone what is being done or can it be kept private between the line manager and the individual?</p> <p>What is taken into consideration when considering reasonable adjustments?</p> <p>How is the success of the reasonable adjustments determined?</p>

	What is the impact of the work sector and nature of the role on reasonable adjustments?
Reasonable adjustments- team perspective	Is it fair that a colleague is treated differently? Has the team any experience of a team member having reasonable adjustments? What was that experience? What impact did it have on the team? Do team members feel it is their right to know if a colleague has reasonable adjustments?
Diagnosis/labelling- Individuals' perspective to diagnosis	Do individuals have a diagnosis? How do individuals feel about having a diagnosis? Does having a diagnosis make any difference to how individuals view themselves? Do individuals think that having a diagnosis defines them? Do individuals tell anyone about their diagnosis? If so, whom? Do individuals feel that if they tell someone their diagnosis they will be treated differently? Do individuals want to be treated differently because of their diagnosis? Do individuals use their diagnosis as a reason for not being able to do some elements of their work?
Diagnosis/labelling- Manager's perspective	Do line managers think it is helpful to have a diagnosis? What is line managers understanding of the diagnosis? What difference does having a diagnosis make to how line managers manage someone with diagnosed mental health issues? How do line managers make the judgement on what is fair to expect from someone with a diagnosis? Does anyone with mental health issues use their diagnosis as an excuse or an explanation?
Ideal Worker	Is there a picture of an ideal worker: <ul style="list-style-type: none"> <li>• by the organisation</li> <li>• by HR</li> <li>• by line managers</li> <li>• by the individual employee with mental health issues</li> <li>• by employees who do not have mental health issues?</li> </ul> What is the picture? Are the pictures compatible? How does this picture affect behaviour and attitudes? How does it affect individuals with mental health issues?
mental health issues and small business	How does the size of the business affect the management, support, employability, and attitudes to mental health issues?

## 5.4 Concluding remarks

This study has sought to explore the significant issues at work for people with diagnosed mental health issues, from the perspective of individuals and line managers. Whilst there is a



range of research conducted in the field of mental health issues at work, little has been done on the day-to-day experience of work and what are the significant issues and key influences, and so this study has arrived at an original contribution to knowledge, see figure nine. This model provides a visual representation of the contribution by splitting the wide range of experiences, influences, and factors into three clusters: individual, social/relational and organisation, the key factors within those clusters and the tensions are presented.

Surrounding the outside of the three clusters are societal issues including the biomedical model and stigma and discrimination which shape and influence all three clusters and their factors. Keeping in mind the limitations and evaluation of the quality of the research it is important to recognise that this is not a grand theory, or a middle range theory as described by Creswell and Creswell (2018) but is a substantive theory that has used a set of interrelated concepts and ideas to explain the experience of work for people with mental health issues (Lee and Lings, 2008). This provides the basis for future research to develop this theory and the factors and influences described within the theory.

A key achievement of this study is the drawing together of rich, in-depth, and complex stories of experiences by individuals and managers with a range of literature. This combination has brought together disparate literature that lacks theoretical and conceptual underpinning (Elraz, 2017; Follmer and Jones, 2018) with people's experiences to produce new understandings of the experience of work for individuals with mental health issues and what the key factors are that influence that experience. It is upon this combination that a framework for future research has been created.

This thesis has provided a starting point for learning about work and mental health issues and the important issues and factors for individuals and managers. This has created the outside edges of a complex and multi-faceted jigsaw puzzle of work and mental health issues. The

puzzle pieces that have been generated are from the voices of the people experiencing the issues. Voices that are often unheard and not recorded in research. This thesis has recorded and celebrated the depth of knowledge found by listening to people who are the experts in their experiences.

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## 7 Appendix 1: Briefing document

**Researcher:** Lindsay Badger

**Researcher contact;** [lindsaylouise.badger@plymouth.ac.uk](mailto:lindsaylouise.badger@plymouth.ac.uk)

**Research Title:** Exploration of the management of individuals with mental health issues in the workplace

**Project information:** A research project to be undertaken as part of a PhD at Plymouth University and has received ethical approval from the Plymouth University Ethics Board.

