Understanding illness experiences of employees with common mental health disorders

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Background

Common mental health disorders (CMHDs) are a leading cause of sickness absence. To address this, a Fit for Work Service (FFWS) was introduced in Greater Manchester, UK, in 2010, offering case-managed and multidisciplinary interventions to early-stage sickness absentees experiencing physical health conditions and/or associated psychosocial problems, to enable a speedy return to work.

Aims

To explore the illness experiences of employees who contacted or were referred to the Greater Manchester FFWS (GM-FFWS).

Methods

A qualitative in-depth study, using narrative interviews with GM-FFWS service users who experienced mental ill-health. Interviews were recorded, transcribed and analysed for key themes.

Results

There were 21 interviews available for analysis. Multiple disruptive life events overwhelmed employees’ capacity to cope, triggering mental ill-health. For some individuals, the onset of mental ill-health was unexpected and had profound psychological effects on participants’ sense of self and personal identity. In certain cases, previous bouts of emotional distress contributed to an underlying psychology of low self-esteem. Mobilizing resources was often a significant factor in supporting recovery. The illness experience led to a process of self-re-evaluation among some participants.

Conclusions

Disruptive events at work have the potential to threaten an individual’s sense of self. Employee’s experiences of CMHDs can only be fully understood if there is awareness of how these experiences emerge from a person’s biography and subsequently inform their responses to contemporary life events. The design of future clinical and non-clinical workplace interventions should take account of these biographical aspects of the illness experience.

Key words

Fitness for work; mental ill-health; sick leave; workplace interventions.

Introduction

Common mental health disorders (CMHDs) such as depression, stress and generalized anxiety disorders, along with musculoskeletal disorders, are the main causes of sickness absence and worklessness among Britain’s working age population [1, p. 10]. The Office for National Statistics [2] estimated in 2011 that out of a total of 131 million working days lost to sickness and injury in the UK, 13.3 million working days resulted from CMHDs. In common with severe mental health conditions (e.g. psychosis) [3], CMHDs can have debilitating impacts on physical health, result in ‘long-term disability’ [4, p. 4] and significantly disrupt people’s daily lives, including work [5]. However, even those employees with severe mental health conditions can return to employment with effective interventions [6].

Recognizing this, the UK government’s cross-departmental health, work and well-being initiative aims to improve the health and well-being of working age people [7], including those with CMHDs. This initiative was informed by an independent review, which found that work can be beneficial for a person’s physical and psychological health but only if they are employed in a ‘good job’ [8, p. 34]. This concept of ‘good work’ has become an established orthodoxy [9] in UK policy circles. Building
on this concept, Dame Carol Black’s review of the health of Britain’s working age population suggested that early interventions can prevent short-term sickness absence from progressing into long-term absence or worklessness [1]. Black proposed a Fit for Work Service (FFWS) offering case-managed and multidisciplinary interventions to employees experiencing health conditions and/or associated psychosocial problems to enable early-stage sickness absentees to return to work quickly. In 2010, 11 FFWS pilots were established across the UK with the intention of testing different service delivery models. From April 2011, seven of these pilots received funding for a further 2 years, including the Greater Manchester FFWS (GM-FFWS). The GM-FFWS pilot is predominantly delivered via a telephone-based intervention. It uses a ‘bio-psychosocial’ approach to assess each client based on the principle that the health and well-being of the individual is determined by a combination of biological, psychological and social factors.

This article is based on a qualitative study commissioned by the former North West Strategic Health Authority and was undertaken by the University of Liverpool’s Health Services Research Department during 2011–12. The aim of the study was to gain a deeper understanding of the factors that precipitated the emergence of work-related problems and subsequent sickness absenteeism or presenteeism among GM-FFWS clients with CMHDs. In addition, the study examined the illness experiences of clients and how they subsequently recovered as a consequence of their experiences. It also sought to provide insights to inform the design of future interventions that could more effectively support employees experiencing work-related mental illness.

Methods

Narrative interviews were conducted with a random sample of typical service users who contacted or were referred to GM-FFWS during its first year of operation. Participants were recruited from a contact list of 100 service users and interviews were carried out between October and November 2011. Potential participants received information outlining the purpose of the study and those willing to participate were asked to sign and return an interview acceptance form and a research consent form. Researchers telephoned participants to arrange a date and time for interview. To maximize contact rates, participants were offered either a face-to-face or telephone interview. Narrative interviewing was selected to elicit a rich account in order to gain new insights into employees’ lived experiences of work-related mental illness and sickness absence [10]. This method also limited the extent to which researchers could impose their biases on the interview process. Narrative interviewing follows a number of sequential phases, summarized as preparation, initialization, main narration, questioning phase and concluding talk [10]. The preparation phase involved the practical planning of the fieldwork. Initialization involved explaining to the participant the nature of the research and of the narrative interviewing process. The main narration began with the primary research question: ‘Can you tell me how you arrived at a point in your life that led you to contact or be referred to the Fit for Work Service?’ Throughout the narration the interviewer remained a passive listener. Once the narration concluded the interviewer asked follow-up questions, allowing the participant to expand on issues raised during their narration. Interrogative questions were avoided to prevent introducing researcher bias into the interview process [10].

