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**Something to declare?  
The disclosure of common mental health  
problems at work**

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## **Abstract**

Drawing on two recent qualitative studies that explored the theme of mental health and employment, this paper will consider some questions and complexities that pertain to the disclosure of common mental health problems in the workplace. These complexities relate to the ways in which mental health problems are understood, including the terms or language in which experiences are talked about and whether indeed people feel that there *is* something of significance that needs to be discussed with their employer. The paper will reflect on the implications of different disclosure decisions for employer and employee responses to mental ill health in the workplace.

Recent years have seen a growing awareness, in policy debate, policymaking and legislation, of the significance of common mental health problems (primarily stress, anxiety and depression) among the working age population. One driver for this increased attention has been the high proportion of incapacity benefits recipients whose 'main disabling condition' is recorded as a mental health problem, standing at 40 per cent of new claims in 2006. Furthermore, it has been estimated that the cost to business of mental ill health totals almost £26 billion per year, through a combination of sickness absence, lost productivity and staff turnover.

Current government policy is targeted at enabling individuals who become unwell to retain their employment or to move quickly back into work. If people are to be effectively supported in work when they experience mental health problems, then it can be argued that employer awareness of an employee's circumstances is an important factor. Disclosure of a mental health problem may be a necessary step in obtaining workplace adjustments to enable people to carry out their work successfully alongside ongoing health problems and is essential if an employee wishes to draw formally on the provisions of the Disability Discrimination Act. Therefore, understanding the processes, experiences and outcomes of workplace disclosure is important, if policy goals of supporting people who have mental health problems to retain or re-enter employment are to be achieved.

## 1. Introduction

This article considers the question of disclosure of mental health problems in the workplace. Drawing on two recent qualitative studies that explored the theme of mental health and employment (Irvine, 2008; Sainsbury *et al.*, 2008), this paper extends the existing empirical literature on the processes and experiences of disclosing mental health problems in the workplace by raising some questions that pertain particularly (though not exclusively) to experiences of common mental health problems.

Most previous research that has considered disclosure of mental health problems at work has concentrated on the experiences of people with severe and enduring conditions (e.g. Boyce *et al.*, 2008; Ellison *et al.*, 2003) or has encompassed a range of disabilities including physical health conditions (e.g. Brunner, 2007a; Stanley *et al.*, 2007). This paper explores some of the complexities surrounding workplace disclosure for people who experience 'mild to moderate' or 'common' mental health problems, typically including anxiety, depression and 'stress', which appear to have received less attention in the disclosure literature to date. These complexities relate to the ways in which mental health problems are understood, including the terms or language in which experiences are talked about and whether indeed people feel that there *is* something that needs to be discussed with their employer.

The past five years have seen growing awareness of the significance of mental ill health among the working age population in policy debate, policymaking and legislation (e.g. Hain, 2007; Layard, 2005; Layard and CEP, 2006; Lelliott *et al.*, 2008; Sayce and Boardman, 2008; SEU, 2004; the Disability Discrimination Act, revised 2005). One driver for this increased attention has been the high proportion of incapacity benefits recipients whose 'main disabling condition' is recorded as a mental health problem. In 2006, this figure stood at around 40 per cent of new claims (DWP, 2006). Taking into account secondary conditions, it is estimated that over half of incapacity benefits recipients experience mental health problems (Black, 2008) and unemployment itself has been shown to be detrimental to mental health (Waddell and Burton, 2006). Furthermore, not only are there economic costs to the exchequer relating to worklessness, but it has also been estimated that the costs to business of mental ill health among employees total almost £26 billion per year (SCMH, 2007).

