# PATTERNS OF WORKPLACE SUPPORT: AN EXPLORATION OF THE EXPERIENCES OF WORKERS WITH MENTAL HEALTH DISABILITIES

by

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# Abstract

**Purpose:** To evaluate differences in perceived workplace social support for different disability groups, and to better understand the support experiences of persons with mental health disabilities. **Methods:** A sequential mixed methods design was used. Phase I involved the analysis of an existing dataset to compare perceived social support scores between participants with different disabilities. Phase II, rooted in the phenomenology tradition, involved interviews with workers with mental health disabilities. Triangulation of methods was done in the analysis phase by comparing participant interviews with their corresponding support scores. **Results:** *Phase I* **-** No significant differences were found between participants with orthopaedic and emotional disabilities regarding their total perceived social support score, or support scores according to type (e.g. informational) or source (e.g. supervisor) of support; however, trends suggested that participants with emotional disabilities had higher perceived support scores for friends/family support and lower perceived support scores for appraisal support. Regression models developed from the demographic variables did not predict the perceived amount of social support. *Phase II* – 9 theme clusters concerning the role of supervisors, external and internal factors, and disclosure emerged from the interviews with workers with mental health disabilities regarding their experiences of support in the workplace. **Conclusions:** This was the first mixed-methods study to examine the workplace support experiences of individuals with mental health disabilities using a workplace and disability context specific support scale and interviews rooted in phenomenology. No significant differences in perceived support scores between orthopaedic and emotional disabilities were found and this may be attributable to small sample size. In addition, although the qualitative findings provide interesting insight into support experiences, additional research with more participants from a variety of industries would add to the findings.

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# Chapter 1

# Introduction

## 1.1 General Introduction

Disability rates in Canada continue to rise. National surveys by Statistics Canada show that between 2001 and 2006, the number of persons reporting a disability increased by three-quarters of a million to reach 4.4 million in 2006 (Statistics Canada, 2002; Statistics Canada, 2008). This increase in self-reporting is due to both changing shifts in the structure of the Canadian population, as well as changing perceptions and understanding of what constitutes a disability (Statistics Canada, 2008). As a result, Canada's national disability rate rose from 12.4% in 2001 to 14.3% in 2006 (Statistics Canada, 2002; Statistics Canada, 2008). In particular, the aging population and the growth in reporting of less traditional disabilities, such as those related to mobility, pain and agility, have contributed to this increase in the overall disability numbers (Statistics Canada, 2008). The reporting of mental illnesses has also increased from overall numbers in the past years and has contributed to the rise in Canada's disability rates (Statistics Canada, 2008).

These rising disability rates are accompanied by surging claims for work disability benefits (International Labour Organization, 1998). According to the Public Service Alliance of Canada, unionized public servants filed 3, 234 disability claims in 2008, an incidence of 14.26 claims per thousand, up from the 12.77 claims per thousand in 2007 (Butler, 2009). Although there have been attempts to promote the employment of individuals with disabilities, these strategies have not been adequate to assist individuals with what the International Labour Organization (1998) terms "new" occupational diseases, such as those related to stress, mental

illness and chronic pain. The shortfall of aid in this area can become problematic as the number of persons working with these types of disabilities is on the rise. A 2004 Ipsos Canada survey found that stress is the second highest contributor to absenteeism and health costs in the workplace—with depression, anxiety, and other mental health disorders at the top (Ipsos Canada, 2004). The need to offer support to promote well-being and maintain employment for people with these types of disabilities is clear as the economic burden of disability may potentially become increasingly substantial if these disabilities continue to rise and are not addressed.

## 1.2 Background Information

### 1.2.1 Shifting Perceptions of Disability

In recent years, the construct of disability has undergone a conceptual shift and has significantly changed (DePoy & Gilson, 2004). Once viewed under a predominantly biomedical lens, the concept of disability is generally now understood as a complex phenomenon that involves several perspectives on health: biological, individual, and social (World Health Organization, 2002). As a result of this conceptual shift, the way rehabilitation is carried out and perceptions of what actually constitutes a disability are also changing. These changes do not present themselves without problems and have created areas to be further explored through research, particularly in the context of disability in the workplace.

There have been two major conceptual models of disability that have been proposed over the years (World Health Organization, 2002). The first is the medical model, which has been the one most prominent in the past. This model views disability as an attribute of the person, suggesting that disability is directly caused by a disease, trauma, or other health condition that requires medical intervention by a professional in order to correct the problem with the individual (World Health Organization, 2002).

The second major conceptual model of disability is the social model. This model views disability as largely unrelated to the individual. The social model sees disability as a socially created problem that demands a political intervention, suggesting that disability is produced by an unaccommodating physical environment brought about by attitudes and other features of the social environment (World Health Organization, 2002).

Individually, the medical and social models do not adequately explain disability. A more comprehensive conceptualization of disability is the biopsychosocial model, which worldwide has become the commonly adopted view of disability. The World Health Organization's (2002) biopsychosocial model amalgamates the medical and social models and synthesizes the perspectives of disability from the biological, social and individual viewpoints. This model suggests that disability results from the interaction between an individual's health condition (disease, disorder, injury) and contextual factors (environmental and personal) that impair an individual's functioning and participation in society (World Health Organization, 2002). The biopsychosocial model of disability is inclusive of a wider range of disabilities, including mental health disabilities, and provides a broader context for rehabilitation strategies that extend beyond functional improvement.

Although it is now more common to view disability beyond the medical model, this formerly predominant view of disability has lingering influence. A general belief about disability that has evolved from the medical framework is that disability is associated with stable, permanent and visible physical impairments. To date, this appears to still be a commonly held notion. A study by Grewal, Joy, Lewis, Swales & Woodfield (2002) about people's understanding of disability found that four commonly held beliefs about disability were that, 1) disability relates to a physical impairment, 2) disability is visible to others, 3) disability leads to

incapacity or dependence, and 4) disability is a permanent, unchanging state. These beliefs are held even by some who have disabilities. For example, one study found that individuals with epilepsy associated disability with visible impairments and did not consider themselves disabled (Rhodes, Small, Ismail & Wright, 2008). Stone (2005) suggests that we are taught that by attending to auditory and/or visual cues, we are able to determine who does and does not belong in the disabled category. As a result, our notion of disability is associated with the tangible and physical. As the conceptualization of what constitutes a disability continues to change, this dominant image of disability being physical and recognizable can become problematic.

Mental health disabilities are often considered to be invisible or hidden disabilities; that is, they are not readily apparent or easily discovered by others. These disabilities are difficult to understand because people who have them appear 'normal'. Social convention has taught us that disability is easily seen and has left little room for recognizing that those who appear able and 'normal' may have unseen difficulties (Stone, 2005). Disclosure then becomes an important decision for individuals with these disabilities. Although disclosure has been found to have a positive impact on participation in competitive employment (Sakai, Hashimoto & Inuo, 2009), the choice to disclose is a difficult decision as workers are often concerned that it may result in dismissal or stigmatization in the workplace (Wilton, 2006). Trust may play a vital role in their decision to disclose, which would impact the employer's ability to recognize the worker's needs and accommodate them accordingly.

Related to disclosure, individuals with mental health disabilities and other less apparent disabilities often must also carry the burden of proving they require assistance in order to secure support from others (Davis, 2005). The implications of this situation can be especially problematic in contexts such as return-to-work, in which the support and assistance from others

can have a great impact on an individual's progress. With "new" occupational diseases such as mental illness on the rise in the workplace (Dewa & Lin, 2000), a closer examination of this issue is warranted.

### 1.2.2 Shifting Return-to-Work Strategies

In an effort to address productivity loss and increase positive outcomes for workers, there has been a shift in the past decade for rehabilitation to move towards earlier workplace rehabilitation strategies, whereby injured/disabled workers return to work earlier than previously with some type of workplace accommodation such as modified duties or hours (Electricity Industry Occupational Health Advisory Group, 2008; Pelham, 2005). This shift can greatly alter the workplace social environment and may substantially impact the worker and his/her colleagues. Successful approaches to accommodation require accounting for the social process of accommodation (Gates, 2000). These "soft" features of workplace environments, such as workplace communication, employer consultation with employees, employer leadership style and workplace social support have the capacity to impede or facilitate the return-to-work process; however, there has been little research done in this area.

Rehabilitation of injured workers has traditionally been a process that occurs outside of the workplace with workplace based interventions becoming popular in the late 1980s (Lysaght & Larmour-Trode, 2008). The goal of rehabilitation in earlier times was to compensate, adapt, or overcome irreparable or permanent impairment (Electricity Industry Occupational Health Advisory Group, 2008). Injured/disabled workers then would not return to work until this goal had been met. This form of rehabilitation can be long in duration and is increasingly no longer ideal as disability rates continue to increase and the economic burden due to disability continues to grow (Statistics Canada, 2002; Statistics Canada, 2008; Moore, Mao, Zhang & Clarke, 1997).

The longer an injured/disabled worker is on disability leave engaged in a process of rehabilitation, the greater the economic loss for the employer due to lost productivity and the related expenses of worker's compensation claims. In addition, this separate stage of rehabilitation can have detrimental outcomes for the worker him/herself, as sickness absence itself can be a barrier to successful return-to-work. Studies have shown that the longer an individual is off work, the lower the likelihood they are to return (Foreman, Murphy & Swerissen, 2006). The cost savings for businesses who embrace early workplace rehabilitation can be potentially significant. Recent findings have shown that the magnitude and impact of disability on the individual worker and society has prompted a shift of return-to-work interventions from traditional separate stage rehabilitation to an early, workplace-based approach (Krause, Frank, Dasinger, Sullivan & Sinclair, 2001; Pelham, 2005). These studies demonstrate the benefits to both employers and workers for organizations to invest in early workplace-based rehabilitation programs. Investing in the health of employees is cost-effective and beneficial for employers; savings can be seen in reduced absenteeism and increased productivity.

The return-to-work process is a multifaceted phenomenon, involving physical, social, and psychological factors acting at different points in time (Krause, Dasinger, Deegan, Rudolph & Brand, 2001). It also involves several players, including the worker, employer, healthcare provider, and insurer (Bultmann et al., 2009). Thus, the return-to-work process is influenced by complex interactions between biological, psychological, and social factors as well as different ''systems'', such as the personal, workplace, health care and insurance systems. There have been many studies evaluating the outcomes of return-to-work programs. Success is influenced by numerous factors, including characteristics of the worker, the job, and the workplace (Friesen, Yassi & Cooper, 2001). In addition, studies have found that predictors for return-to-work include

worker demographic factors (e.g. gender, age), previous injury, perception of pain or disability and the presence of depression (Friesen, Yassi & Cooper, 2001). However, there is little research examining the role of the soft features of the work environment, such as social support, and the impact this can have on return-to-work (Lysaght & Larmour-Trode, 2008). With the recent rise in workplace based rehabilitation, the changes in workplace social dynamics can greatly impact the worker him/herself as well as his/her colleagues. It is of increasing importance to investigate features of this situation that can impact the return-to-work process.

The most well-documented work rehabilitation programs are those designed for individuals with physical disabilities, in particular, musculoskeletal disorders (Briand, Durand, St-Arnaud & Corbiere, 2008). Conversely, there has been little research to date examining work rehabilitation programs for individuals with disabilities related to mental health. While there is growing agreement that these disabilities burden the economy, little is known regarding what impact they have on productivity, particularly compared to physical disabilities (Dewa & Lin, 2000). There may be essential differences in needs and strategies for accommodations for individuals with these types of disabilities. With the World Health Organization projecting that mental illness will become the second most important global cause of disease by 2020 (Dewa & Lin, 2000), and the understanding of what constitutes disability becoming broader and more inclusive of mental health disabilities (Statistics Canada, 2008), research in this area is timely. The differences in return-to-work needs and the components of successful return-to-work interventions for individuals with mental health disabilities as compared to physical disabilities need to be examined.

### 1.2.3 Social Support

Despite social support being a well-researched topic, its role in the return-to-work context has not been thoroughly explored. In a qualitative study by Lysaght and Larmour-Trode (2008), participants identified the importance of a full range of social support dimensions arising from a variety of sources in their return-to-work process. Research on workplace support in general has shown support to have a positive impact on worker performance and organizational commitment (Gates, 2000). Other studies have shown that lack of support has a less positive effect on worker performance and organizational commitment. In the case of workers returning to work from a disability leave, lack of support may negatively impact the motivational effort of workers (Karasek, Triantis & Chaudhry, 1982). Consequently, the return-to-work process for workers who do not receive support may be impeded as they are not moved to ameliorate their progress. It is therefore important to measure workplace support in the context of return-to-work, and to investigate what factors are related to receiving or not receiving support. It is important to identify what particular kinds of support are lacking, why they are lacking, and whether certain types of support are more important to the return-to-work process depending on the nature and course of the disability. The implications of such data can identify areas for improvement for organizations' workplace rehabilitation programs that extend beyond the immediate physical concerns of the disabled/injured worker to the social environment of the workplace.

### 1.2.4 Research Methodology

Mixed methods research designs focus on collecting, analyzing, and mixing both quantitative and qualitative data in a single study. It is steered by the central premise that combining quantitative and qualitative methods provides a better understanding of research problems than either approach alone (Creswell, 2009). Emphasis can be placed on one approach

over the other, or equally. The varying combinations of data collection and analysis leads to several design possibilities, with qualitative and quantitative data collection occurring either sequentially or concurrently (Creswell, 2009).

To date, few studies have examined what factors influence the level and type of support that is offered to and/or perceived by workers with disabilities (Sundin, Bildt, Lisspers, Hochwalder & Setterlind, 2006) or compared differences in support between different disability groups. Many qualitative studies examining work and mental health disabilities have done so through (but are not limited to) examining issues of stigma (Stuart, 2004). Few have addressed the wider support experience process of people with mental health disabilities in competitive workplaces. Social support and disability are complex phenomena. By using the mixed methods approach in this study, the phenomena may be understood from different viewpoints and then integrated to create a more holistic understanding.

## 1.3 Problem Statement

The literature suggests that:

- Disability rates are rising, partly due to the changing conceptualization of disability and the rise of "new" occupational diseases, particularly those related to mental health;
- Rehabilitation strategies for injured workers are becoming workplace-based;
- There is a lack of knowledge of what support differences exist between different disability groups in the context of work; and
- Few qualitative studies have examined the broad experiences of people with mental health disabilities in competitive employment.

### 1.3.1 Purpose Statement

The purposes of this two-phase study were to:

a) Determine if differences in perceived workplace social support exist between individuals returning to work from physical injuries/disabilities versus those returning to work from mental health injuries/disabilities, and to

b) Better understand the workplace support experiences of individuals with mental health disabilities

### 1.3.2 Research Questions

The following research questions and sub-questions were posed:

a) Is there a significant difference between levels of perceived support reported by workers who have returned to work from physical injuries/disabilities and those who have returned to work from mental health injuries/disabilities? The hypothesis, based on literature indicating that disabilities related to mental health receive less support in general, was that there would be significantly less perceived support reported by those with mental health disabilities.

    i) Are there significant differences between the two groups of participants in terms of type of support?

    ii) Are there significant differences between the two groups of participants in terms of source of support?

    iii) What contribution do demographic factors make to perceived levels of support?

b) How do individuals with mental health disabilities experience receiving workplace supports?

   i) What role, if any, does the nature and course of the disability play in perceived support? i.e. Do factors related to the nature and severity of the mental health disability affect support experiences?

   ii) How do factors associated with the workplace environment affect support?

   iii) What role, if any, does disclosure have in the support experiences of people with mental health disabilities?

## 1.4 Overview of Thesis

The purposes of this thesis were to evaluate differences in workplace social support for different disability groups, and to better understand the support experiences of persons with mental health disabilities. This thesis is organized into five chapters. Chapter 1 provides background information on the changes in disability definitions and rehabilitation strategies, social support, and research methodology. Chapter 2 provides a review of the literature related to employment and support, and support and individuals with mental health disabilities. Chapter 3 describes the methodology used in this mixed methods study. Chapter 4 reveals the quantitative and qualitative findings of the study, and Chapter 5 discusses the results with a focus on future research and workplace implications.

# Chapter 2

# Literature Review

## 2.1 Process of Review

The goal of the literature review was to gain a more thorough understanding of social support, its role in workplaces, and its role for those with mental health disabilities. Questions that guided the literature search included: what is social support?; what is the role of social support in health?; how is social support measured?; what impact does workplace support have on workers, with and without disabilities?; what mental health disabilities are prevalent in the workplace?; and, what workplace supports do people with mental health disabilities find beneficial?

Multiple literature searches were conducted using the following databases: PubMed, PsychInfo, CINAHL and EMBASE. A search of the grey literature using Google and GoogleScholar was also conducted. A combination of various search terms was used. These terms included: mental health disabilities, mental illness, work, workplace, employment, occupation, return to work, work re-entry, supports, social support, and accommodation.