**Research Supervisor;** Sue Kinsey

**Supervisor contact;** [sue.kinsey@plymouth.ac.uk](mailto:sue.kinsey@plymouth.ac.uk)

### **Research aims and objectives;**

The thesis aims to explore the management of individuals with diagnosed mental health issues at work from line managers and individual's perspectives. This PhD seeks to understand more fully:

- The experience of work for people with diagnosed mental health issues,
- What is shaping and influencing people with diagnosed mental health issues experience of work,
- The influence line managers have on the experience of work for people with diagnosed mental health issues
- The experience that managers have of managing people with mental health issues,
- What influence organisational practices have on the experience of work for people with mental health issues and on line managers experience
- The impact that the contexts, constructs and discourses have on the experience of work for people with a mental health issue and on line managers experience of managing people with a mental health issue

### **Details of research:**

Semi-structured interviews will be conducted to explore attitudes, perceptions and views of work and mental health issues. These interviews will be recorded on an audio recorder, transcribed, and anonymised. Anonymization will be done by using pseudonyms for companies, giving you a different name and changing any information that could be used to identify you. These will be stored on a personal laptop within a password protected folder.

If you so wish, you can have access to the transcriptions. The information gathered from you will be used as part of my PhD research and will be included in my thesis and may be used in the future for publications.

You have every right to withdraw up until the end of data collection (date will be provided). This will mean that all information collected from you will be deleted and not used in analysis, write up or publication. This is a right that you have and will not have any impact.

The transcribed interviews will be used in the analysis and quotes will be included in the PhD thesis. I am aiming to use this research as part of writing to be published in journals.

The focus of this research is the experience of work but if you find that any of the issues that we talk about difficult or challenging please seek support for that. Provided is an information sheet of resources and services which may be useful.

Your G.P. and access to therapy service are always a good starting point. In Plymouth, Plymouth Options are a good resource- <https://livewellsouthwest.co.uk/services/plymouth-options>. If you would like to access counselling, in Plymouth, Simply Counselling are good - <http://www.simplycounselling.org/>. Other resources that you may find useful are- <https://www.mind.org.uk/information-support/>, <https://www.rethink.org/>, <https://www.blurtitout.org/>.

## 8 Appendix 2: Topic guide for interview with individuals with mental health issues

Topics to be covered	<p>Demographics</p> <p>Nature of work</p> <p>Length in role</p> <p>Job title</p> <p>Diagnosis</p> <p>Have you disclosed</p>
	<p>Experience of work</p> <p>Impact of mental health issues</p> <p><b>Specific examples – stories</b></p> <p>Tell me about positive experiences</p> <p>Tell me about not so good experiences</p> <p>Bullying? Harassment? Stereotyping? Discrimination?</p> <p>Previous work experiences (if in role for less than a year)</p> <p>What works and doesn't</p> <p>Do you feel able to talk about your experience in your workplace?</p> <p>Do you feel listened to?</p> <p>Treated fairly?</p>
	<p>Experience of disclosure at work</p> <p>Who did you disclose to</p> <p>What was your experience</p> <p>What part did your line manager play</p>
	<p>Performance/ presenteeism</p> <p>Has your mental health issues effected your performance at work?</p> <p>What was your experience? Performance appraisals? Who was involved?</p> <p>What part did your line manager play</p>

	<p>Team</p> <p>Have you come into work knowing you weren't running at your best? Why?</p>
	<p>Have you gone through any reasonable adjustments negotiations</p> <p>What was your experience</p> <p>What part did your line manager play</p> <p>Who else was involved</p> <p>Are you aware of your rights?</p>
	<p>Have you gone through any sickness absence</p> <p>What was your experience</p> <p>What part did your line manager play</p> <p>Who else was involved</p>
	<p>Tell me about your experience of being managed</p> <p>The role of the line manager</p> <p>The impact on your wellbeing</p> <p>How did it make you feel</p>
	<p>Tell me about positive experiences of being managed</p> <p>What do you mean by positive</p> <p>What behaviours by your line manager were positive</p> <p>Tell me about not so good experiences</p> <p>What have you learnt from these experiences</p>
	<p>Language</p> <p>What language does the organisation use?</p> <p>What language does your line manager use?</p> <p>What language do you use?</p>

	How do you think mental health issues are viewed in your organisation?
	Any training you are aware of? Have you seen an impact?
	Have you explored your organisations wellbeing initiatives  Helpful?
Probing questions	Give me examples  How did you cope with the situation  What influence did you have  What would you do differently?  What have you learnt from these experiences  How did that make you feel  What are your thoughts on that situation?