Decision making about whether and how employers (and others in the workplace) are to be informed about mental health problems, and the consequences of doing so (or not) will be a central feature of many people's experiences. Disclosure may be a necessary step in obtaining effective support within the workplace, to enable people to carry out their work successfully alongside mental health problems, and is essential if an employee wishes to draw formally upon the provisions of the Disability

Discrimination Act<sup>1</sup> (Stanley *et al.*, 2007; Hatchard, 2008). Moreover, concealing an 'invisible stigma' such as a mental health problem may have a further negative impact on psychological wellbeing (Pachankis, 2007; Ragins, 2008). Therefore, understanding the processes, experiences and outcomes of disclosure is important, if policy goals of supporting people who have mental health problems to re-enter the workforce and retain employment are to be achieved.

In the sections that follow, I begin by giving a brief overview of the two mental health and employment studies on which this article is based, before going on to outline understandings of the processes of disclosure that have been derived from previous research. I then present some data from the two mental health and employment studies which, I argue, illustrate an additional dimension to the process of disclosure of common mental health problems in the workplace. Finally, a discussion section offers some thoughts and reflections on how this additional layer of complexity might be addressed or overcome.

## **2. The mental health and employment studies**

In 2007, the Department for Work and Pensions (DWP) commissioned two pieces of qualitative research exploring people's experiences of mental health and employment. The first study (Sainsbury *et al.*, 2008) contained two strands of enquiry. One focused on the experiences of people who had come to claim an incapacity benefit<sup>2</sup> due to a mental health condition, looking at routes out of work and onto benefits and also at what helped people to make the transition off benefit and back into employment. The other strand considered the experiences and viewpoints of employers on recruiting and employing individuals with mental health condition.<sup>3</sup> The second study (Irvine, 2008) explored the experiences of people who had *sustained* employment throughout a period or periods of mental ill health.

Participants who shared their personal experiences of mental ill health in the first study (Sainsbury *et al.*, 2008) were recruited from DWP records of incapacity benefits recipients whose claim was recorded as primarily relating to a mental health condition (n=60). The study group comprised 26 males and 34 females, aged between 19 and 64 years. Fieldwork was conducted in three regions of England, covering rural and urban areas. For the second study (Irvine, 2008), a range of strategies (including approaches via employers and employment support organisations) was used to recruit people who were in paid employment and who

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<sup>1</sup> The Disability Discrimination Act (1995, revised 2005) requires employers to make 'reasonable adjustments' to recruitment procedures and employment conditions for disabled employees, but only if this disability is made known to them.

<sup>2</sup> 'Incapacity benefits' here refers to claims of contribution-based Incapacity Benefit and also income-based Income Support due to incapacity. Note that, for new claimants, Incapacity Benefit was replaced in October 2008 by the Employment and Support Allowance.

<sup>3</sup> The employer strand was conducted by researchers at the Institute of Employment Studies.

considered themselves to have experience of a mental health condition (n=38). The study group included 16 males and 22 females, aged between 24 and 56, with a concentration of participants in their mid 30s to late 40s. The research was conducted across a number of regions in England and Scotland.

Data gathered across the two studies predominantly reflected experiences of 'common' mental health problems,<sup>4</sup> with fewer than ten individuals in total describing conditions among those typically referred to as 'severe and enduring' (for example, schizophrenia, psychoses and bipolar disorder). For the first study, the sample was purposively weighted towards individuals whose condition, for the purposes of their benefit claim, was broadly recorded as anxiety or depression. The study group also included a smaller number of people whose claims were primarily in relation to drug or alcohol use or other 'unspecified' conditions. In the second study, there were no preset criteria for what types of mental health condition would be included among the sample; volunteers to the study opted in according to their personal assessment of whether their experience fitted with the broad study objectives.<sup>5</sup> Most participants described anxiety conditions, depression, stress or a combination of these, though a small number of people had diagnoses of bipolar disorder or had experienced episodes of psychosis.

Both studies involved in-depth qualitative interviews focusing on a range of themes including people's work history, most recent employment, experiences of mental health problems, the involvement of medical practitioners, support received in work (or lack thereof), knowledge and understanding of the Disability Discrimination Act, the role of others outside of work and plans for the future. An interpretive, thematic approach to analysis was taken, grounded in the narratives and language of the study participants. In both projects, interview participants were asked about their thoughts and decisions about talking to others at work about their mental health difficulties and it is on this aspect of the data that the present paper draws.