All recordings were anonymized and transcribed verbatim. Thematic analysis using an inductive approach was used to analyse the data, allowing key themes to emerge from it. Each transcript was repeatedly read by the lead researcher in order to become familiarized with the data. The analysis focused on understanding how participants conveyed, interpreted and gave meaning to their experiences. Other research team members also read a selection of the transcripts. Discussion among the team ensued until a consensus of opinion was reached on the key themes relevant to the research aims. The data were then coded and analysed within this agreed thematic framework. Ethical approval was granted by the National Health Service National Research Ethics Service, North West, Central Liverpool.

Results

Twenty-one service users were interviewed. Participants were aged between 23 and 61 and worked in a broad range of employment sectors. Twenty of the 21 participants described themselves as White British/English. The majority of participants experienced moderate-to-severe depressive disorders, which for some individuals were co-morbid with physical conditions (e.g. arthritis), injury or disability. Symptoms were serious enough to result in sickness absence for 18 of the 21 participants. The average period of sickness absence was 3 months and for most participants, this was their first period of sickness absence.

A number of key themes emerged from the data (Table 1). The factors inducing mental illness-health were varied. Stressors external to the workplace identified by participants included personal relationship issues, bereavement, financial difficulties and physical health problems. Participants identified work-related stressors including bullying from or disputes with managers or colleagues, criticism of poor performance, excessive pressure, workload and poor management practices. These stressors often had significant psychological impacts, with some individuals developing a self-perception that criticism from managers or colleagues was indicative
of personal failings or character flaws (Quotation 1). It often took many months before participants were able to rebuild their self-esteem and confidence and contemplate returning to work. The cumulative impact of multiple disruptive life events mentally overwhelmed some individuals’ capacity to cope. Even in cases where problems outside work were the primary stressors, the emergence of problems in the critical life domain [11] of work was often identified by participants as the tipping point triggering a mental health crisis.

There were participants who had experienced previous bouts of emotional distress during their childhood and adolescent years, contributing to an underlying psychology of low self-esteem (Quotation 2). These individuals described how disruptive life events in adulthood had reawakened hitherto dormant emotions or anxieties from their formative years, triggering an episode of mental ill-health.

For some people, the onset of mental ill-health was unexpected. Participants described suddenly reaching a crisis point usually triggered by a workplace incident (Quotation 3). Following such crisis points, participants often presented to their general practitioner (GP) to seek diagnosis and treatment. In most cases, participants requested or were advised to take a period of sickness absence. At this stage, some participants viewed sickness absence as an opportunity to escape and seek relief from the problems they were experiencing in the workplace.

Mental health symptoms had significant impacts. Initially some individuals experienced a sense of ‘inner chaos’ [12, p. 4] as they struggled to comprehend what was happening to them (Quotation 4). For some this led to an impairment of their functional capacity, leading to inability to perform routine tasks (e.g. shopping) and avoidance of social interaction. These psychological responses to the onset of mental ill-health further intensified participants’ sense of social isolation and dislocation. Cognitive functioning was also affected, with some participants experiencing suicidal or self-destructive thoughts.

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<th>Table 1. Summary of participants’ experiences of work-related mental ill-health and sickness absence</th>
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For some participants, the shock of being thrown into turmoil had profound psychological effects on their sense of self. They reported experiencing low self-esteem and a period of intense self-questioning and introspection. These negative self-perceptions were further reinforced among those who felt that succumbing to mental ill-health signified a lack of mental resilience. Some participants feared that if their health condition was revealed, prejudicial social perceptions of mental ill-health could lead to stigmatization from employers or co-workers, resulting in potential damage to both their personal reputation and future employment prospects. For those whose job was central to their sense of identity, losing the capacity to work and becoming a sickness absentee further compounded existing negative self-perceptions and undermined their self-esteem.

Participants initially sought medical interventions to alleviate their symptoms. GPs were often the first point of contact, providing both treatment and referral to medical support services. Access to non-medical interventions was also important in addressing psychosocial stressors affecting participants’ mental health. During this point in the illness experience, the GM-FFWS was able to support clients’ bio-psychosocial needs through referral or direction to advisory services such as debt management, healthy living and counselling services. Our research showed that GM-FFWS mainly performed a psychological support and advisory role. Most participants described GM-FFWS as remaining in the background (Quotation 5), providing a sense of security (Quotation 6) and services that could be accessed when the need arose (Quotation 7). This was particularly important for individuals who lacked social support networks or felt isolated as they did not have access to independent employment advice or support in the workplace (e.g. they were not a trade union member).

Fifteen of the 18 participants who were sickness absentees returned to work. Most of these were keen to resume their existing career as part of the process of rebuilding their lives. This was particularly evident among those (Quotation 8) returning to jobs that they valued [13]. In this regard, returning to work was a therapeutic process that contributed to rebuilding self-worth and provided a sense of direction and purpose after a period of life disruption [12].