## 9 Appendix 3: Topic guide for interviews with managers

Topics to be covered	Nature of work Length in role Job title
	Tell me about your experience of managing individuals with mental health issues
	Had they been diagnosed
	How did you find out
	How did it make you feel
	Do you perceive as conversations about MHI as difficult? Do you feel equipped for the conversation?
	What do you think has shaped how you manage people with mental health issues
	Role of HR
	Any guidance?
	Policy? Procedures? – Helpful?
Devolution to line manager	
Equality and Diversity	
Legislation – what is your awareness?	
Diversity management practices?	
Fairness?	
Personal experience? Family and friends?	
Trade unions? Occupational health? Wellbeing programmes? Counselling services?	
Wellbeing initiatives?	
Employee voice initiatives?	
Have you gone through any reasonable adjustments negotiations	
What was your experience	
What did you do	

	<p>What part did you play</p> <p>Have you gone through any sickness absence management for people with mental health issues</p> <p>What was your experience</p> <p>What did you do</p> <p>What part did you play</p>
	<p>Have you gone through any performance/ presenteeism management</p> <p>What was your experience</p> <p>What did you do</p> <p>What part did you play</p>
	<p>Have you has anyone disclose to you</p> <p>What was your experience</p> <p>What did you do</p> <p>What part did you play</p>
	<p>Tensions</p> <p>Time</p> <p>Business demands</p>
	<p>Training</p> <p>If so, what?</p> <p>Any impact?</p>
	<p>Language</p> <p>What language does the organisation use?</p> <p>What language do you use?</p>
Probes	<p>How did it make you feel</p> <p>What have you learnt from those experiences</p> <p>What influenced your behaviour in that situation</p>



## 10 Appendix 4: Ethical approval from University of Plymouth



Date: 15 February 2019

Dear Lindsay,

**Ethical Approval Application No: FREIC1819.20**

**Title: Exploration of the management of individuals with diagnosed mental health issues at work from line managers and individual's perspectives**

Thank you for your application to the Faculty Research Ethics & Integrity Committee (FREIC) seeking ethical approval for your proposed research.

The committee has considered your application and is fully satisfied that the project complies with Plymouth University's ethical standards for research involving human participants.

Approval is for the duration of the project. However, please resubmit your application to the committee if the information provided in the form alters or is likely to alter significantly.

The FREIC members wish you every success with your research.

Yours sincerely  
(Sent as email attachment)

Dr James Benhin  
**Chair**  
**Faculty Research Ethics & Integrity Committee**  
**Faculty of Business**

James Benhin, Chair, Faculty Research Ethics & Integrity Committee, Faculty of Business, Cookworthy, University of Plymouth, Drake Circus, Devon PL4 8AA, United Kingdom  
T +44(0)1752 585587 E [FoBResearch@plymouth.ac.uk](mailto:FoBResearch@plymouth.ac.uk) W [www.plymouth.ac.uk](http://www.plymouth.ac.uk)

## 11 Appendix 5: Informed consent form

I, the undersigned, confirm that (please tick box as appropriate):