### **3. Understanding disclosure**

Literature on disclosure of mental health problems in the workplace comes primarily from within two disciplines. One body of literature comes from social policy, where there is a focus on *disability* with regard to equality and social inclusion. Another corpus of work can be found in the broader sociological literature where there is discussion of the disclosure of *social stigma*, including mental illness and also such things as homosexuality, criminality or HIV/AIDs. Drawing on both of these fields of

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<sup>4</sup> I use this term in line with current language in mental health theory and practice. In using terms such as 'mild' or 'common' I do not imply that the experience is insignificant for the individual concerned.

<sup>5</sup> This decision was sometimes arrived at through preliminary discussion with the researcher.

interest, this section provides an overview of how processes and experiences of disclosure have been understood to date.

Brunner (2007a) provides a useful distinction between the 'understanding' of disclosure, i.e. *what it is*, and the 'mechanics' of disclosure, i.e. *how it happens*. Within the employment and vocational rehabilitation contexts, disclosure has been defined as 'the process of an employee informing their employer of a disability/impairment' (Brunner, 2007a: 8) and 'the deliberate informing of someone in the workplace about one's disability' (Ellison *et al.*, 2003: 3). Ellison *et al.* (2003) go on, however, to problematise this definition in that disclosure is not always deliberate, as will be explored momentarily. Brunner (2007a, 2007b) notes that workplace disclosure may be *anonymous* and *confidential* (for example, for disability monitoring purposes in a whole-staff survey), or *open*, for example, where specific reasonable adjustments are being sought. It is often observed in the literature that open disclosure is nonetheless frequently 'partial', firstly in that only a select group of people may be informed and secondly in that the individual may choose to limit the amount of information that is disclosed (Brunner, 2007a, 2007b; Ragins, 2008; Sainsbury *et al.*, 2008; Stanley *et al.*, 2007). Corrigan and Matthews (2003) (drawing on Herman, 1993) distinguish three types of disclosure: *selective* (among a restricted group, retaining some level of secrecy); *indiscriminant* (making no active efforts to conceal); and *broadcasting* (seeking out opportunities to disclose with a view to educating others). Brunner (2007a) has also observed that people may underplay the significance of their impairment/disability and has described this as a form of 'underdisclosure'.

For individuals whose disability is not immediately apparent to others, total non-disclosure is a potential option. At the opposite extreme, an approach of 'full disclosure' is implied, although the extent to which this could be achieved in practice is questionable, and Ragins (2008) suggests that full disclosure is more an attitude of the individual rather than an achieved state of affairs. Given these understandings of disclosure as a series of selective and partial revelations occurring in a range of contexts or circumstances, Brunner (2007a) suggests that disclosure is best conceptualised 'a process rather than an event' (p.19). Likewise, Ragins (2008: 194) observes that 'disclosure is not an all-or-nothing phenomenon but occurs, rather, on a continuum that takes place in work and non-work settings'.

Turning to the question of *how* disclosure occurs, a distinction can be drawn between voluntary and involuntary or 'inadvertent' (Goldberg *et al.*, 2005) disclosure. Ellison *et al.* (2003) use the concept of 'favourable' or 'unfavourable' circumstances that lead to disclosure, broadly corresponding to voluntary and to involuntary contexts respectively. Goldberg *et al.* (2005) offer a third notion of 'implicit' disclosure, occurring when an individual obtains work with the overt assistance of a vocational rehabilitation service or enters employment that is specifically and only available to people with mental health conditions.