## 2.2 Social Support Overview

There are various formal definitions of the construct of social support, but colloquially, the term itself suggests that social support is the support we receive through our social networks. A more technical definition by Shumaker and Brownell (1984) states that social support includes any interaction between two people that is intended to produce positive results for the recipient. Cobb (1976), an early researcher on social support, proposed that social support produces a

subjective sensation whereby the recipient feels cared for and loved, esteemed and valued, and belongs to a network of communication and mutual obligation.

Research examining social support has been extensive. Studies have investigated several features related to support, such as the size and structure of social networks as well as the quality of supports that are available and what impact these factors have on support as well as the impact that the support has on the recipient.

### 2.2.1 Types of Social Support

Several dimensions of social support have been identified in the literature. House (1981) categorizes social support into the following:

a) *Emotional support* - characterized by providing empathy, caring, trust, esteem, concern and listening

b) *Instrumental support* - the provision of concrete tangible assistance, such as providing money

c) *Informational support* - giving advice, suggestions, or directives towards resources

d) *Validation/appraisal support* - providing affirmative feedback on one's actions, feelings or status

### 2.2.2 Measuring Social Support

As most social constructs are, social support is a complex phenomenon. It is an interaction between an individual and his or her social network, so both internal factors (e.g. shyness) that influence the individual or external factors (e.g. living in a rural area with no close neighbours) affecting the social network can have both positive and negative impacts on support (Lincoln, 2000). The appraisal of quantity and quality of support can be done through observing supportive behaviours (received support) and by looking at subjective impressions of support

(perceived support). The constructs of received support and perceived support are separate and measured differently. The majority of studies examining social support utilise measurements of perceived support (Vaux et al., 1986). This is arguably because while social support may be manifested in many observable actions, the recipient's interpretation of the support, or lack of support, is the key to what impact the support actually has.

Various scales have been developed to measure social support, including but not limited to: The Social Network Questionnaire (Liem & Liem, 1977) which involves items pertaining to sources of support such as marriage, children, a significant other or confidant, other relatives, friends and participation in social or community activities that may involve strangers; The Inventory of Socially Supportive Behaviours (Barrera, Sandler & Ramsay, 1981) which inquires about the type and amount of support various sources provide with respect to emotional, informational and financial benefits; and The Perceived Social Support Quiz (American Institute of Stress, 2010) which evaluates the support recipient's subjective satisfaction with his/her received support. While the first two scales provide an indication of what kinds of support and how much support is available, the third listed scale provides insight into the significance of the support received.

### 2.2.3 Social Support and Health

The evidence in the literature for social support having a positive impact on health is extensive. It has been demonstrated that strong levels of social support may significantly improve recovery from both physical and mental illnesses (Doebelling, 2007). In addition, the perception of adequate social support is a key factor in health outcomes and the amount of support an individual receives (or does not receive) affects that person's quality of life (Schoofs, Bambini,

Ronning, Bielak & Woehl, 2004). The construct is therefore a critical component in the assessment of a person's overall well-being.

Social support has been shown to have the ability to improve a person's ability to maintain good mental health in stressful situations, to reduce the impact of stress overall, and to offer protection against the possible pathogenic effects of stress (Cohen & Pressman, 2004). This is posited as the "stress-buffering effect" (Cassel, 1976; Cobb, 1976). The provision of support in response to others' needs in times of stress is thought to facilitate adaptation mechanisms and promote coping with the demands of the stressors (Cohen & Pressman, 2004). In other words, social support modifies the effect of stress, with the result being that the effect of stress is greater on those with limited vs. those with adequate sources of social support (Hobfoll, 1986). Social support can affect health directly (i.e. having strong social networks can maintain good health or improve health conditions) or indirectly, by buffering the effects of physical or emotional stress.

Correlation studies testing the stress-buffering hypothesis have generally been confirmatory. Social support has been positively correlated with wellness in general, and the emotional benefits of support have been linked to improvements in various physical disorders and diseases. For example, laboratory studies have shown that when subjects are subjected to stress, emotional support reduces the biological reactions of stress, such as increased blood pressure and the release of stress-related hormones that are damaging to the body (American Institute of Stress, 2010). Emotional support has also been shown to boost the body's immune function in those with HIV and AIDS, and is correlated with longevity and quality of life in breast cancer patients (American Institute of Stress, 2010; Kelly, Soderlund, Albert & McGarrahan, 1999). In one study examining breast cancer and HIV patients (Kelly, Soderlund, Albert & McGarrahan, 1999), higher levels of support were found to manifest benefits in the form of improved mood and better

resilience to fight disease. There has also been evidence linking social support to a number of physiological processes that underlie various negative health conditions. In a review by Uchino, Cacioppo & Kiecolt-Glaser (1996), the authors found that there was relatively strong evidence that social support was related to beneficial effects on aspects of the cardiovascular, endocrine, and immune systems – physiological systems related to many of the leading causes of death in the United States.

Given the benefits of social support for physical health conditions, it is not surprising that social support is also critical for the improvement and prevention of mental health disabilities, such as depression, stress, and anxiety. In fact, the lack of social support an individual has can be a factor in the development of certain mental illnesses. For example, Billings & Moos (1983) found that a child's lack of parental social support can be a factor in the development of childhood depressive symptoms, or in clinical childhood depression. Another study found that individuals who have underdeveloped social networks, and who therefore have decreased levels of support, are more likely to develop symptoms of depression (Wade & Kendler, 2000). Social support (both size of social support network and subjective social support) is therefore a key factor in coping with emotional pain and has been shown to be a predictor of depressive symptoms in major depression (George, Blazer, Hughes & Fowler, 1989).

Despite the beneficial effects of social support for individuals with mental health disabilities, studies on this population show that they receive less support than the general population and receive less support than people in other disability groups (Kelly, Soderlund, Albert & McGarrahan, 1999; Mayer, 2000). Interestingly, one study (Moyer & Salovey, 1999) examining breast cancer and the associated psychological distress of the disease found that low levels of physical functioning led to relative increases in social support, whereas high levels of

psychological distress led to relative decreases in social support. This finding suggests that some aspect of mental health disabilities leads to lower levels of support.

### 2.3 Workplace Social Support

Workplace social support is the context specific form of the construct of social support. It has been defined as the "actions of others that are either helpful or intended to be helpful" (Deelstra et al., 2003, p. 324) and includes a variety of interpersonal behaviours that promote psychological or behavioural functioning in terms of the recipient's work. The sources of support include supervisors, mentors, colleagues, and friends/relatives within the workplace. The types of support are in line with the types of support found by House (1981) - informational, instrumental, emotional, and appraisal - as outlined earlier. Some researchers have further defined the various types of support found in the workplace. For example, Hill et al. (1989), categorized workplace support into four types:

1) Task support, which focuses on sharing and exchanging work assignments and ideas;
2) Career mentoring, which refers to adviser relationships with other individuals who have more experience;
3) Coaching, which involves teaching organizational/professional rules and goals, including organizational politics; and
4) Collegial social support, which includes sharing friendships, personal problems, and confidences.

Research on workplace social support has found it to be predictive of various positive outcomes, including job satisfaction, worker performance and organizational commitment (Harris, Winskowski & Engdahl, 2007; Gates, 2000). Studies have also shown that a lack of

workplace social support can predict a variety of negative outcomes including reduced motivation in workers (Karasek, Triantis & Chaudhry, 1982), absenteeism and turnover (Winstead, Derlega, Montgomery & Pilkington, 1995) and burnout (Myung-Yong & Harrison, 1998).

### 2.3.1 Workplace Social Support and Return-to-Work

Workplace social support, in the disability context, plays an important role in disabled and/or injured workers maintaining healthy states or returning to work from disability leave. This is particularly evident in the provision of workplace rehabilitation programs. Such programs offer the combination of typical rehabilitation interventions, such as functional restoration, and modified work programs (Durand & Loisel, 2001).

A review by Krause, Dasinger & Neuhausser (1998) identified modified work as: light duties, graded work exposure, work trial, supported employment or sheltered employment. Light duties and graded work exposure tend to be the type of modified work seen most in workplace rehabilitation programs. Light duties are temporary or permanent work tasks lighter than those the worker had prior to their disability leave, while graded work exposure is a specialized form of light duties in which the hours, duties and/or performance expectations of a job are gradually increased for the worker over time (Krause, Dasinger & Neuhausser, 1998). “Light” duties are applicable to both physical tasks that require the rebuilding of strength and stamina, as well as tasks that require varying levels of concentration, judgement, and other skills that may be affected by mental health status.

Modified work programs have been shown to be a positive form of workplace support. In particular, studies examining graded work exposure have been favourable. One study by Grunert et al. (1992) found that at 6 months following an intervention incrementally exposing the workers

to work tasks and situations that caused anxiety, the percentage of individuals who had experienced post-traumatic stress disorder following work-related hand injuries still working was 88%. Another study by Loisel et al. (1997) looking at individuals with sub acute low back pain found that a rehabilitation intervention using graded work exposure returned workers to regular work almost two and a half times faster than the usual care intervention (treatment from physician only) at one year follow-up

Less formal forms of support are also found to be beneficial for workers. These supports are related to the interpersonal relationships that exist within the workforce. In a qualitative study by Lysaght and Larmour-Trode (2008), participants identified the importance that trust, communication and knowledge of disability played in their return-to-work process.

### 2.3.2 Measuring Workplace Social Support

Various scales for measuring workplace social support exist. This includes but is not limited to a scale developed by Hill et al. (1989) called the Mentoring and Communication Support Scale, a 15-item measure that yields subscale scores for types of workplace supports identified by the authors: Career Mentoring, Coaching, Collegial Social Support, and Task Support. Some support scales have been developed for specific working populations, such as the Supervisor Support Scale and the Co-Worker Support Scale developed by McQuarrie (1999) to assess the role workplace support had on workers who were involved in serious leisure activities – activities that require a significant and sustained investment of time and skill.

In the context of disability and return to work, no comprehensive and validated tool currently exists to measure the construct of workplace social support. A new scale by Lysaght & Larmour-Trode was developed to address this void and was based on their qualitative study

(2008) of exploring social support as a factor in return-to-work. The original scale (Lysaght, Larmour-Trode, Fabrigar, Friesen & Stewart, 2010) contained 61-items and was divided into four sources of support (supervisor, coworker, organization, and family/friends) and four types of support (informational, instrumental, appraisal and emotional). In a recent study by these researchers (Lysaght et al., 2010), a validation and refinement of their 61-item scale was performed. At the completion of the study the scale was reduced to 45 items, with all items related to organizational support eliminated and items related to appraisal support in relation to coworker support and friends/family support eliminated. Cronbach's alpha for the total scale was .954.

## 2.4 Mental Health Disabilities and Employment

"Mental" health disabilities are generally understood to be disabilities that include both psychological and emotional aspects, such as stress, anxiety, and depression. "Common mental illnesses" are those that consist of experiences that are relatable to most people, such as fear or sadness, while "severe mental illnesses" are those that consist of experiences that are not relatable to most people – such as hearing voices (Richards, Bradshaw & Mairs, 2003). Many individuals experience common mental health problems, such as stress, anxiety, and depression during their prime working years, resulting in sick leave and limited productivity. While many mental health issues may be developed outside of the workplace, the workplace itself can either promote mental health or contribute to and exacerbate mental health problems. Workplaces have a particularly negative effect on the mental well-being of employees in situations where work and life are not balanced and in workplaces that perpetuate or tolerate harassment, discrimination and stigma.

Mental health problems in the workplace are costly. In Great Britain, the estimated cost of stress-related sickness absences is $4 billion per year (Gray, 2000), while stress, burnout, and

physical or mental issues have been cited as the main issues affecting workers in Canada (FGIworld, 2005) and resulting in the loss of 35 million workdays each year (Galt, 2006). Mental health disability claims are the fastest growing category of disability costs in Canada, now accounting for up to 40% of all disability insurance claims (Galt, 2006), and represent 4% to 12% of payroll costs (Wilson, Joffe & Wilkerson, 2002).

In addition to the economic costs, mental health disabilities, especially those involving high stress levels, can cause additional health problems or aggravate existing ones. In a report by Health Canada (2001), high stress levels were associated with higher levels of infectious diseases, cardiovascular problems, back pain, repetitive strain injuries and colorectal cancer.

The early identification and treatment of mental health problems are key to early recovery and to reducing the chances of chronicity (Wilson, Joffe & Wilkerson, 2002). This is an important factor for workers and employees as those with chronic symptoms of mental health problems are more likely to be absent from work (Druss, Schlesinger & Allen, 2001).

### 2.4.1 Supports and Accommodations

Mental health disabilities are often referred to as the "invisible disability" of the workplace. The signs and symptoms, such as cognitive difficulties and fatigue, are often subtle and unrecognizable to an outside observer and often times in the early stages, unrecognizable to the person with the problem as well. This lack of awareness can make the provision of supports and accommodations in a timely matter difficult. More problematic however, is the stigma related to invisible disabilities. In a study by Corrigan et al. (2003) of people with mental illness, more than half of the participants reported instances of discrimination, with the most frequent area of discrimination concerning employment. Stone (2005) posits that for those with visible

disabilities, we are taught by social convention not to expect as much from them as we would everybody else, but for those with invisible disabilities, we judge them against the standards held to everyone else. With this stigma perpetuated in the workplace, those with mental health disabilities may fear they would be discriminated against and feel discouraged about seeking treatment and accommodations, choosing instead to suffer silently.

Coworker attitudes and reactions towards mental health issues have a substantial impact on those with mental health disabilities. Coworkers play an important role in helping to implement accommodations, a role which can be impeded if they feel the accommodations are unfair or if voicing these concerns perpetuates negative public reactions to the accommodations (Colella, Paetzold & Belliveau, 2004). Research has found that the more contact and familiarity a person has with individuals with mental health disabilities, the more likely they are to have positive reactions to their disabilities and the less likely they are to support stigmatizing attitudes concerning them (Holmes, Corrigan, Williams, Canar, & Kubiak, 1999). A study by Peters & Brown (2009) on the reactions to coworkers with mental illness found that coworkers who supported accommodations such as flexible hours and counseling were more likely to self-disclose and seek assistance for a mental-health related problem if they believed their coworkers were being treated fairly, and were more likely to support hiring of people with mental illness.

Workplace interventions for promoting mental health, bringing awareness to mental health issues, and accommodating mental health problems in the workplace are beneficial for both workers and employees. Many companies have already made strides on the prevention level. For example, at Ontario Power Generation Inc., stress levels are monitored by human resources staff and immediately investigated when a noticeable rise occurs in any one department (Galt, 2006). In another example, in the United States, a randomized control trial by Harvard Medical

School (Harvard Health Publications, 2010) was implemented whereby telephone screening and depression care management was provided for workers at 16 large companies from various industries. The results showed that those with the telephone screening had improvements in mood and were more likely to keep their jobs, as compared to the control group.

While there have been strides in the promotion of mental health and the prevention of mental health problems in the workplace, there continues to be room for the improvement of accommodations for mental health disabilities in the workplace and the attitudes and reactions surrounding these accommodations, particularly in the return to work context (Mental Health Works, 2010). According to the director of Mental Health Works (2010) it is not an uncommon scenario for workers on leave with mental health issues to come back to very little change in their work environment and negative changes in coworker attitudes and treatment. This issue needs to be addressed, as accommodations are cost-effective for employers, resulting in improved productivity (Harvard Medical Publications, 2010) and beneficial for the overall recovery and health of the employee.

## 2.5 Summary of Review

Social support has been correlated with improvements in various physical conditions and shown to have protective effects against stress and positive influences on mental health problems. Research has shown that accommodation and support for disabilities in the workplace has a positive influence both for the employer and the employee. However, while there has been a rise in the reporting of mental health disabilities in the workplace, studies indicate that those with mental health problems in general receive less social support than individuals with other diseases and disabilities. While various tools for measuring social support exist, only recently has a validated tool for measuring support in a disability and workplace context been created. Although

there have been strides in the promotion of mental health in the workplace and the prevention of mental health problems, the experiences of those with mental health disabilities and their support experiences upon returning to work have been less explored. This study will be the first to examine workplace support experiences of workers with mental health disabilities by using a mixed methods approach, by measuring support using a disability and workplace specific social support tool and by conducting qualitative interviews rooted in phenomenology.