1.	I have read and understood the information about the project, as provided in the briefing document dated _____.	<input type="checkbox"/>
2.	I have been given the opportunity to ask questions about the project and my participation.	<input type="checkbox"/>
3.	I voluntarily agree to participate in the project.	<input type="checkbox"/>
4.	I understand I can withdraw up to 30/09/2019 without giving reasons and that I will not be penalised for withdrawing nor will I be questioned on why I have withdrawn.	<input type="checkbox"/>
5.	The procedures regarding confidentiality have been clearly explained (e.g. use of names, pseudonyms, anonymisation of data, etc.) to me.	<input type="checkbox"/>
6.	The use of the data in research, publications, sharing and archiving has been explained to me.	<input type="checkbox"/>
7.	I understand that anonymised data will be available to other researchers only if they agree to preserve the confidentiality of the data and if they agree to the terms the researcher has specified in this form.	<input type="checkbox"/>
8.	I would like to have access to the transcript before the researcher used it.	<input type="checkbox"/>
8.	I, along with the Researcher, agree to sign and date this informed consent form.	<input type="checkbox"/>

**Participant:**

\_\_\_\_\_  
 Name of Participant                      Signature    Date

**Researcher:**

\_\_\_\_\_  
 Name of Researcher                      Signature    Date

## 12 Appendix 6: Debriefing document

Thank you so much for being part of this research. Your stories and experiences are invaluable.

**Researcher:** Lindsay Badger

**Researcher contact;** [lindsaylouise.badger@plymouth.ac.uk](mailto:lindsaylouise.badger@plymouth.ac.uk)

**Research Title:** The experience of work for people with mental health issues and what is shaping and influencing that experience.

**Project information:** A research project to be undertaken as part of a PhD at Plymouth University and has received ethical approval from the Plymouth University Ethics Board.

**Research Supervisor;** Richard Saundry

**Supervisor contact;** [Richard.saundry@plymouth.ac.uk](mailto:Richard.saundry@plymouth.ac.uk)

### **Research aims and objectives;**

The thesis aims to explore the management of individuals with diagnosed mental health issues at work from line managers and individual's perspectives. This PhD seeks to understand more fully:

- The experience of work for people with diagnosed mental health issues,
- What is shaping and influencing people with diagnosed mental health issues experience of work,
- The influence line managers have on the experience of work for people with diagnosed mental health issues
- The experience that managers have of managing people with mental health issues,
- What influence organisational practices have on the experience of work for people with mental health issues and on line managers experience
- The impact that the contexts, constructs and discourses have on the experience of work for people with a mental health issue and on line managers experience of managing people with a mental health issue

### **Information;**

Your interview has been recorded on an audio recorder, and will be transcribed, and anonymised. Anonymization will be done by using pseudonyms for companies, giving you a different name and changing any information that could be used to identify you. These will be stored on a personal laptop within a password protected folder.

If you so wish, you can have access to the transcriptions. Please just ask.

The information gathered from you will be used as part of my PhD research and will be included in my thesis and may be used in the future for publications.

You have every right to withdraw up until the end of data collection (date will be provided). This will mean that all information collected from you will be deleted and not used in analysis, write up or publication. This is a right that you have and will not affect anything.

The transcribed interviews will be used in the analysis and quotes will be included in the PhD thesis. I am aiming to use this research as part of writing to be published in journals.

The focus of this research is the experience of work but if you find that any of the issues that we talk about difficult or challenging please seek support for that. Provided is an information sheet of resources and services which may be useful.

Your G.P. and access to therapy service are always a good starting point. In Plymouth, Plymouth Options are a good resource- <https://livewellsouthwest.co.uk/services/plymouth-options>. If you would like to access counselling, in Plymouth, Simply Counselling are good - <http://www.simplycounselling.org/>. Other resources that you may find useful are- <https://www.mind.org.uk/information-support/>, <https://www.rethink.org/>, <https://www.blurtitout.org/>.

## 13 Appendix 7: Information sheets given to individuals with mental health issues after the interview

Mental health issues can be challenging to talk about and I am very grateful for your input into my research, sharing your experiences and stories and taking the time and energy to do so. I hope talking about your experiences has been okay but if it has been difficult here are some useful information and people you could talk too. If you need or would like the resources printed please let me know.

### Sources of support

#### Samaritans

**Telephone:** 116 123 (24 hours a day, free to call)

**Website:** [www.samaritans.org](http://www.samaritans.org)

Provides confidential, non-judgemental emotional support for people experiencing feelings of distress or despair, including those that could lead to suicide. You can phone, email, write a letter or in most cases talk to someone face to face.