Mental health problems fall within what have been described as ‘unseen’, ‘invisible’ or ‘non-apparent’ disabilities (Stanley *et al.*, 2007; Brunner, 2007a), and in the broader sociological literature as ‘invisible’ or ‘concealable’ stigma (Goffman, 1963; Pachankis, 2007; Ragins, 2008). Compared with visible or apparent health conditions or disabilities, the question of disclosure is more complex, given that there is a greater element of ‘choice’ on the part of the individual. Decision-making about disclosure often involves a weighing of costs and benefits. The range of potential and perceived pros and cons of disclosure that have been identified in the literature are summarised in Figure 1. While the potential costs of disclosure largely pertain to negative impact on employment circumstances, it is notable that the potential advantages extend beyond obtaining workplace adjustments to include broader benefits to the individual’s recovery journey and to improving societal understandings.

**Figure 1 Potential and perceived costs and benefits of workplace disclosure**

<b>Benefits of workplace disclosure</b>	<b>Costs of workplace disclosure</b>
<ul style="list-style-type: none"> <li>• to exercise rights under the DDA</li> <li>• to access specialist support schemes</li> <li>• to obtain better tailored/more effective adjustments and support in the workplace</li> <li>• may aid self-advocacy and adjustment to work</li> <li>• experience may be looked upon favourably or be a requirement of certain posts</li> <li>• may be an important and empowering stage in recovery</li> <li>• can reduce the stress/negative psychological impact of concealment</li> <li>• to educate others and challenge stigma</li> </ul>	<ul style="list-style-type: none"> <li>• not being selected for interview</li> <li>• not being appointed to job</li> <li>• exclusion from certain professions that have ‘fitness for work’ standards</li> <li>• being perceived by employer/colleagues as less competent, less reliable or less able to ‘cope’</li> <li>• being treated ‘differently’ at work</li> <li>• changed (more negative) attitudes/behaviours of others</li> <li>• being dismissed from job</li> </ul>

Sources: Boyce *et al.*, 2003; Corrigan and Matthews, 2003; Dalgin and Gilbride, 2003; Ellison *et al.*, 2003; Hatchard, 2008; Pachankis, 2007; Roberts *et al.*, 1995; Williams and Healy, 2001.

A person making a decision about disclosing mental health problems at work is thus faced with a number of questions to consider, commonly summarised in the literature (e.g. Ellison *et al.*, 2003; Brunner, 2007a; Roberts *et al.*, 1995; Stanley *et al.*, 2007) as including:

- Whether to disclose at all
- When (and how) to disclose
- What (and how much) to disclose
- To whom disclosure will be made

In this article, I suggest that there is a further dimension to disclosure decisions which arises particularly with regard to experiences of common mental health problems: that of whether there *is* in fact something to 'disclose' and if so, how this is described. These questions are explored further in the next section.

#### **4. Common mental health problems: something to declare?**

In many ways, the findings of the mental health and employment studies echoed those of earlier research on workplace disclosure. Themes of perceived stigma, discrimination and taboo appeared frequently as reasons for restricted or non-disclosure, there were accounts of voluntary and involuntary disclosures and the studies provided further evidence that disclosure of mental health problems in the workplace is often a 'partial' and gradual process, not a one-off or discrete event.<sup>6</sup> However, the mental health and employment studies brought to light two types of scenario in which the complex nature of common mental health problems could further complicate the matter of workplace disclosure. Firstly, there were situations where what the individual had 'disclosed' to their employer was not a mental health problem but rather an expression of difficulties in the workplace or in their personal life. Secondly, there were instances where the individual had delayed disclosure because they did not perceive their experience to be a mental health problem but rather a 'normal' level of stress or sadness.

The majority of foregoing literature on workplace disclosure of mental health problems begins from a starting point of an individual who has an awareness of some kind of personal attribute or status (be that current or historical) about which they may make decisions regarding divulgence to others. Moreover, many studies have considered this from the perspective of disclosing 'disability'.<sup>7</sup> However, for many people in the mental health and employment studies, the starting point of their experience, as they described it to the researchers, was not one of illness or disability, but of sadness, stress or worry. Ultimately, a majority of people in the studies came to be medically diagnosed with depression, anxiety disorders, or other forms of mental health condition, leading (in the case of participants in the first study) to a claim for incapacity benefit or (for many people in the second study) to extended periods of certified sickness absence. However, for some people, especially those

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<sup>6</sup> These empirical findings are presented in more detail in the project reports (Irvine, 2008; Sainsbury *et al.*, 2008).