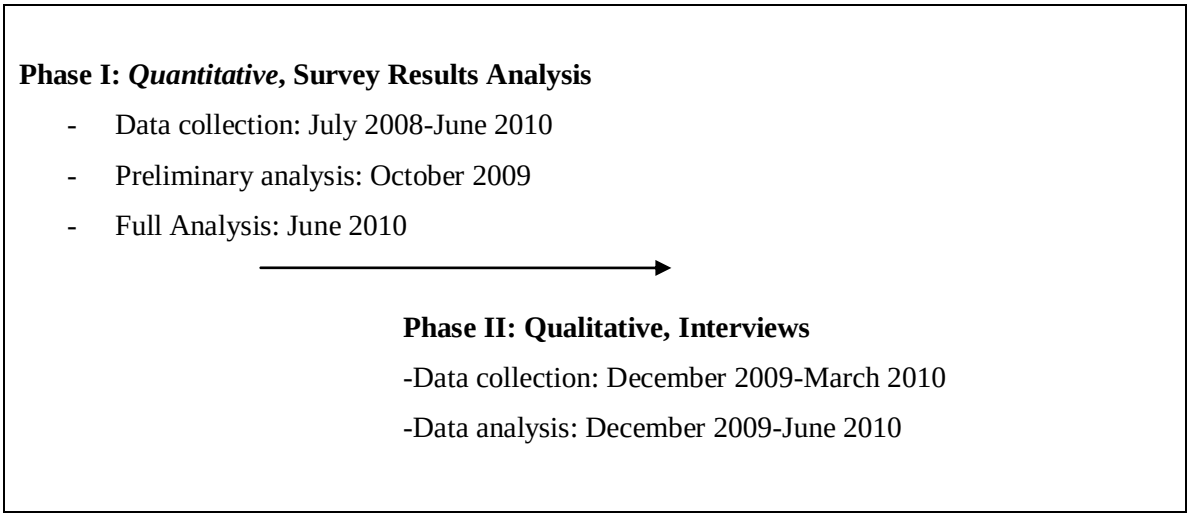
# Chapter 3

# Methods

## 3.1 Research Design

The purposes of this project were to better understand the workplace support experiences of individuals with mental health disabilities, and to determine whether their experiences are likely to differ in terms of amount, source, and type of support from those of workers with physical injuries/disabilities. A sequential mixed methods design, combining quantitative and qualitative methodologies, was used. In this two-phase study, Phase I involved the quantitative data analysis of an existing dataset, followed by Phase II which involved qualitative data collection and analysis. Due to the circumstances of data collection in Phase I, there was slight temporal overlap between the two phases during data collection and analysis (see Figure 1 Study Design using a Sequential Mixed Methods Approach with Overlap between Phase I and Phase II). Phase I of the study provides an overview of patterns of workplace social support. This informs the first central research question and its sub-questions of whether or not and if so where significant differences of support exist between the two groups of participants. Phase II of the study provides insight into the second central research question and its sub-questions, providing a rich description of the support experiences of people with mental health disabilities in competitive employment. This chapter will first describe Phase I in its entirety, including a description of data collection and analysis procedures, followed by a description of Phase II.

**Figure 1: Study Design using a Sequential Mixed Methods Approach with Overlap between Phase I and Phase II**




### 3.1.1. Research Paradigm

The mixed methods research approach adheres to the compatibility thesis and the philosophy of pragmatism. The compatibility thesis is the idea that quantitative and qualitative methods are harmonious and can be used in a single research study (Johnson & Christensen, 2007). The philosophy of pragmatism follows the belief that researchers should use what research approach or approaches work best for their study, regardless of any philosophical, paradigmatic, or any other type of assumptions (Johnson & Christensen, 2007).

In this study, a survey method (quantitative) and an interview method (qualitative) were used. These methods support and inform each other. This can especially be seen when comparing participants' interviews to their responses on the surveys. Data can be compared to see whether the participants' responses remain stable between the two types of data collection methods, and explanations for why certain supports were lacking or what played into receiving certain supports

can be drawn out. In addition, with the supplementation of a qualitative portion to the quantitative, other methods of support or non-support that were not included in the questionnaire can be identified. A description of each research approach will be provided in the following phase descriptions.

## 3.2 Description of Phase I: Workplace Social Support Patterns and Employee Characteristics

The purpose of survey research is to generalize from a sample to a population in order to make inferences about a particular population (Babbie, 1990). A recent validation study by Lysaght et al. (2010) was performed on a tool created to measure perceived workplace social support for those with disability needs. The tool was validated with a varied sample that included people with different types of disability from several Canadian provinces who hold a wide variety of positions in companies of varying sizes. The refined data from this study offers insight into patterns of perceived workplace support, including overall levels of support, levels of support by type (emotional, information, appraisal, and instrumental), and levels of support by source (coworkers, supervisor, organization, and family/friends). In addition, the study collected demographic factors such as age, sex, workplace size, and nature of disability that may contribute to the outcome of support. As a result, the data from this study also offer an opportunity to examine differences in perceived workplace social support during work re-entry across different disability groups. Using an existing dataset is beneficial for the purposes of this study, as time constraints and difficulties associated with recruitment could have been potentially problematic in completing this study in a timely matter.

### 3.2.1 Instrumentation: Workplace Social Support Questionnaire

The instrument used to collect quantitative data on workplace social support was the Workplace Accommodation of Disability Needs Questionnaire (Lysaght et al., 2010). This scale was developed to address the lack of validated tools available to measure perceived social support in the context of work re-entry and disability needs. Items were developed using qualitative methodologies (Lysaght & Larmour-Trode, 2008) and refined by researchers using a structured review process as well as from additional input from a small sample of subjects with work-related injuries. The instrument is available in both a paper copy and in a web-based format. The scale was administered to a sample of injured/disabled workers from July 2008 to June 2010 as part of a large-scale validation study of the instrument. Test-retest reliability remains to be determined but will be assessed in a follow up study. The scale developers' study used other measures of workplace support in order to provide data for criterion validity testing and to further refine the instrument.

The instrument contains the proposed social support scale, a demographic form, and measures of validation (please refer to Appendix A: Instruments). The workplace social support questionnaire used in the study contains 61 Likert-scale type items. The validation study was recently completed and the number of items on the scale has since been reduced to 45 items (Lysaght et al., 2010). The items involve statements concerning receipt of workplace related support and participants indicate their level of agreement with the statements on a scale of 1 (strongly disagree) to 5 (strongly agree). The scale measures various types of support (emotional, informational, appraisal, and instrumental) and various sources of support (coworkers, supervisors, organization, family/friends).

### 3.2.2 Participant Selection

The analysis for Phase I of this study was a secondary analysis of data collected through a larger instrument validation study. This study used data collected from the validation study of the Workplace Accommodation of Disability Needs Questionnaire. This is a voluntary convenience sample, selectively looking at the data from participants who have indicated on the demographic form that their medical concern is either orthopaedic or emotional, in order to create a sample of participants with physical and mental health disabilities/injuries respectively. These are broad categories without specific criteria, and as a result include a broad range of orthopaedic and emotional disabilities that the participant and his/her doctor have identified as such.

Participants in the validation study were recruited by various methods over the span of two years (2008-2010). These include using flyers posted in physiotherapy clinics, newspaper ads, group insurance company case managers, and human resources departments within companies to help identify possible participants. For group insurance and human resource departments, contact personnel were used to help with recruitment. Once the contact person had agreed to help with recruitment, he/she forwarded the information letter and questionnaire to possible participants and the decision to complete the questionnaire was left to the individual employee. The population is broad and includes workers of various occupations and company sizes from across Canada including: Ontario, Manitoba, Newfoundland, Alberta, British Columbia and Prince Edward Island. Although the recruitment methods undertaken were exhaustive, difficulties in obtaining participants resulted in a low number of returned questionnaires.

Before the commencement of Phase II of the study, an initial analysis of sample size numbers in the Phase I database was calculated. In order to address the low sample size in the

emotional category, participants who were involved with Phase II of the study were invited to complete the Phase I questionnaire and additional recruitment was done to specifically obtain participants with emotional disabilities.

### 3.2.3 Data Management

Phase I questionnaires that were additionally collected by the investigator of this study were entered by the investigator into the existing SPSS dataset created by the investigators of the validation study. Questionnaires were stored in a locked filing cabinet in a locked research office at Queen's University in Kingston, ON.

### 3.2.4 Outcome Variables and Analysis Procedures

All analyses conducted in Phase I of this study were done using SPSS Statistics Gradpack 17.0.

The independent variable for the Phase 1 study was the disability category, orthopaedic or emotional. The item on the survey that pertains to this variable is the demographic question: "Please indicate the medical concerns that were included in this claim". Participants that indicated an orthopaedic or an emotional disability were filtered out into a separate database for analysis. Participants who indicated an orthopaedic or an emotional disability in combination with other disabilities were not included in the sample for analysis, as it is not known which disability elicited their received support. Some participants in Phase II of the study indicated additional physical disabilities but reported their experiences were related to their emotional disability; therefore the data for these participants were used in the analysis despite the aforementioned exclusion criteria.

The participants with orthopaedic and emotional disabilities were assessed for differences in demographic variables using t-tests or Chi-square tests depending on whether the data were continuous or categorical, accordingly.

The outcome measures of interest were levels of support: overall social support, support broken down by type (emotional, instrumental, appraisal, and informational), and support broken down by source (coworkers, supervisor, organization, and family/friends). These types and sources were assessed by various items in the scale:

- total support: 61 items
- supervisor support: 23 items
- coworker support:17 items
- organization support: 11 items
- friends/family support: 10 items
- informational support:10 items
- emotional support:25 items
- instrumental support : 17 items
- appraisal support: 7 items.

Negatively worded items on the questionnaire were recoded and a summed-score procedure was used to obtain total levels of support. Mean scores out of 5 were then calculated for total level of support and for levels of support by source and type, with higher scores indicating higher levels of support. The demographic form collected information on seven types of accommodations participants may or may not have actually received. These accommodations are related to the construct of instrumental support, thus the mean number of accommodations for each disability category was calculated for analysis. In order to answer the research questions of

Phase I of the study, t-tests were conducted to determine if differences in the means of the support scores and accommodation numbers differed between participants with orthopaedic and emotional disabilities.

Support network size and sex have been found in previous research to be mediating variables to social support, with the trend for females and those with larger social networks to receive higher levels of support (Daalen, Sanders & Willemson, 2005). Correlations and multiple regressions were done on these (sex and department size as a representation of social network) and other demographic variables (nature of disability, number of previous claims, supervisory responsibility and first claim status) in order to determine their relationships and predictive power relative to total level of support scores.

## 3.3 Description of Phase II: Interviews

Phase II of the study involved a qualitative research design rooted in the phenomenology tradition. The objective of this phase was to explore the support experiences of people with mental health disabilities in competitive employment.

### 3.3.1 Phenomenology Tradition

The phenomenology tradition is identified by Creswell (1998) as one of the five main qualitative research traditions. The aim of the researcher is to describe as accurately as possible the phenomenon by remaining true to the facts and understanding the perspectives of the people involved (Welman & Kruger, 1999). In other words, the researcher is concerned with the 'lived experience' of the person and what meaning the person ascribes to that experience (Creswell, 1998).

### 3.3.2 Interviews

Personal interviews with those who experience a phenomenon can elicit in-depth, comprehensive, and detailed information through the use of sensory, feeling, knowledge, and behavioural questions (Patton, 2002). In this study, personal interviews were chosen as the method of data collection for two reasons:

1) This method remains true to understanding a person's lived experience, the rooted objective in the phenomenology tradition. To understand the meaning of an experience, it is best to view the person who has lived the experience as the expert.
2) A recipient's interpretation of support, or lack of support, is the key to what impact the support actually has. Only the participants themselves can truly describe how they experience support.

### 3.3.3 Participant Recruitment and Selection

Phase II sampling was purposive. Purposive sampling is a strategy used in qualitative research in which participants who have indeed experienced the phenomenon are sought (Creswell, 2009). Because these individuals have lived the experience, they have in-depth and rich information pertinent to the study.

Participants were recruited with the help of various people who had access to individuals with mental health disabilities in competitive employment. The primary source of recruitment was through health care personnel in Ottawa, ON. Other participants were recruited with the help of human resource personnel in the Kingston, ON. Recruiters were given a telephone script and/or email script (see Appendix B: Recruitment) that described the study and gave contact information for the primary investigator. Recruiters then passed this information on to possible

participants. Individuals who chose to participate in the study initiated the contact with the investigator.

In qualitative research, recruitment of participants occurs until redundancy of information begins and no new information is being obtained from additional data collection, a phenomenon known as "saturation" (Creswell, 2009). According to Boyd (2001), two to ten participants is considered a sufficient number to reach saturation in a phenomenological study, while Creswell (2009) recommends a sample size of 10 individuals. With a total of seven individuals interviewed in this study, the sample is within the guidelines that allow for describing meanings attributable to a particular experience. However, due the variability seen in participants' disability levels and support levels, saturation was not met in all themes. A larger study with more participants would need to be done to support the findings of this study.

### 3.3.4 Interview Protocol and Procedure

Interviews took place from December 2009 to March 2010. All interviews were conducted face-to-face either in a private office in Ottawa, in the participant's home, or in a private meeting room at Queen's University. Once participants had expressed their interest in participating by contacting the investigator and had received any additional requested information about what their participation required, those that remained interested were scheduled an interview time and location according to their convenience and preference. All participants who made contact with the investigator participated. An information and consent form (see Appendix C: Information and Consent Form) was provided at the beginning of the interview. To those for whom it was applicable, participants were allotted time to complete the Phase I questionnaire before beginning the interview. Interviews were digitally recorded and later transcribed by the

primary investigator in Microsoft Word 2007. Transcripts and audio files were kept on a password protected drive on the investigator's personal computer

The interviewer followed a semi-structured interview guide (see Appendix A: Instruments). Questions were developed by the researcher to explore the support experiences of workers with mental health disabilities. Questions were designed with the aim of understanding the person's disability in the context of their work, the process of receiving (or not receiving) support, and the impact it had on the individual.

### 3.3.5 Qualitative Analysis Procedure

Various frameworks have been developed to assist with the complex analysis of phenomenological data. This study followed the method outlined by Colaizzi (1978) to provide descriptions of the meanings of the lived experience of the participants in this study. Colaizzi's method is used frequently for analysis (Forrest, 1989) and is well suited for descriptive phenomenology studies as his method is rooted in Husserlian descriptive principles, which aims to identify experiences of a phenomenon as described by the research participants (Koch, 1995). The following outlines Colaizzi's 7-steps to analysis and the procedures used to analyse the data:

1. *Acquiring a sense of each transcript*
    - In this step, the aim is for the researcher to gain a sense of each participant's description of their lived experience via their transcripts. Thoughts and feelings of the investigator that arise during this step are recorded in order to aid with the investigator's bracketing and reflective practice.
    - Gaining a sense of each transcript was achieved by the investigator's practice of conducting the interview, transcribing the interview, proof-reading the interview, and re-

reading the interview. Ideas and thoughts that arose during each process were recorded on paper and later transcribed in an electronic document, sorted by participant.

2. *Extracting significant statements*
    - In this step, statements in each participant's transcript that highlight the participant's experience are identified.
    - The investigator read and re-read each individual transcript. Statements that were deemed to highlight the participant's experience were highlighted and then copied into a separate document.
3. *Formulation of meanings*
    - More general restatements and meanings for each significant statement are formulated at this stage. Bracketing and setting aside of presuppositions should also occur at this stage.
    - The investigator examined the statements that were extracted and colour coded for different ideas. The statements were then generalized to one or a few words. Ideas of what the "bigger picture" of the statements could mean and areas that stimulated questions by the investigator were bracketed. A subjectivity statement was written by the investigator at the outset of the study, but was revisited at this stage in order to adhere thoroughly to Colaizzi's method.
4. *Organizing formulated meanings into clusters of themes*
    - In the next step of analysis, formulated meanings are arranged and grouped into larger clusters that collapse into themes.
    - The colour coded meanings were compared across transcripts and combined based on similarity and then further combined based on broader ideas that were identified.

5. *Exhaustively describing the investigated phenomenon*
    - At this stage, a detailed, analytic description is compiled of the participant's feelings and ideas on each identified theme.
    - The investigator identified how each theme was applicable to each individual participant.
6. *Describing the fundamental structure of the phenomenon*
    - The exhaustive descriptions are reduced to a clear statement of the fundamental structure of the phenomenon.
    - Themes were finalized and brief descriptions of each theme were developed.
7. *Returning to the participants*
    - The findings are taken back to the subjects who check to see if the researcher has omitted anything.
    - Once the interviews were transcribed by the investigator they were sent by email to the participants for review and clarification.

### 3.3.6 Trustworthiness

In considering rigor in phenomenological research, trustworthiness is a process that helps to ensure the study is believable and accurate. The following methods have been identified by Creswell (1998) in order to ensure trustworthiness:

1. Prolonged engagement with the data
2. Triangulation, or using various sources of data, methods, investigators and theories
3. Peer review or debriefing with a colleague regarding the findings
4. Negative case analysis, in which initial patterns of data are revisited if contradictory patterns are found

5. Clarifying researcher bias, which includes the positioning of the researcher's preconceived notions or experiences from the beginning of the study
6. Member checking the findings with participants for feedback and to ensure credibility
7. Using extracts from participants' verbatim accounts, their own rich thick quotes, provides the reader with the ability to make judgments as to whether the findings are transferrable to another situation
8. External audit trail of decisions taken during the data collection and analysis process, including the use of an independent person to evaluate the accuracy of the findings.