#### Mind Infoline

**Telephone:** 0300 123 3393 (9am-6pm Monday to Friday) or text 86463

**Email:** [info@mind.org.uk](mailto:info@mind.org.uk)

**Website:** [www.mind.org.uk/information-support/helplines](http://www.mind.org.uk/information-support/helplines)

Mind provides confidential mental health information services. With support and understanding, Mind enables people to make informed choices. The Infoline gives information on types of mental health problems, where to get help, drug treatments, alternative therapies and advocacy. Mind works in partnership with around 140 local Minds providing local mental health services

To find your local Mind group - <https://www.mind.org.uk/information-support/local-minds/>

#### Rethink Mental Illness Advice Line

**Telephone:** 0300 5000 927 (9.30am - 4pm Monday to Friday)

**Website:** <http://www.rethink.org/about-us/our-mental-health-advice>

Provides expert advice and information to people with mental health problems and those who care for them, as well as giving help to health professionals, employers and staff. Rethink also runs rethink services and groups across England.

#### Saneline

**Telephone:** 0300 304 7000 (4:30pm-10:30pm)

**Website:** [www.sane.org.uk/what we do/support/helpline](http://www.sane.org.uk/what_we_do/support/helpline)

Saneline is a national mental health helpline providing information and support to people with mental health problems and those who support them.

### **Resources for general information;**

<https://www.time-to-change.org.uk/about-mental-health>

<https://www.time-to-change.org.uk/about-mental-health/mythsfacts>

<https://www.rethink.org/>

<https://www.mind.org.uk/information-support/a-z-mental-health/>

<http://www.hse.gov.uk/stress/mental-health.htm>

<https://www.time-to-change.org.uk/about-mental-health>

### **Resources for work;**

<https://www.rethink.org/living-with-mental-illness/money-issues-benefits-employment/work-and-mental-illness>

<https://www.mind.org.uk/workplace/mental-health-at-work/taking-care-of-yourself/tips-for-employees/>

<https://www.mind.org.uk/workplace/mental-health-at-work/taking-care-of-yourself/five-ways-to-wellbeing/>

### **Resources for legal advice;**

<https://www.rethink.org/living-with-mental-illness/mental-health-laws>

<https://www.gov.uk/when-mental-health-condition-becomes-disability>

<https://www.gov.uk/rights-disabled-person/employment>

<https://www.rethink.org/living-with-mental-illness/mental-health-laws>

## **Information sheet on mental health issues**

The charity Mind state that in many ways, mental health is just like physical health: everybody has it and we need to take care of it (Mind, 2017).

Good mental health means being generally able to think, feel and react in the ways that you need and want to live your life. But if you go through a period of poor mental health you might find the ways you're frequently thinking, feeling or reacting become difficult, or even impossible, to cope with. This can feel just as bad as a physical illness, or even worse.

Mental health issues affect around one in four people in any given year. They range from common problems, such as [depression](#) and [anxiety](#), to rarer problems such as [schizophrenia](#) and [bipolar disorder](#).

Experiencing a mental health problem is often upsetting, confusing and frightening – particularly at first. These fears are often reinforced by the negative (and often unrealistic) way that people experiencing mental health issues are shown on TV, in films and by the media. This may stop you from talking about your problems, or [seeking help](#). This, in turn, is likely to increase your distress and sense of isolation.

However, in reality, **mental health problems are a common human experience.**

Most people know someone who has experienced a mental health problem. They can happen to all kinds of people from all walks of life. And it's likely that, when you find a combination of [self-care](#), [treatment](#) and [support](#) that works for you, you will [get better](#).

Please look at the useful links as they provide a lot of information and may help you with some of the issues discussed.