<sup>7</sup> Whether or not individuals who experience mental ill health consider themselves to have a disability or impairment is a further question of importance, and one which arose during the mental health and employment studies. Some participants expressed doubts about whether their mental health difficulties could or should be described as a disability. This is of particular significance in relation to people's decisions about invoking their rights to reasonable adjustments under the Disability Discrimination Act. Further consideration of this aspect of the disclosure experience is beyond the scope of the present paper, but see Wilson and Beresford (2002), Beresford (2004), Sayce and Boardman (2008) and Dalgin and Gilbride (2003) for further discussion.

experiencing their first episode of mental ill health, there was often a period where it was not apparent to them that talking to or seeking support from employers regarding a 'mental health problem' was appropriate to what they were experiencing. In the following two subsections, I draw on examples from the data to illustrate these complexities.

#### **4.1 Disclosure of 'difficulties'**

The first type of scenario emerging from the mental health and employment studies, in which the matter of 'disclosure' becomes complicated, is where people had spoken to others at work about problems they were experiencing either in the workplace or in their home lives, but did not (at least initially) describe these in terms of a mental health problem.

Many study participants linked their experiences of mental ill health to events in their personal and/or work lives and for some, these were the terms in which they first spoke to others at work about their difficulties. For example, some people had initially approached a manager, personnel or occupational health department with concerns about unfeasible workloads, bullying or poor line management. Others had spoken to colleagues or managers about difficulties they were experiencing in their domestic life, for example, relationship breakdown, bereavement or supporting their children through traumatic events. In other words, there were people who had said *something* to others at work about problems they were experiencing, but this was not specifically a disclosure of a mental health condition.

Several of the examples where people had talked to their employer about some 'precursor' to their diagnosed mental health problem involved the build up of work-related stress. A number of people had mentioned that they were 'struggling' with their workload or were having difficulties with a colleague or manager. Often, however, people felt that their early 'cries for help' had been ignored or downplayed. Where people in the studies did talk to others at work about worries, troubles or stress, employers often did not make active or engaged responses until such time as the problem became 'medicalised' through certified sickness absence or a formal diagnosis, by which time the individual had often become acutely unwell. With the benefit of hindsight, some people felt that earlier intervention from line managers might have been able to prevent work-related stress from becoming a more serious mental health problem. There were also examples where people felt that more supportive responses to personal life difficulties might have helped them to manage better at work throughout this time of distress.

The interview extracts in Box 1, below, illustrate study participants' reflections on scenarios where expressions of work-related stress, workplace bullying or other personal problems received little in the way of engaged employer response:

### **Box 1 Employer non-response to expressions of distress**

Par: *I had complained previously that I was getting stressed and nothing was done.*

Int: *When, when was that, before you were ill?*

Par: *Yeah...*

Int: *Ah, tell me about that*

Part: *... about four or five months before I was ill*

Int: *So you, you knew that things weren't right ...*

Part: *Yeah.*

Int: *You mentioned earlier about when you did actually approach Personnel when you were having difficulties with the, kind of, ego issues and the bullying. I mean, what happened at those points?*

Par: *I went down, had a chat, and that was it, really, and I kept going down, and kept saying, but nothing ever was done. They- it does seem to be of the opinion that you've had your moan, so everything's okay*

Int: *Right, so again, no, sort of, concrete action's come from it?*

Par: *No, nothing.*

Par: *I just felt too much pressure from work, too much, too much pressure and, you know, if you go to work and you say to them like "Why don't we have counselling?" To me, right, if someone come in my office and said that to me, that's a cry for help, someone needs someone, but nothing seemed to get done about it.*