Creswell (1998) recommends using at least two of the eight listed procedures in order to ensure trustworthiness of research findings.

In this study, several different procedures were used to ensure trustworthiness. These steps are outlined below:

1. Before the commencement of Phase II, the principal investigator wrote a subjectivity statement (see Appendix D: Subjectivity Statement) to explicitly declare any presuppositions and acknowledge subjective judgments.
2. After each interview, memoing was done to record initial thoughts for analysis and preparation for the next interview.
3. Triangulation of different methods was done by comparing each person's interview statements to their survey responses.
4. Several participants provided rich, thick quotes describing their experiences, which enhanced the credibility of the themes that emerged.
5. An audit trail of all decisions, thoughts, feelings, and reflections made during the research planning, data collection and analysis stages was kept by the principal investigator.

## 3.4 Ethical Considerations

Ethical clearance for this study was received from the Queen's University Research Ethics Board (REH-456-09). Additional amendments to the study were sought for changes in recruitment procedures. In an effort to recruit more participants, ethics approval was required for a modification to the study recruitment procedures. The new recruiters required a script for describing the study and thus a draft of this was required for approval (see Appendix E: Ethics Approval for Additional Recruitment Methods).

Confidentiality was maintained via the anonymous nature of the Workplace Accommodation of Disability Needs Questionnaire and by substituting numeric codes for participant names on the verbatim transcripts and audio files of the interviews. In addition, the electronic audio-taped interviews and verbatim transcripts were uploaded into the principal investigator's personal computer and secured by a password. All paper and audio materials saved onto a USB key were locked in a filing cabinet and held in a locked room.

There were no potential risks expected from the participation in this study and while there were deemed to be no direct potential benefits in participating, it was hoped that the participants' contributions would have an impact on the future planning and delivery of support services for individuals returning to work with disabilities. Informed consent regarding the purposes, risks and benefits in participating in the study was received from all study participants.

# Chapter 4

# Results

This chapter will first focus on the results obtained from the Workplace Accommodation of Disability Needs Questionnaire in Phase I of the study, including demographic information, social support scores, and predictive abilities of demographic variables regarding total social support scores. The qualitative findings obtained from the Phase II interviews regarding support experiences of workers with mental health disabilities will follow. The chapter will conclude with the results from the triangulation of data from the two phases.

## 4.1 Phase I Results

### 4.1.1 Demographic Information

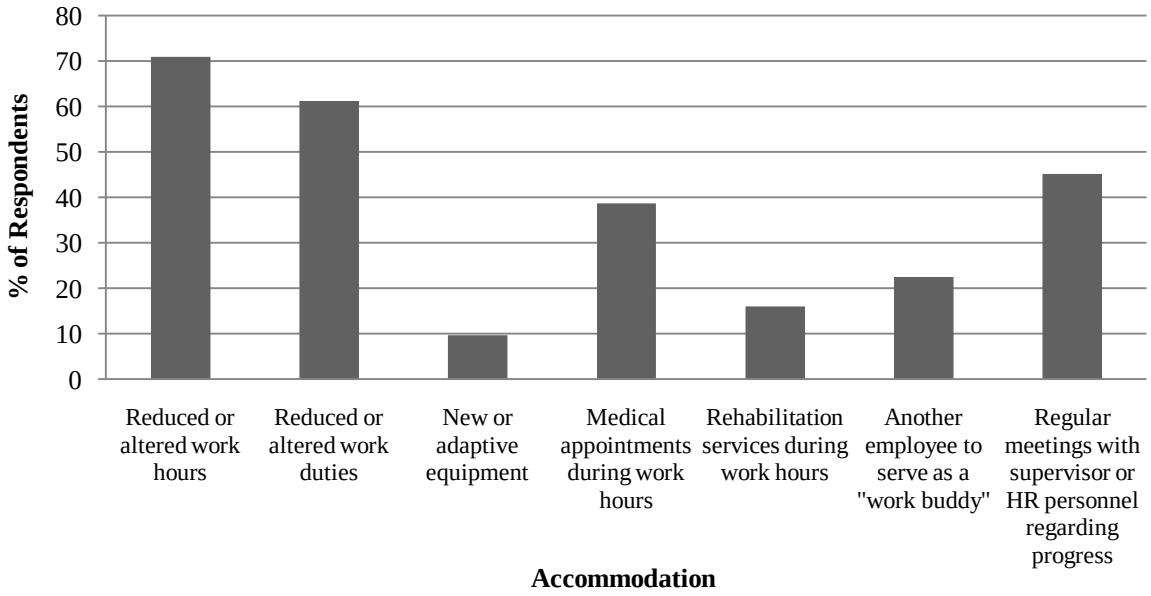
The total Phase I sample size was 31, with 18 participants in the orthopaedic disability category and 13 participants in the emotional disability category. Some participants did not complete the demographic form completely, thus sample sizes differ from question to question. Participants included in the study came from various provinces across Canada with the majority from Ontario (51.6%) and Manitoba (35.5%), and others from Alberta (3.2%) and Prince Edward Island (3.2%). The location of two participants (6.5%) was unknown. Participants with emotional disabilities came from Ontario and Manitoba only, with the majority from Ontario.

Participants varied in their return-to-work status at the time of completing the questionnaire. The majority (58.1%) were working in their previous position and work group, with full duties and time commitment; 19.4% of participants were working in their previous position and work group, but with modified duties or time; 9.7% were working in a different

position or work group, with full duties and time; 6.5% of participants were working in a different position and work group, with modified duties or time and the final 6.5% of participants were off work.

Figure 2: Frequency of Received Accommodations outlines the breakdown of seven different accommodations participants may or may not have received, as reported by the participant. *Reduced or altered work hours* was the most frequently reported accommodation while *new or adaptive equipment* was the least frequently reported accommodation.

**Figure 2: Frequency of Received Accommodations**




4. 1.1.1 Demographic Differences Between Participants with Orthopaedic and Emotional Disabilities

Table 1: Demographic Information outlines the results of the remaining demographic variables, sorted by disability category.

**Table 1: Demographic Information**

| Variable | Disability Category | | | |
|---|---|---|---|---|
| | n | Orthopaedic | n | Emotional |
| Mean Age | 18 | 49.28(SD 7.21) | 12 | 45.58 (SD 10.97) |
| Mean Department Size | 17 | 31.41 (SD 40.15) | 12 | 27.42 (SD 22.42) |
| Mean Company Size | 17 | 624.06 (SD 1029.56) | 11 | 1208.82 (SD 1444.17) |
| Mean Number of Previous Claims | 18 | 0.94 (SD 1.00) | 12 | 0.42 (SD 0.79) |
| Mean Number of Accommodations | 18 | 3.00 (SD 1.24) | 13 | 1.92 (SD 1.66) |
| Sex | 18 | | 13 | |
| Male | | 38.90% | | 23.10% |
| Female | | 61.10% | | 76.90% |
| Supervisory Responsibility | 18 | | 12 | |
| Yes | | 55.60% | | 33.30% |
| No | | 44.40% | | 66.70% |
| First Claim | 18 | | 12 | |
| Yes | | 44.40% | | 75.00% |
| No | | 55.60% | | 25.00% |

Age, department size, company size, number of previous claims, and number of accommodations were checked for normality using Q-Q Plots and Shapiro-Wilk's test. Differences between the disability categories regarding age, department size and company size

were assessed using non-parametric measures, as the Shapiro-Wilk's test showed the data to have a non-normal distribution, while all others were assessed using parametric measures.

Chi-square using Fisher's exact test showed no significant differences between the participants with orthopaedic and emotional disabilities in terms of sex ($p=0.45$), supervisory responsibility ($p=0.28$), or first claim status ($p=0.14$). Mann-Whitney U calculations showed no significant differences between the participants with orthopaedic and emotional disabilities in terms of age ($p=0.46$), department size ($p=0.66$) or company size ($p=0.19$). T-test analyses (unadjusted) showed no significant differences between the participants with orthopaedic and emotional disabilities regarding mean number of previous claims ($p=0.14$): however, a statistical difference did exist between the participants for the mean number of accommodations ($p=0.047$) with those reporting orthopaedic disabilities having a higher mean number of accommodations than those reporting emotional disabilities.

### 4.1.2 Social Support

Mean social support scores out of 5 were obtained for total support score, support score by source (supervisory, coworker, organization, and friends/family), and support score by type (informational, emotional, instrumental, and appraisal) by summing the items in the questionnaire related to each category and dividing by the total number of items in that category. Only cases where at least 90% of questions in a category had been completed were included in the calculation of the overall mean for that category. If a participant missed an item in a category, their mean score was obtained by dividing by the number of items completed. Table 2: Mean Social Support Scores by Disability Category outlines the mean scores for each support category, sorted by disability.

**Table 2: Mean Social Support Scores by Disability Category**

| Support Category | Disability Category | | |
|---|---|---|---|
| | Orthopaedic (n=18) | Emotional (n=12)* | p** |
| Total Support | 3.53 | 3.67 | 0.54 |
| Supervisor Support | 3.39 | 3.37 | 0.99 |
| Coworker Support | 3.43 | 3.78 | 0.21 |
| Organization Support | 3.35 | 3.42 | 0.82 |
| Friends/Family Support | 4.23 | 4.51 | 0.17 |
| Informational Support | 3.38 | 3.38 | 0.98 |
| Emotional Support | 3.58 | 3.75 | 0.38 |
| Instrumental Support | 3.33 | 3.52 | 0.44 |
| Appraisal Support | 3.15 | 3.02 | 0.13 |

*n=12 for all support categories except friends/family, where n=13

** t-test unadjusted

All social support scores were verified for normality using QQ-Plots and Shapiro-Wilk's test. T-test analyses showed no significant differences between the mean scores of the participants with orthopaedic and emotional disabilities regarding total support (p=0.54), supervisor support (p=0.99), coworker support (p=0.21), organizational support (p=0.82), friends/family support (p=0.17), informational support (p=0.98), emotional support (p=0.38), instrumental support (p=0.44) or appraisal support (p=0.13). Differences in mean scores for friends/family support and appraisal support were approaching significance, with the trends indicating participants with emotional disabilities had more friends/family support but less appraisal support than participants with orthopaedic disabilities.

### 4.1.3 Correlations between Demographic Information and Total Social Support Scores and Regression Analyses

In order to determine if any demographic variables were related to support scores, correlations or ANOVAs between the demographic variables and total perceived social support

score were conducted. Correlations between age and department size and the dependent variable of total social support score were computed and no significant correlations were found (p=.095 for age and p=.984 for department size). ANOVAs were conducted to determine if there were significant differences for the categorical demographics of sex (p=.547), supervisory status (p=.430), first claim status (p=.644) and return to work status (p=.474) on total social support score. No significant differences were found.

To test whether any of the demographics had predictive capabilities, three regression analyses were tested. In particular, the regressions were run to see if disability category was a significant predictor of support. Because of the small sample size, models were created to look at disability category in association with other logically-connected factors. Model 1 was comprised of sex, age, and disability category. Model 2 was comprised of disability category, first claim status, and return-to-work status. Finally, Model 3 was comprised of disability category, department size, and supervisory status. Regression analyses showed no significant capabilities of Model 1 (p=.121), Model 2 (p=.875) or Model 3 (p=.798) to predict total social support score.

### 4.1.4 Summary of Phase I Results

Total sample size for Phase I was 31, with slightly more participants with orthopaedic (n=18) than emotional (n=13) disabilities. The majority of participants (both those with emotional disabilities and those with orthopaedic disabilities) came from Ontario and Manitoba and had returned to work with full duties and time in their previous position and work group. No significant differences were found between the participants with orthopaedic and emotional disabilities in terms of age, sex ratio, first claim status, department or company size, supervisory role, and mean total number of previous claims. There was a significant difference regarding mean total number of reported accommodations between the two groups of participants, with the

participants with orthopaedic disabilities receiving more accommodations than the participants with emotional disabilities. No significant differences were found between the groups of participants in terms of total perceived social support score, or any of the subscales regarding source and type of support; however, differences in levels of perceived friends/family support and perceived appraisal support were approaching significance with participants with emotional disabilities receiving more perceived friends/family support but less perceived appraisal support than participants with orthopaedic disabilities. No significant correlations between age or department size with total perceived social support score were found. Additionally, ANOVAs showed no significant differences in total social support score depending on gender, first claim status, supervisory responsibility, or return-to-work status. None of the models developed from the demographic variables had predictive capabilities for total perceived social support.

## 4.2 Phase II Results

### 4.2.1 Participants

In total, seven in-person interviews were conducted with workers with mental health disabilities over the course of December 2009 to March 2010. Table 3: Characteristics of Phase II Participants outlines some general demographic information of the participants and their employment details.

**Table 3: Characteristics of Phase II Participants**

| Participant | Age | Sex | Self-Reported Diagnosis | Employment |
|---|---|---|---|---|
| 1 | 56 | M | Dissociative Personality Disorder | President of a self-startup software company<br>-Previously in hi-tech sales |
| 2 | 56 | F | Depression | Unemployed at time of interview<br>-Previously employed as an event coordinator for a hi-tech company |
| 3 | 41 | F | Depression<br>-additionally: fibromyalgia, arthritis | Unemployed at time of interview<br>-Previously a case manager for an insurance company |
| 4 | 53 | F | Depression<br>-additionally: chronic pain | Scanning clerk in a Federal Government department<br>-Previously an administrative assistant in the same sector |
| 5 | 50 | M | Stress<br>-additionally: kidney failure | Senior project manager for the public service<br>-Previously a senior project manager in a hi-tech company |
| 6 | 54 | F | Depression | Disability claims specialist for an insurance company |
| 7 | 46 | M | Depression | Electrical engineer for a hi-tech company |

The male: female ratio of participants (3:4) was fairly even and the majority of participants were in their early to mid-fifties. All participants were employed in office settings. Depression was the most common mental health disability and several participants had co-occurring medical conditions. Interview times ranged from 40 minutes to 2 hours and 30 minutes, with most interviews in the 1-hour range.

The participants in this sample varied in terms of personality characteristics and support experiences. In order to better understand the cases on which the thematic analysis was based, a snapshot of each participant's personal characteristics (a combination of their own description and the interviewer's observations) and their support experiences is provided.

*Participant 1:*

Throughout the interview it was evident that Participant 1's work identity was extremely important to him. He identified himself as growing up with the belief that the man had to be the provider in the family and had difficulties adjusting when this role was jeopardized by his mental health disability. Participant 1 may also be described as a solution seeker – he was eager to educate himself about his disability and find solutions and strategies to manage his symptoms.

Participant 1 reported he was unaware of his disability for quite some time and never considered the possibility that it was a "mental" problem. He felt that the supports existed in his workplace and he would have been fully supported if the problem had been known and he had sought help. He had a misunderstanding about the purpose of employee assistance programs (EAP's) and this prevented him from making use of this resource. Participant 1 spoke highly of the amount of support from his wife, both emotional and instrumental, but felt a certain level of guilt for how much she had and continues to have to do.

*Participant 2:*

Participant 2 described herself as a helper – she reported that she always felt compelled to do whatever she can to help others. She is a people pleaser that had a hard time saying no. In her work life and personal life she often took on more than she could handle, which played a role in the build-up of her stress levels. In times of difficulties, the participant described herself as good at putting on a "brave face".

Participant 2 had a build-up of life events that led to her eventual depression diagnosis. "The drop that spilled the bucket" was a very negative experience with an out-of-town manager. She went on leave after this event and when she returned there were massive layoffs happening

and she was let go. She was supported by her work via long-term disability and via phone calls/emails from coworkers while she was off. Participant 2 felt that everyone at this particular workplace was always very understanding of her problem and her need to be off work, but had witnessed negative experiences of support in subsequent workplaces.

*Participant 3:*

Participant 3 presented as soft-spoken. As the interview went on she described herself as not having an aggressive personality like her supervisor. Quiet but strong-willed, she described her greatest strength that allowed her to do her job well was her empathy for her clients with mental health disabilities because she felt she could relate to them.

At the time of the interview, Participant 3 was recently let go by her employer. Her support experience with her supervisor was extremely negative. In addition to not receiving accommodations, she felt that her supervisor resented her for her disability and was targeting her to be fired. Their relationship had not always been this way, and Participant 3 strongly felt things changed for the negative after she disclosed her problem. Participant 3 felt her coworkers were supportive, but the negativity of her supervisor left her with the impression that the company in general was unsupportive. The work environment was one in which she felt she was not able to use the strategies she had developed to cope with her problems. She contrasted this experience with her previous employer and felt the differences were extreme – noting that in the unsupportive environment her problems were getting worse, whereas in the previous supportive environment she was actually getting better.

*Participant 4:*

Participant 4 considered herself to be a very private person. She was chatty and noted that she liked to be social with her coworkers in the workplace, but she values her privacy and stated that at certain times she can become very isolated and non-social. Her depression was severe and chronic, as was her chronic pain. She was on very strong medication that had some negative side-effects but felt the relief was worth it. She noted that the depression and pain were correlated with each other.