Useful websites;

<https://www.mind.org.uk/media/25263166/how-to-implement-the-thriving-at-work-mental-health-standards-final-guide-online.pdf>

[https://www.mind.org.uk/media/2222919/mind\\_gla\\_report\\_web.pdf](https://www.mind.org.uk/media/2222919/mind_gla_report_web.pdf)

[https://www.mind.org.uk/media/43247/Resource1\\_Mentally\\_Healthy\\_workplacesFINAL\\_pdf.pdf](https://www.mind.org.uk/media/43247/Resource1_Mentally_Healthy_workplacesFINAL_pdf.pdf)

[https://www.mind.org.uk/media/44253/Managing\\_and\\_supporting\\_MH\\_at\\_work.pdf](https://www.mind.org.uk/media/44253/Managing_and_supporting_MH_at_work.pdf)

[https://www.mind.org.uk/media/29259579/mental-health-at-work-1\\_tcm18-10567.pdf](https://www.mind.org.uk/media/29259579/mental-health-at-work-1_tcm18-10567.pdf)

<https://www.mind.org.uk/information-support/a-z-mental-health/>

## 14 Appendix 8: Information sheets given to managers after the interviews

The charity Mind state that in many ways, mental health is just like physical health: everybody has it and we need to take care of it (Mind, 2017).

Good mental health means being generally able to think, feel and react in the ways that you need and want to live your life. But if you go through a period of poor mental health you might find the ways you're frequently thinking, feeling or reacting become difficult, or even impossible, to cope with. This can feel just as bad as a physical illness, or even worse.

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Please look at the useful links as they provide a lot of information and may help you with some of the issues discussed. Please let me know if you want a printed copy of any of these as I think these are really useful resources.

### Useful websites;

For general information;

<https://www.mind.org.uk/information-support/a-z-mental-health/>

<http://www.hse.gov.uk/stress/mental-health.htm>

<https://www.time-to-change.org.uk/about-mental-health>

Information for line managers;

[https://www.mind.org.uk/media/44253/Managing\\_and\\_supporting\\_MH\\_at\\_work.pdf](https://www.mind.org.uk/media/44253/Managing_and_supporting_MH_at_work.pdf)

[https://www.mind.org.uk/media/29259579/mental-health-at-work-1\\_tcm18-10567.pdf](https://www.mind.org.uk/media/29259579/mental-health-at-work-1_tcm18-10567.pdf)

[https://www.mind.org.uk/media/43330/line\\_manager\\_Webinar\\_FAQs\\_final.pdf](https://www.mind.org.uk/media/43330/line_manager_Webinar_FAQs_final.pdf)

<https://www.time-to-change.org.uk/get-involved/get-your-workplace-involved/>



Information for organisations;

<https://www.mind.org.uk/media/25263166/how-to-implement-the-thriving-at-work-mental-health-standards-final-guide-online.pdf>

[https://www.mind.org.uk/media/2222919/mind\\_gla\\_report\\_web.pdf](https://www.mind.org.uk/media/2222919/mind_gla_report_web.pdf)

[https://www.mind.org.uk/media/43247/Resource1\\_Mentally\\_Healthy\\_workplacesFINAL\\_pdf.pdf](https://www.mind.org.uk/media/43247/Resource1_Mentally_Healthy_workplacesFINAL_pdf.pdf)

<http://www.hse.gov.uk/stress/standards/index.htm>

Legal advice;

<https://www.gov.uk/when-mental-health-condition-becomes-disability>

<https://www.gov.uk/rights-disabled-person/employment>

<https://www.rethink.org/living-with-mental-illness/mental-health-laws>

## Information on mental health issues

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[https://www.mind.org.uk/media/2222919/mind\\_gla\\_report\\_web.pdf](https://www.mind.org.uk/media/2222919/mind_gla_report_web.pdf)

[https://www.mind.org.uk/media/43247/Resource1\\_Mentally\\_Healthy\\_workplacesFINAL\\_pdf.pdf](https://www.mind.org.uk/media/43247/Resource1_Mentally_Healthy_workplacesFINAL_pdf.pdf)

[https://www.mind.org.uk/media/44253/Managing\\_and\\_supporting\\_MH\\_at\\_work.pdf](https://www.mind.org.uk/media/44253/Managing_and_supporting_MH_at_work.pdf)

[https://www.mind.org.uk/media/29259579/mental-health-at-work-1\\_tcm18-10567.pdf](https://www.mind.org.uk/media/29259579/mental-health-at-work-1_tcm18-10567.pdf)

<https://www.mind.org.uk/information-support/a-z-mental-health/>