Par: *Obviously I had to tell people that I've broken up with my boyfriend, and it was quite a big deal, but my line manager didn't really ever speak about that again. And it was really hard for me to keep going to work, because I was obviously really upset about what had happened, and I was quite distracted, and I don't know whether maybe if I'd have had a bit more support at work with that at the time, or just to, kind of, ask "How are you, is everything alright?", which I didn't get.*

These situations raise the question of how employers (including line managers, senior managers, personnel/human resources and occupational health staff) respond to 'disclosures' of information that are not expressed explicitly in terms of a health condition or illness. As will be considered in the discussion, there are implications for workplace support systems in ensuring that employers recognise and make appropriate and timely responses to employees' expressions of distress, whatever form these may take. However, as we now consider, there are also challenges that

arise from the individual's own perceptions of their state of mental health and the influence this has on disclosure decisions.

#### 4.2 The borderlines of 'normal' stress or sadness

The second complicating factor in the disclosure of common mental health problems is that of whether or not the individual is aware that what they are experiencing has moved out of the realm of 'normal' emotion or reaction into that of mental ill health. Here, rather than expressing problems in non-medicalised terms (as described in the previous section), people did not say *anything* at work because they were not (yet) aware that their experience could or should be described as a mental health problem.

Many of the examples here again came from experiences of mounting work-related stress which eventually became acutely problematic. A number of people had continued for some time to 'struggle on' (Sainsbury and Davidson, 2006) in the face of work-related stress, sometimes not recognising the severity of impact on their health, sometimes feeling that they *should* be able to cope with the pressure. Here, then, there was sometimes a combination of an individual's lack of *insight* into mental health problems combined with a lack of *acceptance* of the fact that they were experiencing difficulties coping with workload or domestic circumstances. Both of these factors could present an obstacle to disclosure, as illustrated by the quotes from participants in Box 2, below.

##### **Box 2 Recognising mental ill health**

*It was very hard to tell where you start being actually ill. You know you're not coping and you know you don't feel good, but, you know, when is that just that you're a bit tired and when is that becoming just an overwhelming problem?*

*I think at the time I didn't really see myself as being ill, more as being perhaps too weak psychologically if you like, or mentally, to do what the job entailed.*

*I was aware that I was not firing on all guns but how do you gauge it, how can you gauge it at the time? You know, you feel funky for a couple of weeks, you just put it down to life don't you.*

*Being ill requires you to know that you're ill. And one of the significant features of my mental health problem, at the point at which I was very worst, I wasn't aware that I was ill at all ... I'd thought this was just a combination of circumstances.*

These quotes illustrate how the way in which individuals themselves perceive their circumstances will also influence the way that they manage their situation and what they share with others. People may not always be aware of the extent to which personal or workplace problems are impacting on their mental wellbeing and so may not recognise or perceive that what they are experiencing is cause for intervention or involvement of their employer. There was acknowledgement among some of the study participants that increased understanding of common mental health problems would have been helpful to them, feeling with hindsight that they might have been quicker to recognise or acknowledge that they were experiencing problems and so could have acted sooner in seeking help.

## 5. Discussion

The matter of workplace disclosure has previously been considered primarily in relation to informing an employer of a particular impairment or disability of which the individual has some understanding and recognition. Data from the mental health and employment studies revealed how the question of workplace disclosure may involve a different set of considerations in the case of common mental health problems. Firstly, while people may talk about emotional distress (and its causes) in general terms, they do not necessarily discuss the effects on their mental health in medicalised language. Secondly, people may not recognise or perceive that what they are experiencing is cause for intervention or involvement of their employer and so do not mention this in the workplace. These observations highlight the importance of early recognition and response to mental health difficulties, both by the employer and by the individual concerned, and – I argue here – the need for a more wide-reaching and inclusive way in which to understand the nature of mental health.