At the time of the interview Participant 4 was on sick-leave from her current position. Prior to this position she was in the same department under a different unit. She described the support differences between the units as "night and day". Under the current unit, she felt she was close to almost everyone and that they worked as a team. She spoke highly of her supervisor who she felt was genuinely concerned for her well-being and accommodating to her needs. Under her old unit, she felt people questioned her disability and would not hesitate to "backstab" her. Participant 3 received a large number of accommodations from her workplace. She also had and continues to have a very involved family; however, she felt sometimes their support crossed her line of privacy.

*Participant 5:*

Participant 5 had a good sense of humour, which played out in the interview and in his description of his management style. He described himself as so busy looking out for other people and supporting them that he forgot that he might need support as well. He described his strategy for dealing with stress as "masking" it. Participant 5 was quick to point out that he did not

necessarily have a "mental health disability" – he had an underlying medical condition that was aggravated by workplace stress.

Participant 5 was very pleased with the support and accommodations he received while he was dealing with his underlying medical condition (kidney failure & dialysis treatment). However, there were massive layoffs happening in the company at the time that added a lot of emotional and physical stress that the participant felt the company did not provide much support to management for. Participant 5 felt that because people usually came to him for support, this may have led people to not realize he may have needed some support as well. He was not sure as to why he never asked for support in the workplace but noted that he did receive support from his wife.

*Participant 6:*

Participant 6 had taken on a lot of responsibility outside of work and although the stress became high, she described herself as a very strong person. She internalized her weaknesses and felt it was especially important to do so in her workplace.

At the time of the interview Participant 6 had recently returned from a disability leave. She had a good experience of support from human resource personnel but did not consider her overall work environment supportive. She felt that her manager at the time contributed to making the work environment "toxic". She did not disclose to the manager her problem as she had seen others who were treated unfairly after disclosing and did not want to go through the same thing. She received a lot of emotional support from coworkers and friends and family. There was currently a new manager in her department at the time of the interview and she felt the work atmosphere was already changing.

*Participant 7:*

Participant 7 described himself as very "left-brained" – he approached problems logically and methodologically. He struggled to accept his depression diagnosis but was striving to understand it and cope. Participant 7 described his "old self" as being very high strung and caught up on details, but felt he was now able to let more things go and understands he cannot control everything.

Participant 7 described his workplace as very supportive and accommodating. He had been given everything he'd asked for, and felt that because he is a valued employee they were willing to accommodate him in order to keep him. He felt that his demands were within reason and the company continues to be supportive because he does not abuse their support. He did not talk much about coworker support, and felt that he had somewhat distanced himself in the workplace. He had good friendship support but family relationships were strained so he did not receive support from them.

### 4.2.2 Qualitative Findings

Interviews with the seven workers with mental health disabilities revealed commonalities and differences in support experiences, both between participants and within individual participant situations and their various workplaces. Table 4: Theme Clusters lists the 9 clusters of themes that emerged from the interviews. Participants described their experiences of working with a mental health disability, the role external factors had in influencing support, and the internal characteristics that influenced support.

Some participants were more descriptive and articulate in describing their experiences than others. Some participants did not have extensive experiences of mental health in the

workplace while others spoke of different experiences in different workplaces. As a result, verbatim quotes from some participants are used more frequently than others in this thesis. Full saturation was not achieved for all of the identified theme clusters. This was due to small sample size, variability in type and level of mental health disability, diversity of personality characteristics, and diversity of work settings. A description of each qualitative theme cluster with supporting quotes follows Table 4.

**Table 4: Theme Clusters**

1. **Challenges of working with a mental health disability**
    a) Stigma
    b) Physical, cognitive, and emotional effects
    c) Effects on trust with coworkers and supervisors
    d) Effects on quality of work
2. **Coping strategies and factors that influence their use**
    a) Influence of work environment on use of coping strategies
    b) Influence of support on use of coping strategies
3. **Personal attributes shaping the receipt of support**
    a) Roles of individuals
    b) Personality type determines what support is wanted and when
    c) Nature and severity of disability determine what support is helpful and when
4. **The leader sets the tone**
    a) The role of the supervisor in setting the tone of the workplace environment
    b) The importance of direct level of support from supervisor
    c) How the supervisor treats others as a reflection of what could happen
5. **The turtle in the shell**
    a) Retreating for privacy, pushing away from support,
    b) Retreating in defeat, pushing away because of lack of support
    c) The shell as armor, defying the need for support
6. **Awareness and knowledge of needs and rights in acquiring supports and accommodations**
    a) Self-awareness
    b) Importance of other's awareness
    c) Self awareness – developed from personal experience and help from others
    d) Knowledge and understanding of supports – the role of human resource personnel
7. **Support before it's too late**
    a) The importance of prevention and the role work can have
    b) Turning points
    c) Timing of certain supports are key
8. **Implications of disclosure**
    a) Individual choice to disclose
    b) Role of trust in selective disclosure
    c) The elephant in the room
    d) Materialization of supports after disclosure
9. **Differences between no support and beyond unsupportive**

### *1. Challenges of working with a mental health disability*

Participants identified many challenges of working with a mental health disability. These challenges manifested in physical changes in the body (fatigue, aggravation of existing physical problems), cognitive changes (difficulty in concentration and focus), and overall emotional changes (personality changes, general well-being).

The following are examples of different challenges participants faced. Participant 3 and Participant 5 described their physical and cognitive changes as follows:

> "It aggravated my fibromyalgia so I had increased pain plus the medication I was on caused me to have loss of concentration, memory, lack of focus... I was really tired I couldn't focus couldn't do my job but I'd still go to work. *(Participant 3)*"

> "My body is showing the symptoms that it's feeling the stress. My doctor tells me that there are strong indications that my liver is not working well because of all the stress and he gave me a warning that if I do not stop working he would take me off the transplant list because my body would not be able to handle that *(Participant 5)*."

Participant 5 also described changes in his work personality that resulted from his stress:

> "I am not as playful. In my area my management style is that I'm not a manager, I'm part of the team doing a different job. So we would go out have lunch, have drinks, we would joke around and we would do practical jokes. I found that that was all gone. It became very straight work-like relationships *(Participant 5)*."

These challenges were also influenced by participants' perceived stigma from others regarding mental health disabilities and their desire to avoid stigma. Participants were reluctant to admit their challenges to others or to themselves in order to receive special treatment.

Participants discussed changes in trust from other coworkers and supervisors. Some participants overcame these trust issues because they held senior positions and were respected by other members of the company, while others' work lives and work responsibilities deteriorated because of them.

Participant 1 had a very specific example of how trust was affected for him. He emoted at inappropriate times at work as a symptom of his mental health disability, and in one instance, he emoted during an important presentation. He describes how this affected his trustworthiness:

> "They said 'well what was that, can you go in front of people, can we trust you to go up in front of people anymore?' It completely shattered the trust relationship with my job. So while my boss wanted me around because she wanted me to make the numbers, the president of the company wanted me gone because he took it as a personal affront that I embarrassed his company. *(Participant 1)*"

In another example of compromised trust, one participant described her experience of being "micro-managed." She described the actions of her supervisor as second-guessing and reversing her decisions, when they did not need to be:

> "I don't know how many times that happened and then they'd have to reverse it and go with my decision. And then there's one lady that, she had problems with her shoulder. She was a postal worker. I had her on this return-to-work plan and they didn't agree with the return-to-work plan. It's one week for graduated return-to-work, one week for every month. And she was off for almost a year. So I made it 8 weeks – so they questioned that. And she said 'I'm going to take over the case and I'm going to call the lady.' The lady got mad at her… They're reversing my decisions, they're changing things and getting these people all upset for nothing. *(Participant 3)*"

Participants did not feel their overall quality of work when it was done was affected by any challenges that arose from their mental health disability. This is especially true for work that was simple or non-challenging to the participant. Overall time it took to complete tasks was affected, with many participants noting that it took them longer to do things, with some having so much difficulty in concentration that tasks simply weren't being done.

As examples, Participant 4 describes the difficulty she had with doing work quickly while Participant 1 describes how he was unable to work at all:

> "At times I would take so much time in getting all the things documented and information needed to pass the file on. It would take a long time. Generally when a department asks for an agent, the rule is that within the week the agent/lawyer from the firm is appointed. With me being sick I held things up. *(Participant 4)*"

> "I couldn't perform anymore. I just stopped selling. I was sitting at my desk shuffling papers, going through all the motions, getting ready but not picking up a phone and making calls. My numbers went down, I stopped producing, I wasn't making sales, I wasn't going on calls to see customers *(Participant 1)*".

### *2. Use of coping strategies and factors that influence their use*

Participants developed strategies for dealing with the symptoms of their mental health disabilities. These tricks and resources helped with symptom relief and allowed them to continue working productively and to continue working for longer hours.

Participants noted that the use of these strategies was influenced by work environments and the support of others, namely coworkers.

Participant 4 and Participant 3 in particular were participants who spoke at length about their coping strategies in the workplace. Here Participant 4 describes her strategies while Participant 3 describes how her fast-paced work environment negatively impacted her ability to use her strategies:

> "Sometimes for two reasons, to relieve the boredom and to relieve the pain, at least every hour I make a point of getting up and have a walk around the floor then come back to my desk and sort of feel refreshed. I have found ways to relieve the boredom so I don't make mistakes. And also health-wise because my hip's killing me I need to get up and walk because I'm all tight... I used the sickroom a lot and I think that's what saved me from being able to do the whole day *(Participant 4)*."

> "I was taking breaks when I first started but after a while I couldn't, there was just too much to do. I was eating at my desk, I wasn't taking my breaks. Usually I would be out taking walks, 20 minutes everyday. I wasn't doing that so I wasn't able to incorporate in the strategies to help me maintain my own personal conditions, I wasn't able to *(Participant 3)*".

### *3. Personal attributes shaping the receipt of support*

Different participant characteristics elicited or pushed away support. Participants who held roles as being "the strong one" or "the support giver" believed this influenced people reaching out to them to offer support. They felt that because people were used to them being a strong person, others were not immediately aware that they needed support. In turn, these

participants often did not even think about asking for support. Participant 2 and Participant 5 in particular had these qualities:

> "I'm very good at putting on this brave face. I think in more ways I've felt like I've helped other people. Usually they'll confide in me and they'll ask my advice about a situation and how they should deal with it *(Participant 2)*."

> "I don't know. I never thought of that. I think I'm so busy that I only look at how other people are doing *(Participant 5)*."

Furthermore, personality characteristics often were a factor in non-seeking of support. Participants who described themselves as strong felt they did not need support and so did not seek it. They determined what supports would be helpful to them and controlled what was received at what times. All of the participants, but the self-described strong participants in particular, identified being treated normally as supportive in itself.

The nature and severity of disability also contributed to support. Participants 1, 3 and 4, for example, who had chronic disabilities felt the recurring nature became a strain for some people to offer continued support, while others with acute problems, such as Participant 5, noted support was immediate and plentiful.

Furthermore the difficulties (e.g. fatigue) that arose due the nature of some people's disability affected the type (e.g. instrumental) of support they received or were offered.

***4. The leader sets the tone***

This theme cluster emphasizes the major role supervisors have in influencing support in the workplace. Participants noted that the overall tone of the work atmosphere was set by supervisor attitudes and expectations. As examples, Participant 6 describes the changes in workplace atmosphere as a result of her new manager while Participant 7 describes how a former management team affected his work environment:

> "The change in the atmosphere right now I think is relief for a lot of people. And like I said she's gone out of her way to come say hi everyday, she's a happy person, she has this wild infectious laugh, and she's a tiny little bubbly thing. She's made a positive impact for sure right away *(Participant 6)*."

> "Their attitude was terrible, they'd abuse people. It was openly hostile. I was at meetings where people would tell him to "go F- yourself" and that's pretty serious... Like I said, I was in the navy and I was treated better during the Gulf War. Like it was less stressful sometimes to be at war than it was to be in a meeting with this guy, and that's not an understatement. There were a number of times I actually just got up and walked out and I went to HR and said I just can't deal with this guy *(Participant 7)*".

Direct support (or no support) from supervisors was a major contribution to people's overall opinion of support in the workplace. Participants also spoke about observing how supervisors treated and responded to people with similar problems. These observations were perceived as examples of how they would be treated. Participant 3 in particular describes an instance she witnessed that led her to believe she would never be accommodated:

> "There was another person too - she was pregnant and she wasn't able to keep up with her caseload as well and when she was having a lot of trouble, because she was on a different contract, and she went to the supervisor to talk to the supervisor and the supervisor turned around and said to her 'I'm busy right now and if you have that much work to do don't you think you should be back at your desk doing your work?' *(Participant 3)*"

In turn, in some workplaces the way supervisors treated other workers also played a role in how workers treated each other. Participant 7 shares his specific experience with this:

> "He was very confrontational. He would try to play groups against groups against groups. Very political in a bad way. Created toxicity. People left because of him. Relationships between coworkers were deteriorating. You bring in an individual like that that starts to play people off, things deteriorate *(Participant 7)*."

### *5. The turtle in the shell*

"The turtle in the shell" was a phenomenon that certain participants described as retreating into themselves, isolating themselves, or metaphorically hiding.

Some participants hid for privacy reasons. Support during that time of privacy need was unwanted. Participant 6 shares her specific experience on needing this privacy:

> "Anybody who knew what was going on was great and even people who might have known I was off but not why...I mean everybody was really good – offered to make meals, clean the house...I should have taken advantage of that. I think at first I just needed my privacy. At the time that might have been helpful I needed my privacy, I needed time to just figure out what was going on with me. And then by the time that I had passed that stage I felt good enough – I mean I wasn't cleaning the house top to bottom everyday, but I was picking and choosing and getting stuff done myself *(Participant 6)*."

Other participants hid as a result of reaching out for support and being shunned. They felt defeated and became internalized. Participant 3 in particular experienced this when she first disclosed her problem and did not receive the accommodations she requested. She describes how this affected her:

> "It changed about a year into it and that's when I started having problems. That's when I noticed the change. That's when I questioned myself too like maybe I'm not good at this maybe it's me. So you know, when you start questioning yourself about your job then you don't feel confident. You don't feel confident in meetings, you don't feel confident presenting your ideas, you don't...I had a lot of great ideas you know but I didn't feel confident presenting them so I just went into this little shell and I just went to work *(Participant 3*)".

Other participants meanwhile used this shell as a type of armor. They used it to mask their difficulties and hid as a sign of strength both to appear strong to themselves and to appear strong to others. For example, Participant 5 used the word "masked" to describe how he dealt with the emotional stress he felt during a period of layoff in order to remain strong for the workers he supervised.

***6. Awareness and knowledge of needs and rights in acquiring supports and accommodations***

Early support was not received by many participants, in part because of a lack of awareness. This awareness refers to self-awareness of participants' problems and needs in addition to other people's awareness of their problems and needs (and the action these people take). As an example, Participant 1 was unable to receive accommodations as a result of a lack of awareness

(both self and by others) of his needs, while Participant 3 had self-awareness and awareness of others, but a lack of action was taken to acquire or provide supports:

> "Something was very evidently wrong but no one knew it was mental. I don't know how much more obvious it could be but at the time. I wasn't aware. No one was, we had no idea *(Participant 1)*."

> "In September I had a week where it was a really horrible week for me and that's what I think was the start of it. I could hardly get to work, I was really tired, I couldn't concentrate. When I had the first meeting with her I said I had a really hard week in September and she said 'yeah I noticed.' I'm thinking to myself if you noticed I was having a hard week why didn't you come to me. But her reaction to that was why didn't YOU come to ME. But when an employee is in that situation they don't have the strength to go and ask for help. The employer if they notice the employee having trouble, then the employer part of their job is to go to the employee and say 'I noticed you're having trouble what can I do to help you?' because that is her role *(Participant 3)*."

Participants spoke about the development of self-awareness as a combination of personal experiences and the help of others. Those with chronic mental health disabilities were cognizant of when they were beginning to unravel and others had family and friends that noted changes in them.

Knowledge and understanding of rights, of what supports existed and of the purpose of certain resources also played a pivotal role in participants acquiring supports. Misunderstanding of the purpose of certain services led some participants to avoid these services. Participant 1 in particular experienced this:

> "Like when I first realized that this was here and I realized what was there in short and long-term disability which I had never realized. I had a benefits book but whoever read it? I mean you never read that, you're not going to need that stuff. If I had known that, it would have been phenomenal *(Participant 1)*."

> "We had an EAP, there was a 1-800 number on the wall. I had an EAP for every company that I worked for. There was a number in the photocopy room, you know, 'if you have a problem call.' We all knew, all of us, we joked about it. That if you called that number you'd be out of a job the next day because we all knew that they told your boss that you were having problems *(Participant 1)*."