For certain participants, their experiences of mental ill-health supported a process of self-re-evaluation of their career and life ambitions. This often proved to be transformative and led some to leave their employer and pursue an alternative career path. They were motivated by a desire to develop a career that would provide a sense of personal fulfilment and was more aligned to their personal qualities, temperament and aptitudes. Three participants did not return to their current jobs because of continuing mental and/or physical health problems or irreconcilable differences with their employer (Table 2).

**Discussion**

Our findings demonstrate how disruptive events at work have the potential to threaten an individual’s sense of self. That some individuals should react in this way is understandable given that work is ‘central to individual identity, social roles and social status’ [8, p. 9]. Critical life situations [12,14] outside work were the primary underlying stressors, although in most cases it was an incident in the workplace that finally overwhelmed participants’ capacity to cope. In this sense, the workplace can be understood as a setting within which an employee’s non-work-related life stressors manifest themselves and subsequently play out [1].

Our findings suggest a link between disruptive events earlier in life and an increased susceptibility among some individuals to the onset of mental ill-health later on. As such this supports previous research into mental ill-health, which revealed an association between previous bouts of emotional distress and an increased risk of subsequently developing a CMHID such as depression [15].

Our study highlights ways in which sickness absence systems support the management of mental ill-health. Some participants used sickness absence as a coping strategy [16] by withdrawing [17] to escape from problematic workplaces. This strategy of ‘gaining space’ [18] allowed participants to gain immediate relief from the source of their mental health problems. As the period of sickness absence progressed, absentees used the time and space it provided to access resources to support their recovery and for some it afforded an opportunity to rethink their life courses. How and to what extent employees attempt to use and exploit sickness absence as a relief mechanism and as a means of gaining space remains poorly understood and requires further research.

Mobilizing resources in response to mental ill-health was also critical. A person’s ability to mobilize a mix of both medical and non-medical resources and use these to their advantage was often a significant factor in rebuilding mental resilience and maintaining a sense of optimism for a better future [19]. This was facilitated in many cases by the GM-FFWS. By adopting a holistic case-managed approach based on a bio-psychosocial model, the GM-FFWS proved to be an effective advisory and psychological support intervention particularly in relation to addressing the wide-ranging determinants of CMHIDs.

Our findings are consistent with previous research, in that for those participants who returned to employment, particularly when this was good work [8], there were mental health benefits. Returnees perceived it as a sign to themselves and others that their lives were returning to a state of normality, exemplified by rebounding from a critical life event [14] and restoring their mental health. In regaining the capacity to work, participants re-established their social status and identity as a worker. This was
The experience of mental ill-health led many participants to evaluate their lives and rethink and reconstruct their biographies. This accords with the findings of previous studies, which show that this process of self-reconstruction after a mental health crisis can ‘... lead to self-discovery, self-renewal, and transformation’ [21] or result in ‘accepting and integrating an illness into one’s sense of self’ [22]. Therefore, the experience of mental ill-health, in certain contexts, can be life-changing and beneficial for some individuals. In this regard, our study suggests that some participants benefited from an ‘illness gain’ [23] whereby the experience of illness may result in positive transformations to a person’s identity as a consequence of new insights into life that the illness experience can reveal.

Our findings have policy implications, particularly in relation to supporting the UK government’s agenda of reducing sickness absenteeism and supporting employees to remain in work. Our research indicates that in some people the experience of a CMHD can only be fully understood by appreciating how these experiences emerge from their biographies and subsequently inform and shape their responses to contemporary life events. Critical to this is the need to analyse how and why individuals have sought to understand and attach meaning and significance to specific contemporary and/or historical life experiences and how this may affect their sense of self and identity [14]. For practitioners and policymakers in this field, our findings suggest that the design of future clinical and non-clinical workplace interventions should take account of these aspects of the illness experience, particularly in relation to rebuilding confidence, self-esteem and self-agency, so that people have the capacity to rethink and reconfigure their future biographies in ways relevant to their personal circumstances and long-term needs. For instance, further research could explore how interventions can support employees to reshape or develop new career and life goals aimed at restoring an enduring sense of continuity and meaning to their lives.

There are limitations to this study. Firstly, time and resource constraints prevented adoption of a longitudinal approach, particularly follow-up interviews with participants to track ongoing illness and life experiences in order to ascertain long-term outcomes. Participants were recruited from a specific geographical area, which may have introduced some geographically specific bias into our findings. This was also a small-scale in-depth qualitative study based on a random sample of only 21 participants, which limits the extent to which our findings can be generalized. Further research is required to ascertain whether these findings are applicable to other groups of employees experiencing work-related problems in different geographical locations and workplace environments.

### Key points

- Among our sample of employees with common mental health disorders, it was often the cumulative impact of multiple disruptive life events in combination that overwhelmed their capacity to cope.
- There were therapeutic benefits for mental health among those who returned to work, especially when returning to jobs they valued (i.e. ‘good work’).
- Personal experiences of work-related mental ill-health can only be fully understood if there is awareness of how these experiences emerge from an individual’s biography and subsequently inform and shape their responses to contemporary life events.

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Conflicts of interest

None declared.

References