Debate is ongoing about the nature of the relationship between depression and ‘normal sadness’ and between ‘stress’ and clinical diagnoses of anxiety and/or depression (Aneshensel, 1999; Horwitz and Wakefield, 2007; Parker, 2007; Pearlin, 1999; Pilgrim, 2005; Seymour and Grove, 2005; Summerfield, 2001; Wakefield *et al.*, 2007). However, a concept around which there currently appears to be a degree of consensus, and which resonates with the experiences of many people in the mental health and employment studies, is that of a ‘continuum’ of mental health. Wilson and Beresford offer an elegant summary of this concept as:

... a broader continuum of distress and well-being; a continuum upon which all people would place themselves, in different positions and at different times in their lives. We need to be explicit: the world does not consist of ‘normals’ and ‘the mentally ill’; it consists of people, all of whom may experience mental and emotional distress at some time(s) in their lives.  
(Wilson and Beresford, 2002: 144)

While this concept is undoubtedly helpful in reducing the stigma and 'otherness' of mental ill health, it leaves the key question of at what point along the continuum an individual might or should consider 'disclosing' their position to an employer. Ellison *et al.* (2003) proposed that disclosure is more common among people with diagnoses of more severe mental health conditions. They reason that this is due to the greater need for workplace adjustments under the auspices of disability employment law. However, the findings of the mental health and employment studies suggest that this difference may also in part be due to the additional complexities in disclosing common mental health problems. Although there may be greater stigma attached to severe mental health conditions, it could be argued that in some senses it is less 'complicated' to disclose such conditions, because of the greater clarity about diagnoses, legal rights and employer duties and (in some cases) the personal understanding and support that comes, for example, from involvement with mental health services. In contrast, disclosing a mild mental health problem may be more difficult because of the unclear distinction from 'normal' troubles.

A challenge that was illustrated particularly frequently in the mental health and employment studies was the recognition of and response to stress-related mental health conditions, especially where workplace factors were perceived to have contributed. Part of the necessary action involves employers taking more proactive measures to prevent and recognise work-related stress, and to take seriously the concerns of employees who come to them with concerns about workload, management style or relationships with colleagues – whether or not these are described in medicalised terms. The concept of 'stress' and its relationship with clinical diagnoses of mental health problems is complex. However, what seems clear is that stress can be a precursor to medically diagnosable conditions and that stress can exacerbate existing mental health problems. This is an issue which is already receiving quite significant attention. Advice and guidance on the identification, prevention and management of work-related stress are already available to employers (for example, through the Health and Safety Executive's 'stress management standards') but there is evidently still a need for increased uptake and implementation of effective practices by line managers.

Also of value would be a broader focus on employee 'wellbeing', whereby organisations take a more active and vested interest in the physical, social and emotional needs of employees. Despite the number of accounts of non-response to early disclosures of problems, there were examples in the mental health and employment studies where employers had dealt sensitively with people's personal difficulties, offering a sympathetic ear or arranging working hours to fit with family commitments, without the individual having 'disclosed' a mental health problem. Timely employer responses to the stresses and strains of domestic and working life may be crucial in preventing these from becoming more acute mental health problems. This requires employers to be mindful of the challenges that their staff are dealing with at work and at home, taking a wider interest in personal and social

circumstances. However, there is some evidence that employers perceive limits to their role and responsibilities in relation to 'personal' problems (Rolfe *et al.*, 2007) and so there may be challenges in encouraging a wider focus on holistic wellbeing.

It was also evident from these studies that part of the challenge lies with employees – often those individuals who are very successful, highly 'driven' and who feel a responsibility to 'cope' and so do not speak out when they are struggling. Williams and Healy (2001) suggest that in decisions about disclosure, individuals make assessments of the perceived acceptability of their difficulties to others (and therefore anticipated responses). These assessments involve consideration of the form and context of disclosure (i.e. how and to whom) and social expectations (i.e. is this a justified reason for mental distress). In sum, people's decisions about disclosure may be based on whether they believe others will see their grief or mental distress as 'legitimate'. Where work-related stress is concerned, it seems that some people may fail to disclose problems not because of the stigma of 'mental ill health' specifically, but because to appear not to be coping with work would indicate 'weakness' or because of a personal work ethic which dictates that it is the individual's problem if they struggle to meet the demands of their job. In other words, these struggles are not 'legitimate' disclosures.