Human resource personnel were identified as having a key role in advocating for workers'

accommodations and supports, however they seemed to be underused. Liaising with them helped some participants in the acquisition of what was required. Participant 6 in particular received a better return-to-work plan as result of having human resource personnel as an ally:

> "It's really weird, I've never dealt with her before other than, she does ergonomics and she came and fixed my chair one time so I say hi in the hall but I never knew or worked with her. She was great through the whole thing. She did a lot of pushback with my manager *(Participant 6)*."

### *7. Support before it's too late*

Related to the previous theme cluster about awareness, participants often talked about only receiving support when it was too late. Turning points were the points in time when participants described their condition as reaching a level where it was obvious that support was now required. Participants expressed that if mental health was discussed in the work place, earlier recognition and timely supports could be provided. Participants believed that the workplace could have played a larger role in prevention and believed certain types of support are more beneficial at certain points in time.

Several participants, like Participant 1 and Participant 7, noted that there was just a lack of knowledge and awareness of mental health disabilities in the workplace that lead to not thinking to attribute problems to mental health disabilities or to being too afraid to speak about mental health disabilities before it was too late:

> "The problem in my situation was nobody in my work space in my area knew about this or would even think that we could...you know this just doesn't happen to us *(Participant 1)*."

> "I think people just need to be more open about it and then if you're more open about it people aren't afraid to talk about it and admit there might be an issue and then they can get the appropriate treatment and not have to end up in the psychiatric ward at the hospital like I did before they acknowledge that there's an issue *(Participant 7)*."

### *8. Implications of disclosure*

Disclosure was an individual choice among participants. Not all participants in this study had disclosed their mental health disability and those that did disclose did not necessarily disclose to everyone. Personal relationships, trust, belief of how one would be treated afterwards, and personal beliefs about disclosing in the workplace played a role in the selective process of disclosure. Many of the participants had disclosure experiences similar to Participant 4, based solely on trust and interaction with others, and Participant 5, based on personal reasons dealing with how he wanted to be perceived and how he did not want it to affect others:

> "I'm the one who told certain people that I felt that I could trust. I told them some things but not my whole story. They were very sympathetic. In my old unit, again I told some of the people some information. Some people I never talked to them at all unless it was business related so of course I didn't tell them anything and they never inquired either *(Participant 4)*."

> "It's a very personal reason. I had that strange burden that it was going to add more workload, more stress on other people, including my family. It's a vow that I promised that I have to make everything as normal as possible so that I do not feel different myself. So it's very selfish in a way. I didn't want to feel that "oh, I'm disabled I go to dialysis". I did whatever I could to stay normal *(Participant 5)*."

Others had experiences similar to Participant 7, where it was a combination of personal tendency and selectivity.

> "I just talked to HR about it. I said this is what's happening. I was just open. I felt there's no reason to try to hide it, even though in my understanding it's probably within my perfect right not to disclose anything at work but to say that I had medical problems. But I just felt being open was a better approach. I have a few close coworkers that I divulged the situation because I'm somewhat of a private person. I didn't really want the rumour-mill or the gossip-mill to be fired up however I'm sure people sort of knew, I was just very particular about whom I chose to discuss it with, but definitely HR and my supervisor. It's just not in my personality to be that open about it. Some people like to talk about it. I'm both a male and more mature in my age and attitude so I just tend to be a little bit more private about myself. I just feel it creates a better work environment. I come into work for work I don't like to talk about personal problems, unless they do impact in what I do *(Participant 7)*."

Participants were split in how well received their disclosure was. Participants felt that for

coworkers who did not find out directly from the participant, it presented an "elephant in the room" type situation. Participants did not necessarily feel as if they were being treated negatively, but it created an atmosphere of uncertainty for other people about how they should treat the participant.

For some participants, disclosure played a major role in allowing them to receive the appropriate accommodations. Many, like Participant 7 received more appropriate accommodations as a result of disclosing:

> "The way I look at it is that I felt once they knew what was going on they were much more understanding and sympathetic. I think giving them the information of what was happening to me gave them the ability to try to accommodate my needs. In other words, if I'm going through a mental illness they tried to find ways to make life, work life, less stressful. And they also allowed me to say that ok I'm going to need both modified hours, time off work to go get the care I needed, etc. etc. *(Participant 7)*"

### *9. Differences between no support, unsupportive and beyond unsupportive*

It emerged from the interviews that there was a difference between no support experiences (because of a lack of awareness of needs or because participant gave off impression that they were not needed or wanted), unsupportive experiences (awareness of supports needed but not given) and beyond unsupportive experiences (participants were penalized or targeted somehow as a result of their mental health disability). Participant 3 in particular had several beyond unsupportive experiences:

> "They said to me that if I didn't meet 85% within a month that they would fire me...but I don't think they wanted to deal with me going off again, because everyone else had the same problems as me – no one was answering their phone calls, no one was meeting their...so it felt a little bit like I was targeted and they would have meetings with me but it was all negative, negative, negative *(Participant 3)*."

> "Everyday she would find something that was wrong. It got to the point where people were saying – because I told them – they were saying 'How can you stay, how can you come to work? You have all these deadlines plus you have that X on your head.' *(Participant 3)*"

> "I was asking for vacation time because my parents were there and the employer denied my vacation time. I asked for time off for medical appointments and they denied that too. I ended up having to take time without pay. I found that they were sort of punishing me also because everybody else was able to work from home and they wouldn't let me work at home and I was the only one with a medical condition *(Participant 3)*."

While some unsupportive experiences were related to the fact that there was a lack of resources to be able to offer accommodations, they were generally closely tied with beyond unsupportive experiences. These experiences resulted in further deterioration of health and mental well-being of those who experienced them.

### 4.2.3 Summary of Phase II Results

The findings from Phase II demonstrate that workers with mental health disabilities face various challenges with work according to the symptoms of their disability. Many have developed strategies and some require accommodations and supports in order to continue effectively working. Although they have developed strategies to overcome certain difficulties, they may require support from others at times when their condition is particularly bad. Various internal and external factors contribute to support, including supervisor influence, nature and severity of disability, and various personal characteristics. Support experiences differ greatly among participants and within their individual experiences, varying from good experiences to bad experiences. Supports can help deal with the fallout of workers with mental health disabilities

## 4.3 Triangulation of Data

As a strategy for mixing the methods in the analysis stage, Phase II participants' support experiences as reported in their interviews were compared with their scores on their Workplace Accommodation of Disability Needs Questionnaires. Participant 2 did not complete the questionnaire, thus no comparison can be made for her.

Participant 1: The score for friends/family support was the only support score available. Data for supervisor, coworker, and organization support scores (and subsequently for the scores for the types of support) were unavailable due missing data on the questionnaire. Participant 1 explained in his transcript that the lack of awareness of his mental health disability led to an unavailability of supports in the workplace, but spoke highly of support from his wife, which coincides with the high score in that category.

Participant 2: No support score data available.

Participant 3: Participant 3 expressed in her interview that she received little to no support from her supervisor. She also expressed the belief that her supervisor was questioning her disability and need for accommodations. This coincides with her low scores of support for the supervisor support and appraisal support categories. She spoke highly of coworker support and friends/family which is indicative of her scores for those categories of support.

Participant 4: Participant 4 was on disability leave at the time of her interview. Her condition was severe at the time, but in her interview she spoke highly of her current workplace support system. All support scores were high, coinciding with her most current positive experience of support.

Participant 5: Participant 5 held a management type role. He spoke highly of support from coworkers and his director but indicated there was a lack of support from management during the stress of a layoff period. This is in line with slightly lower support scores for the informational support and instrumental support categories.

Participant 6: Participant 6 spoke highly of coworker and friends/family support and touched upon the lack of support form her supervisor. She noted that the supervisor had problems

with anyone who needed time off work. She also noted that she was a strong person and often times did not need the help of others. This is reflective of lower support scores for instrumental support, appraisal support, and supervisor support than for other categories.

Participant 7: Participant 7 felt fully supported by his workplace. He mentioned he was a private person and only selectively interacts socially with certain coworkers. He also mentioned he lacked family support system. This coincides with slightly lower support scores in the friends/family support and emotional support categories.

In summary, the participant's support scores were indicative of the experiences they shared in the interviews regarding most recent support experiences. No discrepancies were found. Details of why certain scores were lower or higher than others were drawn out from the interviews, and the interviews provided insight into previous support experiences.

# Chapter 5

# Discussion

## 5.1 Discussion of Findings

This study was designed to elucidate the workplace support experiences of individuals with mental health disabilities, and to determine whether their experiences are likely to differ in terms of amount, source, and type of support from those of workers with physical injuries/disabilities. Differences were tested by comparing scores on a new workplace social support scale, and experiences of a sample of workers with mental health disabilities were explored using qualitative methods grounded in phenomenology. The results are discussed in the following sections, along with recommendations for workplaces regarding their provision of support. The chapter concludes with the limitations of this study and implications for future research in this area.

### 5.1.1 Social Support Scores: Differences between Disabilities

No differences in total support, supervisor support, coworker support, organization support, friends/family support, informational support, emotional support, instrumental support or appraisal support scores were found between the participants with orthopaedic and emotional disabilities in Phase I of the study.

At the outset of this study, a projected sample of 25-30 for each disability category was calculated (based on sample size calculation for t-tests with the significance level set at 0.05, a desired power of 0.7, and an expected medium effect size of 0.65-0.7) to determine the approximate number of participants needed with orthopaedic and emotional disabilities in order for differences in scores (if existing) to be found. The actual sample size was lower for each

disability group (18 for the orthopaedic and 13 for the emotional). Differences in mean friends/family support and appraisal support scores between participants with orthopaedic and emotional disabilities were approaching significance ($p=0.17$ and $p=0.13$ respectively). The current trends suggest that those with emotional disabilities may have received more friends/family support but less appraisal support than those with orthopaedic disabilities in this sample. If the sample size had been larger (25-30 as estimated would be needed to reach significance), there is the possibility that significant differences may have been found for these categories and others.

Any such differences might be logically anticipated for a variety of reasons. One possible explanation for a higher level of friends/family support for participants with emotional disabilities may be due to the interaction differences between these people and their friends/family and people with orthopaedic disabilities and their friends/family. In fact, early research on depression and support has found that depressed people tend to elicit supportive behaviours from people in their general surroundings (Coyne, 1976). The nature of their disability may cause them to act in support-seeking ways, and therefore result in receiving more support. On the other hand, lower levels of appraisal support for participants with emotional disabilities may be due to the perceived legitimacy people have relative to emotional disabilities, in part because of their invisible nature. Appraisal support is a validation type of support (House, 1981). If people do not have empathy for certain disabilities, as often is the case with disabilities where people appear to be 'normal' such as emotional disabilities (Stone, 2005), they will be less likely to offer any validation to the person with the disability in regards to their difficulties or needs, resulting in low levels of this particular type of support. In relation to the nature of visible disabilities, orthopaedic disabilities tend to be very apparent as a result of needing adaptive equipment (e.g. cast, crutches,

wheelchair). The readily apparent nature of their disability more readily cues others to their needed support and may result in higher levels of support.

A significant difference was found between the mean total number of accommodations received by those with orthopaedic vs. those with emotional disabilities, with participants with orthopaedic disabilities receiving more accommodations. This is in line with the general finding that people with mental health disabilities receive less support than people with other, specifically physical, disabilities (Kelly, Soderlund, Albert & McGarrahan, 1999; Mayer, 2000). However, the mean total number of accommodations in this study was calculated by a count out of seven presented accommodations on the questionnaire: reduced or altered work hours, reduced or altered work duties, new or adaptive equipment, medical appointments during work hours, rehabilitation services during work hours, another employee to serve as a "work buddy" and regular meetings with supervisor or HR personnel regarding progress. Individuals with orthopaedic injuries may be more inclined to receive adaptive equipment and require more frequent medical and rehabilitation appointments relative to individuals with emotional disabilities. This finding may not accurately capture actual differences in the amount of support relative to different disability needs, and represents the challenges that exist in providing support and accommodations for those with mental health disabilities, as not all types of accommodations are appropriate for a variety of different disabilities. This may be a limitation in the demographics tool relative to mental health disabilities in measuring received accommodations.

Correlations and ANOVAs conducted between demographic variables and total social support score yielded no significant associations. This is surprising as in the literature, being female has been associated with higher levels of social support than being male, partly due to the fact that females tend to have larger social networks and more opportunities for supportive

interactions (Daalen, Sanders & Willemson, 2005). In addition, based on the experiences of participants in Phase II of the study, it would be logical to hypothesize that differences in support levels would be associated with supervisory responsibility and multiple claims status. The participants who reported being in senior or management positions spoke about their role in being the support for others and their concern for others trumping their own needs. These participants were not support-seekers and often were not offered support because of the impression they gave others regarding their strength. Meanwhile, those with chronic conditions spoke about the difficulty they had in receiving support due to the duration and fluctuating nature of their disability. They spoke of others inability to understand how they could be healthy for some periods and struggling and requiring accommodations in others, and how this resulted in trust issues. Studies on other chronic conditions have shown that the lack of understanding of chronic conditions is influential on a person's self-concept and their relationship with others (King, Willoughby, Specht & Brown, 2006).

Three models were developed to test the predictive ability of various demographic variables on total social support score. No significant predictive model was found. A lack of predictive significance may be due to the small sample size (n=31) of this study, as an estimate of n=76 was calculated at the outset of the study for a multiple regression analysis with an alpha level set at 0.05, three predictors for the model, an anticipated moderate effect size and a desired power of 0.80.

At the individual level, comparison of support scores and interview transcripts of the participants in Phase II of the study showed that their scores were indicative of their experiences. Participants who spoke highly of certain sources of supports had high scores for those sources, and low scores for sources in which they spoke of negative experiences. Additionally, however,

low support scores also represented experiences in which the participant spoke about not wanting or needing that type or source of support. Low scores then are not necessarily an indication that workplaces are lacking in the provision of certain supports. Support provision and receipt is an interactive process between support giver and support receiver (Vaux, 1992). The support giver must first perceive that the other person needs support before being able to determine the appropriate reaction (Dunkel-Schetter & Bennett, 1990). If a person interacts in a way that inhibits the giver from perceiving their needs, the giver cannot ascertain that the receiver requires support and cannot behave accordingly.

### 5.1.2 Challenges and Coping Strategies for Workers with Mental Health Disabilities

Workers with mental health disabilities in this study experienced different challenges with working. The challenges differed depending on level and nature of disability and were manifested in physical stress, concentration difficulties, and emotional changes that affected their personalities. The differences in experience gleaned through the interviews in this study show that no universal profile of a worker with a mental health disability exists. Individuals experience unique challenges to themselves and some require more support while others require little to none (Raderstorf & Kurtz, 2006). Many have their own coping strategies for a variety of their challenges but require an overall supportive work environment in order to implement them. Workplaces then need to be sensitive to the unique needs of their workers.

### 5.1.3 Work Environments and Supervisors

Work environments shape the provision of support. Work environments are an overlap of organizational climate and culture, with the climate being the context in which action occurs and culture being the meaning ascribed to those actions (Landy & Conte, 2004). Healthy work environments are those in which positive actions are ascribed positive meanings. Unhealthy work

environments are those in which negative actions are taken, or positive actions are ascribed negative meanings resulting in a distrust or suspicion of the action.

In this study, supervisors were cited as pivotal in creating or maintaining workplace stress and creating environments that were either healthy or toxic and in turn supportive or unsupportive. Their management style in particular was key, with those that held controlling attitudes and unrealistic expectations creating particularly unhealthy and unsupportive work environments. The attitudes, communication, behaviours and actions by managers and supervisors that enable staff to feel supported and thereby able to work effectively, productively and appropriately is termed "supportive leadership" (Muller, Maclean & Biggs, 2009).

Supportive leadership and healthy work environments are beneficial to the stress levels of workers in general, but may offer an additional benefit to those with mental health disabilities in maintaining their condition and allowing them to cope with challenges and continue working.

### 5.1.4 Disclosure of Mental Health Disability and Support

Disclosure, both of the actual mental health disability and of challenges that required support and accommodations, was an individual process for participants based on trust. Decisions to not disclose were based on fear of stigmatization. This is in line with the literature surrounding disclosure and the early seeking of help of individuals with mental health disabilities. A study by Blignault, Woodland, Ponzio, Ristevski & Kirov (2009) found that negative views about mental illness, negative attitudes and discrimination towards people with mental illness, and concerns about confidentiality were the main reasons participants with mental illnesses in their study did not seek early treatment.

In terms of stigmatization from others, many workers in this study who returned to work from mental health disabilities faced the challenge of trying to prove they could still work. Some participants in this study cited fears that they would be micro-managed or not trusted to work as reasons for not disclosing or seeking accommodations. These fears were a result of seeing others with similar problems treated the same way. How people are treated in the workplace and the perpetuation of stigmatizing beliefs then plays an important role in an individual's trust in the workplace and in their disclosure decision and their decision to seek support.

In terms of self-stigmatization (internalized stigma people have towards themselves), many participants in this study were reluctant to admit they had a mental health disability in the early stages, which prevented seeking support and accommodations earlier. Self-stigma has been linked to individuals refraining from seeking or delaying seeking professional help (Mak & Cheung, 2010) out of fear of being treated unjustly due to their 'difference'. In this study, participants' belief of others' lack of understanding of mental health disabilities played a role in disclosure and support seeking behaviour.