## **6. Conclusion**

This paper has argued that investigations and reflections on the matter of workplace disclosure of mental health problems have to date overlooked an important aspect of the process – that of the individual and those around them becoming aware that there is a mental health difficulty to discuss. This argument has at its heart questions about understandings and concepts of mental ill health. The mental health and employment studies highlighted how the way in which people perceive their circumstances can influence the way that they manage their situation and what they share with others. People may not always be aware of the extent to which personal or workplace problems are impacting on their mental wellbeing and so may not recognise or perceive that what they are experiencing is cause for intervention or involvement of their employer. Likewise, non-medicalised expressions of difficulties may not always receive the early intervention from employers that might help prevent the development of more acute mental health problems.

The findings from the present and previous studies indicate a need for better understanding about mental wellbeing, mental health and mental health problems among employees, employers and wider society. This relates to what has been described by Jorm (2000) as 'mental health literacy', a concept he defines as 'the knowledge and beliefs about mental disorders which aid their recognition, management and prevention'. However, beyond a focus on understanding clinically diagnosable mental health conditions, there is additionally a need to engender a

more inclusive and holistic understanding of mental health as something that is an inherent feature of every individual's experience and therefore of universal concern.

To facilitate this, I argue that what is needed is a different discourse around mental health and mental wellbeing that is sufficiently inclusive to draw in those individuals who may not perceive themselves as having a 'mental illness' or mental health 'condition' but who nonetheless are affected by lessened mental wellbeing at particular times in their life. In effect, this includes everybody. While the experiences and difficulties of people with severe and enduring mental health conditions cannot and must not be overlooked, far greater numbers of people are experiencing common mental health problems such as milder forms of depression and anxiety and stress-related mental ill health. While the existing body of literature on workplace disclosure provides useful discussion of the concepts, contexts, benefits and risks of disclosure of mental health conditions, this literature largely fails to address the circumstances of the many individuals whose disclosure decision is not one of whether or not to reveal a diagnosed, clearly defined and relatively well understood mental health condition, but of whether and how to talk about difficulties or distress that are (at least initially) perceived as part of their 'normal' experience.

People need to be conscious of their state of mental health as something that should be nurtured and protected, with knowledge of how to do this and alertness to early signs that mental health is becoming damaged. Alongside this there needs to be more openness about mental health, whereby people have the language and confidence to talk about mental health without this being medicalised or (necessarily) problematised. In such an atmosphere, there could be more scope for and likelihood of individuals, employers or others in the workplace taking early steps to acknowledge and respond to problems when they begin to emerge. Obtaining effective workplace support at times of reduced mental health should not have to depend on 'disclosure' of a 'disability' – particularly if the aim is to intervene early. Mental health needs to be discussed as openly as physical health – and discussed as a positive and everyday concept.

Mental health is recognised as an area of significant and growing concern for the economy, for health services and for employers. However, despite increased public discussion and policy attention around mental health, a cycle of perceived stigma, taboo and misunderstanding persists. Breaking this cycle will depend on both better understanding from employers but also better understandings among individuals about preventive measures to manage better mental wellbeing and an openness which allows people to speak up at an earlier stage when they begin to experience difficulties.

Progress is continually being made in the clinical, psychological and sociological fields in advancing understandings of the origins or causes of mental distress, the roles of social circumstances and biological factors, and the relationship between

stress and mental health conditions. However, both lay and professional understandings remain varied and contested. In seeking to support more people who experience common mental health problems to remain in work, the more important matter, it seems, is not to instil a deep knowledge of diagnostic criteria or establish borderlines between illness and everyday emotion, but to develop a new discourse of mental wellbeing, within which individuals and employers are better able to recognise and respond to expressions of mental distress, whether this be in the form of personal problems, a diagnosed illness or a disability.

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