The above points are an indication that education and open talk about mental health disabilities are warranted in workplaces. Studies have shown that the more exposure a person has to mental health disabilities, the more likely they are to reject stigmatizing beliefs about people who have them (Holmes, Corrigan, Williams, Canar, & Kubiak, 1999). More occurrences of seeing mental health disabilities in the workplace could lead to a better understanding of mental health disabilities, a reduction in negative stigmatizing beliefs from others, and a reduction in self-stigmatization that prevents individuals with mental health disabilities from disclosing and seeking support. Anti-stigma strategies have been developed and posted on Canadian websites such as Mental Health Works (mentalhealthworks.ca) and the Canadian Mental Health

Association (cmha.ca), but based on the experiences of workers in this study, an improvement in uptake of these resources and strategies in workplaces is warranted.

### 5.1.5 Awareness of Needs and Accommodations

Participants in this study received support as a result of asking for it and as a result of what people offered them. This is tied to the interactive process of support (Vaux, 1992). The support giver must have a perception of required support in order to act accordingly (Dunkel-Schetter & Bennett, 1990). The receipt of accommodations and supports, therefore, result from an awareness of one's needs, which may elicit support seeking behavior, as well as from other people's awareness of one's needs that elicit support giving behavior. Individuals need to be aware of their challenges and learn how and when to ask for support, while others need to recognize their challenges and learn how and when to offer support.

## 5.2 Recommendations for Workplaces

Appropriate support for workers with mental health disabilities is a combination of various factors, including the individual unique needs of the worker and factors related to the work setting. The following are a few recommendations, based on the experiences of workers in Phase II of the study, of what workplaces can do to help accommodate and support workers with mental health disabilities. These recommendations involve the utilization of knowledge, strategies, and resources that have already been developed and in existence. Strides in knowledge translation related to strategies developed by organizations such as Mental Health Works and the Canadian Mental Health Association are needed to transfer these practices into the workplace:

1) Workplaces should strive to create healthy work environments and utilize healthy management techniques to maintain worker morale and well-being and promote trust.

Evidence from this study indicates that in environments in which workers felt comfortable, those with mental health disabilities were able to use their own health management strategies to remain well and were more likely to disclose problems and ask for accommodations when needed.

2) Given the evidence that mental health disabilities and mental health support needs of workers are rarely discussed and are poorly understood in workplaces, strides should be made to provide education on and openly discuss mental health disabilities. This will aid in bringing exposure to the subject, discourage stigmatization, help with the recognition of signs and symptoms of mental health deterioration, and encourage seeking help.

3) As support in the early stages of mental health disabilities can prevent further derailing, workplaces (both workers and managers) should become educated on how to recognize the early signs of mental health deterioration. Resources of where to get help should be made available to workers and strategies for how supervisors and coworkers can take action to provide support while remaining sensitive to the unique needs of individuals would be beneficial.

4) Given that many workers with mental health disabilities have a lack of understanding of their rights and available services, providing information regarding these subjects in a format where individuals will actually uptake the information would make education on these matters more efficient.

## 5.3 Limitations and Implications for Future Research

A major limitation of this study was the small sample size in Phase I. Questionnaires were English-language only and could not be distributed in Quebec or New Brunswick.

Additionally, many potential recruitment personnel (e.g. human resource personnel from various organizations) declined the invitation to participate in the study. Reasons may have been due to time constraints it would have taken to identify participants or fear that poor results would be linked to their workplace. Further research with larger samples is needed to determine if significant differences in support exist between those with emotional disabilities and those with orthopaedic disabilities, to determine if certain demographic variables are able to predict levels of perceived support, and to create a more representative sample of workers across Canada.

From the triangulation of data it was found that that low support levels are not necessarily an indication that there was a lack of support offered regarding that particular source or type of support, but that participant characteristics played a role in the receipt of support. In future studies using this tool, inclusion of a satisfaction scale regarding satisfaction with sources and types of support may offer a means of interpreting the support received by the degree to which it met workers' needs.

In Phase II, the sample size and variability in the nature of the reported mental health disability prevented saturation of some of the themes that emerged from the participant interviews. The essence of support experiences of workers with mental health disabilities then was also difficult to ascertain because of variability of experiences between participants, and is limited to workers in office settings. Further research with more workers in various industries would be warranted. Additionally, if time had permitted, multiple interviews with participants in order to review ideas that were emerging would have been helpful to better inform the themes.

Finally, this study examined perceived support. Although it offered an important insight into how provided support was interpreted by the workers, it does not offer empirical data on the

nature and adequacy of supports provided. Future research examining this other important element of support would be beneficial.

## 5.4 Conclusions

This study was the first mixed-method study to examine the patterns of workplace support experiences of individuals with mental health disabilities using a support scale related to disability and return to work and interviews grounded in phenomenology.

While no significant differences were found between participants with emotional and orthopaedic disabilities regarding total, type, and source of support on the Workplace Accommodation of Disability Needs Questionnaire, further research with larger sample sizes is warranted. Trends towards differences in participants with emotional disabilities receiving more friends/family support may be attributed to support eliciting behavior that accompanies this disability more so than in orthopaedic disabilities, while trends towards differences in participants with emotional disabilities receiving less appraisal support may be attributed to the perceived legitimacy associated with these types of disabilities.

No demographic variables were shown to have predictive ability relative to total support score, but further research with larger sample sizes is warranted.

Triangulation of the data indicates that the support scores are generally representative of people's support experiences, however low scores may also be a result of participant characteristics that prevent other's provision of support.

While the results of the qualitative portion of this study provided interesting insights into support experiences of workers with mental health disabilities, the study was limited to office

workers in Ontario. Additional research with more subjects would more fully inform the themes developed in this study.

Support experiences of participants in the qualitative phase differ for workers with mental health disabilities depending on work environment and personal factors. Some personality characteristics inhibit the provision of support from others, while personal and other's awareness of needs can also inhibit support. Supervisors play a major role in creating healthy and supportive work environments. Mental health disabilities are not spoken about openly in work settings, which may encourage stigmatizing views of these types of disabilities. Strategies for improving workplace support should address education, provision of early support, open discussion of mental health in the workplace and general management techniques to create healthy work environments. Many strategies have been developed by mental health organizations and these strategies and resources should be sought out as a guide for workplace improvement.

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# Appendix A

# Instruments

## Workplace Accommodation of Disability Needs Questionnaire

Worker Demographics

Information about your work and injury situation ….

Sex: Male Female Age _____

Job title _____

Number of people in your department _____

Number employees in your company (at your site) _____

Do you have supervisory responsibilities within your workgroup? Yes No

Please indicate the medical concerns that were included in this claim:

___ Muscle strain (i.e. back or neck injury, muscle pull, etc.)
___ Orthopedic (i.e. bone fracture, crush injury of spine or limbs, etc.?
___ Repetitive motion injury (i.e. carpel tunnel syndrome, etc.)
___ Emotional disability/job strain
___ Other traumatic injury (cuts, burns, etc.)
___ Other (please describe) _____

Is this your first claim or lost time injury? Yes No

How many previous claims have you had with this employer? _____

Which of these best describes your current status in terms of return-to-work?

___ Working in previous position and work group, full duties and time
___ Working in previous position and work group, modified duties or time
___ Working in different position or work group, full duties and time
___ Working in different position or work group, modified duties or time
___ Off work

Please check off any of the following accommodations you have received over the course of **this work injury**:

___ Reduced or altered work hours
___ Reduced or altered work duties
___ New or adaptive equipment
___ Medical appointments during work hours
___ Rehabilitation services during work hours
___ Another employee to serve as a "work buddy"
___ Regular meetings with supervisor or HR personnel regarding progress

Below are some questions about your supervisor at work, your coworkers, your organization, and your family and friends. Read each item carefully and circle the number **that best describes your level of agreement** with the statement, from 1 (Strongly Disagree) to 5 (Strongly Agree).

| | **Strongly Disagree** | **Disagree** | **Neither Agree nor Disagree** | **Agree** | **Strongly Agree** |
|---|---|---|---|---|---|
| **My Supervisor…** | | | | | |
| provided information on how to complete paperwork | 1 | 2 | 3 | 4 | 5 |
| offered flexibility in work hours | 1 | 2 | 3 | 4 | 5 |
| willingly provided time off to attend appointments | 1 | 2 | 3 | 4 | 5 |
| made me feel guilty about needing accommodations | 1 | 2 | 3 | 4 | 5 |
| demonstrated knowledge of the work re-entry process | 1 | 2 | 3 | 4 | 5 |
| expressed genuine and sincere concern | 1 | 2 | 3 | 4 | 5 |
| responded quickly to address my injury/disability-related needs at work | 1 | 2 | 3 | 4 | 5 |
| told me to take it easy when I was having problems | 1 | 2 | 3 | 4 | 5 |
| contacted me outside of work to enquire as to my welfare | 1 | 2 | 3 | 4 | 5 |
| ensured accommodations were provided in a timely manner | 1 | 2 | 3 | 4 | 5 |
| gave me feedback on how I was doing my job while I was recovering | 1 | 2 | 3 | 4 | 5 |
| praised me for effort I was putting in | 1 | 2 | 3 | 4 | 5 |
| let me know my contributions were valued even when I was functioning below capacity | 1 | 2 | 3 | 4 | 5 |

| | Strongly Disagree | Disagree | Neither Agree nor Disagree | Agree | Strongly Agree |
|---|---|---|---|---|---|
| provided me with honest feedback when I returned to work | 1 | 2 | 3 | 4 | 5 |
| provided mostly negative feedback in regards to my progress when I returned to work | 1 | 2 | 3 | 4 | 5 |
| pressured me to take on additional duties before I was ready | 1 | 2 | 3 | 4 | 5 |
| did not always follow the recommendations of my health providers | 1 | 2 | 3 | 4 | 5 |
| demonstrated that he/she trusted me | 1 | 2 | 3 | 4 | 5 |
| did not provide information unless asked | 1 | 2 | 3 | 4 | 5 |
| assigned other people to assist me with my work | 1 | 2 | 3 | 4 | 5 |
| was supportive of changes that were needed in my duties or schedule | 1 | 2 | 3 | 4 | 5 |
| was open to talking about my concerns | 1 | 2 | 3 | 4 | 5 |
| verbally attacked me at times. | 1 | 2 | 3 | 4 | 5 |
| **My Coworkers...** | | | | | |
| gave me help in knowing the steps regarding my injury / disability | 1 | 2 | 3 | 4 | 5 |
| were willing to help out with my work tasks | 1 | 2 | 3 | 4 | 5 |
| showed little understanding of my problems | 1 | 2 | 3 | 4 | 5 |
| offered to help me in some way | 1 | 2 | 3 | 4 | 5 |
| checked in with me outside of work to see how I was doing | 1 | 2 | 3 | 4 | 5 |
| let me have as much privacy as I needed when I wasn't wanting to talk | 1 | 2 | 3 | 4 | 5 |

| | Strongly Disagree | Disagree | Neither Agree nor Disagree | Agree | Strongly Agree |
|---|---|---|---|---|---|
| gave me feedback on how I was doing the job | 1 | 2 | 3 | 4 | 5 |
| resented having to "go the extra mile" when I wasn't able to carry a full load | 1 | 2 | 3 | 4 | 5 |
| genuinely seemed to care about my health and well-being | 1 | 2 | 3 | 4 | 5 |
| would ask me how I was doing | 1 | 2 | 3 | 4 | 5 |
| were hostile or distant when I was functioning below capacity | 1 | 2 | 3 | 4 | 5 |
| gave me good advice relative to my injury / disability | 1 | 2 | 3 | 4 | 5 |
| were able to share information from their own experience | 1 | 2 | 3 | 4 | 5 |
| jumped in and offered to take some of the load off me | 1 | 2 | 3 | 4 | 5 |
| seemed to doubt that my problems were legitimate | 1 | 2 | 3 | 4 | 5 |
| offered to help me with things outside of work | 1 | 2 | 3 | 4 | 5 |
| were willing to listen to my problems | 1 | 2 | 3 | 4 | 5 |
| **In My Organization...** | | | | | |
| forms and procedures to follow with regard to disability are well known and accessible | 1 | 2 | 3 | 4 | 5 |
| appropriate measures are taken to avoid injury and disability | 1 | 2 | 3 | 4 | 5 |
| resources are available to help with return to work after injury or disability | 1 | 2 | 3 | 4 | 5 |
| management was supportive of job modifications I required | 1 | 2 | 3 | 4 | 5 |
| it was not clear to me what actions I had to take after I was injured | 1 | 2 | 3 | 4 | 5 |

| | Strongly Disagree | Disagree | Neither Agree nor Disagree | Agree | Strongly Agree |
|---|---|---|---|---|---|
| people are supportive of disability needs | 1 | 2 | 3 | 4 | 5 |
| an administrative or occupation health staff person provided feedback on my progress when I returned to work | 1 | 2 | 3 | 4 | 5 |
| managers took a personal interest in my situation | 1 | 2 | 3 | 4 | 5 |
| union representatives helped me to understand my rights | 1 | 2 | 3 | 4 | 5 |
| an occupational health staff person made sure the appropriate supports were in place for me | 1 | 2 | 3 | 4 | 5 |
| management personnel made me feel guilty about needing accommodations for my injury / disability | 1 | 2 | 3 | 4 | 5 |
| **My Family and / or Friends...** | | | | | |
| showed they supported me | 1 | 2 | 3 | 4 | 5 |
| helped out with responsibilities at home | 1 | 2 | 3 | 4 | 5 |
| gave me suggestions on how to deal with my problems | 1 | 2 | 3 | 4 | 5 |
| care about what happens to me | 1 | 2 | 3 | 4 | 5 |
| seemed resentful of the extra help I needed | 1 | 2 | 3 | 4 | 5 |
| give me love and affection | 1 | 2 | 3 | 4 | 5 |
| are available to talk to me about my personal problems | 1 | 2 | 3 | 4 | 5 |
| are available to talk to me about my work-related problems | 1 | 2 | 3 | 4 | 5 |
| would help if I needed transportation | 1 | 2 | 3 | 4 | 5 |
| would help if I was having problems due to my injury / disability | 1 | 2 | 3 | 4 | 5 |

During the past 4 weeks, how much difficulty have you had doing the following work activities because of any ongoing health problems or health concerns? You may choose any response between 1 ("None" or "Slight") and 4 ("So much difficulty it is no longer done"). If this activity does not apply to your job, please choose N/A ("Not Applicable").

| | None or Slight | Quite a Bit | A Great Deal | So Much Difficulty No Longer | Not Applicable |
|---|---|---|---|---|---|
| Keeping up with required standards of personal appearance, dress, personal safety and hygiene? | 1 | 2 | 3 | 4 | N/A |
| Keeping up with requirements for training, certification, licensure, education or experience? | 1 | 2 | 3 | 4 | N/A |
| Maintaining required attitudes toward your work? | 1 | 2 | 3 | 4 | N/A |
| Doing require commuting or local and long-distance traveling? | 1 | 2 | 3 | 4 | N/A |
| Walking or moving around your usual work area or building? | 1 | 2 | 3 | 4 | N/A |
| Doing things that require you to recognize sounds, signals, temperatures, textures, consistencies, or smells? | 1 | 2 | 3 | 4 | N/A |
| Doing things that require you to concentrate, remember, make decisions, solve problems, or make judgments? | 1 | 2 | 3 | 4 | N/A |
| Doing things that require you to use or move all or part of your body in your work? | 1 | 2 | 3 | 4 | N/A |
| Using and controlling SMALL or light-weight devices, tools, machines or equipment? | 1 | 2 | 3 | 4 | N/A |
| Using and controlling LARGE or HEAVY devices, tools, machines or equipment? | 1 | 2 | 3 | 4 | N/A |
| Arranging, moving or otherwise physically handling materials used in your work? | 1 | 2 | 3 | 4 | N/A |
| Maintaining required relationships or behavior with employers, supervisors, coworkers or the public? | 1 | 2 | 3 | 4 | N/A |
| Doing your work in required space and environmental conditions? | 1 | 2 | 3 | 4 | N/A |
| Doing your work well and on time? | 1 | 2 | 3 | 4 | N/A |

## Support Appraisal for Work Stressors

Instructions:

The following questions ask about the reliability of various people in providing you with support when you experience problems at work.

Please respond to each question by circling a number from the rating scale below in all three columns. In this way, for each question, you will rate separately your direct supervisor, your work colleagues and your partner/family/friends.

How much can you rely on your…

| Not at all | A little | Somewhat | Very Much |
|---|---|---|---|
| 1 | 2 | 3 | 4 |

| | Direct Supervisor | Work Colleagues | Non-work (partner/family/friends) |
|---|---|---|---|
| …to help you feel better when you experience work-related problems? | 1 2 3 4 | 1 2 3 4 | 1 2 3 4 |
| …to suggest ways to find out more about a work situation that is causing you problems? | 1 2 3 4 | 1 2 3 4 | 1 2 3 4 |
| …to share their experiences of a work problem similar to yours? | 1 2 3 4 | 1 2 3 4 | 1 2 3 4 |
| …to give you practical assistance when you experience work-related problems? | 1 2 3 4 | 1 2 3 4 | 1 2 3 4 |
| …to help when things get tough at work? | 1 2 3 4 | 1 2 3 4 | 1 2 3 4 |
| …to listen to you when you need to talk about work-related problems? | 1 2 3 4 | 1 2 3 4 | 1 2 3 4 |
| …to provide information which helps to clarify your work-related problems? | 1 2 3 4 | 1 2 3 4 | 1 2 3 4 |
| …to be sympathetic and understanding about your work-related problems? | 1 2 3 4 | 1 2 3 4 | 1 2 3 4 |
| …to acknowledge your efforts to resolve your work-related problems? | 1 2 3 4 | 1 2 3 4 | 1 2 3 4 |
| …to spend time helping you resolve your work-related problems? | 1 2 3 4 | 1 2 3 4 | 1 2 3 4 |
| …to reassure you about your ability to deal with your work-related problems? | 1 2 3 4 | 1 2 3 4 | 1 2 3 4 |
| …to help you evaluate your attitudes and feelings about your work-related problems? | 1 2 3 4 | 1 2 3 4 | 1 2 3 4 |

Inventory of Supportive and Unsupportive Managerial Behaviours

Below is a list of things supervisors/managers may do or say to their employees. Please read every item carefully and indicate **how frequently your supervisor does this** using this scale:

| Almost Never | Occasionally | Fairly Often | Often | Always |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |

| | | | | | |
|---|---|---|---|---|---|
| When I am experiencing difficulties, he or she sympathizes. | 1 | 2 | 3 | 4 | 5 |
| Smiles / Appears happy to see me. | 1 | 2 | 3 | 4 | 5 |
| Overrides decisions I make. | 1 | 2 | 3 | 4 | 5 |
| Gives me positive feedback when deserved. | 1 | 2 | 3 | 4 | 5 |
| Encourages me to take on work that will help me develop professionally. | 1 | 2 | 3 | 4 | 5 |
| Thanks me for things I do. | 1 | 2 | 3 | 4 | 5 |
| Goes to bat for me at work when I need it. | 1 | 2 | 3 | 4 | 5 |
| Keeps me informed about things going on at work. | 1 | 2 | 3 | 4 | 5 |
| Communicates with me in an open and direct manner. | 1 | 2 | 3 | 4 | 5 |
| When reviewing my work, focuses more on negative things than positive things. | 1 | 2 | 3 | 4 | 5 |
| Asks me how I'm doing and means it. | 1 | 2 | 3 | 4 | 5 |
| Explains the reasoning behind decisions that affect me. | 1 | 2 | 3 | 4 | 5 |
| Makes himself or herself easily accessible to me. | 1 | 2 | 3 | 4 | 5 |
| Grants time off work when I need it. | 1 | 2 | 3 | 4 | 5 |
| Tells me that he or she would have handled work-related tasks differently. | 1 | 2 | 3 | 4 | 5 |
| Provides me with clear expectations of my work responsibilities. | 1 | 2 | 3 | 4 | 5 |
| Praises my work in front of others. | 1 | 2 | 3 | 4 | 5 |
| Answers question I ask in a timely manner. | 1 | 2 | 3 | 4 | 5 |
| Ensures I have everything I need to get my work done efficiently. | 1 | 2 | 3 | 4 | 5 |
| Allows me to decide my work schedule as much as possible. | 1 | 2 | 3 | 4 | 5 |
| When a problem comes up and I need help, he or she provides me with suggestions but leaves the final decision to me. | 1 | 2 | 3 | 4 | 5 |
| Works with me on things using a collaborative style. | 1 | 2 | 3 | 4 | 5 |
| When I make decisions or perform tasks, he or she second guesses them. | 1 | 2 | 3 | 4 | 5 |
| Gives clear instructions. | 1 | 2 | 3 | 4 | 5 |
| Shows interest in what's going on in my life outside of work. | 1 | 2 | 3 | 4 | 5 |
| Limits my participation in meetings. | 1 | 2 | 3 | 4 | 5 |
| Gets visibly upset when I don't do things correctly. | 1 | 2 | 3 | 4 | 5 |

## ORGANIZATIONAL POLICY AND PROGRAMS – An Employee Survey

The following questions refer to your current job or your most recent job if you are not currently working. Please circle the number which indicates how strongly you agree or disagree with each statement.

| Strongly Agree | Agree | Disagree | Strongly Disagree |
|---|---|---|---|
| 1 | 2 | 3 | 4 |

| **At my WORKPLACE...** | **Strongly Agree** | **Agree** | **Disagree** | **Strongly Disagree** |
|---|---|---|---|---|
| The employer involves employees in plans and decisions made concerning our work. | 1 | 2 | 3 | 4 |
| Workers have trust in the employer. | 1 | 2 | 3 | 4 |
| Communication is open and employees feel free to express concerns and make suggestions. | 1 | 2 | 3 | 4 |
| Working relationships with other workers are cooperative. | 1 | 2 | 3 | 4 |
| Workers tend to stay with this employer for a long time. | 1 | 2 | 3 | 4 |
| Top management is actively involved in the safety program. | 1 | 2 | 3 | 4 |
| The employer spends time and money on improving safety. | 1 | 2 | 3 | 4 |
| The employer considers that safety is just as important as speed and quality in the way work is done. | 1 | 2 | 3 | 4 |
| Unsafe working conditions are identified and improved promptly. | 1 | 2 | 3 | 4 |
| Equipment is well maintained. | 1 | 2 | 3 | 4 |
| Action is taken when safety rules are broken. | 1 | 2 | 3 | 4 |
| Employees are provided training in safe work practices for the job hazards they will face. | 1 | 2 | 3 | 4 |
| Jobs are designed to reduce heavy lifting. | 1 | 2 | 3 | 4 |
| Jobs are designed to reduce repetitive movements. | 1 | 2 | 3 | 4 |
| Someone from the workplace contacts a worker shortly after a work-related injury or illness to express concern and offer help. | 1 | 2 | 3 | 4 |
| The employer keeps track of the injured worker's absence and return to work. | 1 | 2 | 3 | 4 |
| The employer works with the insurer ***and the worker's doctor*** to develop a plan for an injured worker to return to work. | 1 | 2 | 3 | 4 |
| The employer makes accommodations such as special equipment, flexible hours or modified job duties to allow an injured worker to return to work. | 1 | 2 | 3 | 4 |
| When the injured worker returns to work, the employer/facility follows up to adjust the work situation as needed. | 1 | 2 | 3 | 4 |
| When an injured worker cannot return to his or her previous job, the employer provides re-training or re-assignment to a different job. | 1 | 2 | 3 | 4 |
| Labour and management work as partners in returning an injured worker to work. | 1 | 2 | 3 | 4 |
| Labour and management work as partners in health and safety. | 1 | 2 | 3 | 4 |

**Interview Guideline**

1) *Understanding the person and his/her disability in the context of his/her work environment*

- Why don't we start off by talking about your job? Tell me about it.
    - What do you do?
    - How long have you been there?
    - Can you give me a sense of what the work environment is like?
        - What is the company size?
        - Noise level?
        - Pressure?
        - Amount of contact with others?
    - What are the employers/coworkers like?
    - Do you like your job/workplace/people you work with?

- If you're comfortable, could you tell me a bit about the mental health disability you're facing?

- How has this affected your work?
    - How long has it had an impact on your work?
    - How does it affect your ability to work?
    - How does it affect your work relationships?
    - Can you tell me about a specific time it affected your work or your workplace relationships?

- How do people react to your disability in the workplace?

- How does your disability make you act in the workplace?

- Do you think people "see" your disability?
    - Tell me about this

2) *Understanding the process of disclosing the problem in order to receive support*

- Did you disclose your mental health disability?
    - What were your reasons for disclosing or not disclosing?
- Tell me about disclosure
    - Could you describe the process of disclosing your problem in the workplace
    - Who did you disclose to first?
    - Who have you and have you not disclosed to?
    - Was there a difference in the way you disclosed to different people? (employers vs. peers)
    - How did people react to the disclosure?
    - How did their reactions make you feel?
    - How did you feel after you disclosed?
    - How did disclosing affect your ability to work?
    - How did disclosing affect your relationships at work?

*3) Receiving/not receiving support*

- Tell me about your experiences of support in the workplace
    - Tell me a story of a positive experience
    - Tell me a story of a negative experience

- Tell me about the kind of support you've received in the workplace
    - What was offered and what did you have to ask for?
    - If you had to ask for support, how did this make you feel?
    -
- What has played a role in your receiving or not receiving support?

- How accommodating do others seem?
    - What do they do or don't do that make them seem accommodating or not?

- How have the supports you received affected your ability to work?

- What were other people's reactions to you receiving support?
    - How have their reactions affected you?

- How has receiving support affected your relationships at work?

- Are there aspects of your work that you feel are still limited because of your emotional problems?
    - What kind of support do you think would help?

4) *Is there anything else you would like to add about your experience of support in the workplace?*

# Appendix B

# Recruitment

## Telephone/In-Person Script

Project Title: *Patterns of Workplace Social Support: A quantitative analysis of perceived support in the workplace for individuals with physical and mental health disabilities, with a qualitative focus on the lived experience of those with mental health disabilities*

Hi _____ I am currently helping a student at Queen's University recruit participants for her thesis project. I think this may be of interest to you. If you have some time, I would like to explain the study to you. Do you have a few moments right now?

This study is part of Dorothy's, a Queen's University Masters Student, research about workplace support. I would like to stress that your participation is completely voluntary. This is in no way related to the work we are doing together. Whether you choose to participate or not will not affect our working relationship now or in the future.

Her study involves taking a closer look at the experiences of persons working with mental health disabilities in competitive employment. There are two components of the study. The first component is a short questionnaire that will take approximately 15-20 minutes to complete. The second component involves an approximately 45-minutes to one-hour interview with Dorothy, either in person or by phone. You will be asked to talk about your experiences of support in your workplace. These interviews are completely confidential and in no way will affect your status in your workplace.

If you are interested in participating, Dorothy will contact you, or you can contact her at your convenience to find out more.

Is this something you would be interested in participating in?

Would you be comfortable with the student contacting you to further explain the study and to set up a time and location for the interview?

**If yes***: record name and number*

**If no***: Would you prefer the option of contacting her via email to set up a time and location for the interview? (contact email: 7dl22@queensu.ca)*

## Email/Letter Script

Project Title: *Patterns of Workplace Social Support: A quantitative analysis of perceived support in the workplace for individuals with physical and mental health disabilities, with a qualitative focus on the lived experience of those with mental health disabilities*

Dear Potential Participant:

I have been asked by researchers at Queen's University to assist them in contacting people who might be willing to participate in a research project having to do with workplace supports for people with disabilities. This portion of the study involves taking a look at the experiences of persons with mental health difficulties who are working. Since you have had a claim that includes a mental health component/reported a mental health disability you would be eligible for this study.

Your involvement would be:

- Completing a short series of questionnaires (15-20 minutes)
- Having an interview with a student researcher either personally or over the phone (around 45 minutes).

Please don't feel any pressure to participate. I am acting only as a liaison to help the researchers gain access to some people that might be appropriate to participate in this work and who might be willing to help.

If you are interested, you can get more information by contacting the Queen's master's student, Dorothy Luong, at: 7dl22@queensu.ca

Thanks.

Sincerely,

# Appendix C

# Information Letter and Informed Consent

## Information Letter and Informed Consent

**Project:**

Patterns of Workplace Social Support: A quantitative analysis of perceived support in the workplace for individuals with physical and mental health disabilities, with a qualitative focus on the lived experience of those with mental health disabilities

**Background Information:**

You are being invited to participate in a research study directed by Dorothy Luong, a MSc student in the Department of Rehabilitation Science at Queen's University, to determine patterns of workplace support. This study is being done as a thesis project to complete the researcher's MSc degree requirements. This study has been reviewed for ethical compliance by the Queen's University Health Sciences and Affiliated Teaching Hospitals Research Ethics Board.

**Details of the Study:**

The purpose of this study is to 1) measure levels of workplace support received by individuals returning to work after a disability, sickness or injury leave, and 2) to better understand the experience of receiving workplace support for those with mental health disabilities. You will be considered for the study if you 1) have a mental health disability, 2) are working, and 3) have received support from your workplace. Dorothy Luong will read through this consent form with you and describe procedures in detail and answer any questions you may have.

You will be asked to complete a short questionnaire (you have the option of a paper copy or an online version) where you will rate your level of agreement with various statements regarding supports you received. You will then be asked to participate in an interview in order to understand in more detail your experiences of receiving supports.

There are no expected risks to your involvement in this study. Although your participation in this study may not benefit you directly as an individual, it is hoped that your contributions will have an impact on the future planning and delivery of support services for individuals returning to work with injuries or disabilities.

**Privacy:**

Your anonymity will be protected at all times. The questionnaire does not contain any self-identifying information. The information obtained from the questionnaires will be reported in summary form and your name will not be attached to any quotes that may be presented publicly.

Your participation in this study is voluntary. You may withdraw from this study at any time without consequence.

**Subjective Statement and Signature Section:**

I have read and understand the consent form for this study. I have had the purposes, procedures and technical language of this study explained to me. I have been given sufficient time to consider the above information and to seek advice if I chose to do so. I have had the opportunity to ask questions which have been answered to my satisfaction. I am voluntarily signing this form. I will receive a copy of this consent form for my information.

If at any time I have further questions, problems or adverse events, I can contact

| | | |
|---|---|---|
| Dorothy Luong | at | 7dl22@queensu.ca |
| or | | |
| Dr. Rosemary Lysaght | at | (613) 553-2134 |

If I have questions regarding my rights as a research subject I can contact

Dr. Albert Clark, Chair, Queen's University Health Sciences and Affiliated Teaching Hospitals Research Ethics Board at (613)533-6081 / clarkaf@queensu.ca
Or
Dr. Elsie Culham, Director, School of Rehabilitation Therapy, Queens University at (613) 533 - 6727 or elsie.culham@queensu.ca

By signing this consent form, I am indicating that I agree to participate in this study.

| | |
|---|---|
| _____ | _____ |
| Signature of Participant | Date |
| _____ | _____ |
| Signature of Witness | Date |

**Statement of Investigator:**
I, or one of my colleagues, have carefully explained to the subject the nature of the above research study. I certify that, to the best of my knowledge, the subject understands clearly the nature of the study and demands, benefits, and risks involved to participants in this study.

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|---|---|
| _____ | _____ |
| Signature of Principal Investigator | Date |

# Appendix D

## Statement of Subjectivity

- I believe that through my educational background, I have developed a firm understanding of the construct of social support and factors that can affect the provision and receipt of it.

- I value the role social support in times of need can have and believe everybody at some point requires support, whether they ask for it or not.

- I believe some people abuse the support of others, while some do not take enough advantage of it, and I feel that people's experience with this will affect how they will treat others.

- I believe that there is a stigma that exists around having a mental health disability - that there is a lack of trust in it.

- I believe self-stigma can prevent people from reaching out for support.

- I believe the work environment is a major part of a person's life and can help alleviate or worsen mental health problems.

- I value research surrounding mental health because I believe the findings can be applied to strategies to help those with mental health disabilities and enrich their lives.

- I value both quantitative and qualitative research and believe mixed methods is a comprehensive method for answering certain questions.

- I believe that hearing about the support experiences of people with mental health disabilities can provide insight into strategies to improve supports.

- I have been touched by several people with mental health disabilities. Due to my personal connection to this topic, I empathize with those who struggle silently with mental health disabilities and was eager to pursue this area of research.

# Appendix E

# Ethics Approval for Additional Recruitment Methods

Queen's UNIVERSITY

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February 1, 2010

Ms. Dorothy Luong
School of Rehabilitation Therapy
Louise D. Acton Building
Queen's University

**Re: "Patterns of Workplace Social Support: A Quantitative Analysis of Perceived Support in the Workplace for Individuals with Physical and Mental Health Disabilities, with a Qualitative Focus on the Lived Experience of Those with Mental Health Disabilities" REH-456-09**

Dear Ms. Luong,

I am writing to acknowledge receipt of your email which requested approval for the following:

- Request to add 1 to 2 other people to assist with recruitment
- Request to have these people contact potential participants by email
- Provision of a telephone-in-person script

I have reviewed this request and the script and hereby give my approval. Receipt of these materials will be reported to the Health Sciences Research Ethics Board.

Yours sincerely,

Albert Clark

Albert Clark, Ph.D.
Chair
Research Ethics Board

AFC/kr

c.c.: Dr. R. Lysaght, School of Rehabilitation Therapy