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Mental health disclosure in the workplace – An interpretative phenomenological analysis of the employee experience

Research Article

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Abstract: The decision to disclose or not disclose a diagnosis of mental illness (MI) is complex and influenced by a variety of factors. Research into MI disclosure has commonly focused on investigating the singular parts of the disclosure process, thus failing to capture an understanding of the individual's holistic experience of MI disclosure. This paper seeks to gain an understanding of the phenomenon of workplace MI disclosure from the perspective of the disclosing employee. By doing so we gain an understanding of how they make sense of this experience which should help shape MI workplace policies and practices. Using a qualitative research approach and interpretative phenomenological analysis (IPA), interviews took place with three Irish women who had previously disclosed a mental illness in the workplace. Within the findings, three superordinate themes emerged: (1) Antecedents of Disclosure, (2) Disclosure Outcomes and the Organisation (3) Disclosure Outcomes and the Self. Without an understanding of the consequent impact of disclosure on employees' post-disclosure work-life, appropriate resources and supports cannot be developed.

Keywords: *Disclosure; mental illness; stigma*

INTRODUCTION

Over the past decade, mental health in the workplace has become a key issue in the health and business communities, both nationally and internationally. The WHO (2020) estimates that around one billion people globally live with a mental disorder including mental illnesses (MI). Many of these individuals are active in the workplace. The prevalence of MIs in the Irish population is reportedly higher than international estimates (Hyland et al., 2022). Recognition of increasing prevalence rates and soaring costs of mental health issues at work has fuelled concerns about the nature of these and how to address them. As a result, there is now a greater awareness and recognition of mental health issues in the workplace with increased emphasis on diversity and inclusion efforts (Elraz, 2018, Kennedy et al., 2019, Gayed et al., 2018).

The terms *mental health* and *mental illness* are often used interchangeably, but they differ in meaning. Westerhof and Keyes (2010) suggest that mental illness and mental health are related but very distinct dimensions. The World Health Organization (2004, p. 2) defines mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community." Mental illness, the focus of this study, is a term that refers collectively to all diagnosable mental disorders (Goldman and Grob, 2006) where "mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning" (U.S. Department of Health and Human Services, 1999, pp. 4–5). A lack of consensus

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exists around defining mental illness (see Martinez-Martinez, 2020 for a full review). Previous definitions have been criticised for being too ambiguous and lacking precise criteria (Bachrach, 1988). MI has since been operationalised in terms of 3 criteria: diagnosis, disability and duration (Ruggeri et al., 2000). Diagnostic dimensions consider nonorganic psychosis or personality disorder. Disability is typically defined as meeting three out of five criteria including social behaviour requiring intervention by the mental health system; mild impairment in activities of daily living; moderate impairment in social functioning, work performance, or nonwork activities. Finally, the duration of the disorder is characterised as involving prolonged illness and long-term treatment, which is operationalised as a two-year or longer history of MI or treatment. (Schinnar et al., 1990). Common MI include anxiety disorders, schizophrenia, bipolar disorder and personality disorders (Morgan et al., 2021).

Employment has been found to act as an essential facet in the MI recovery process (Dunn et al., 2008). Research suggests that employment is beneficial for people with a mental illness due to its positive impact on self-esteem, mitigation of psychiatric symptoms, and reduction of dependency (Cook and Razzano, 2000). With MI on the rise, there will be a corresponding increase in the number of employees dealing with balancing their work lives alongside the management of their MI. When an individual with a mental illness engages in competitive employment, the stigma associated with a mental health condition can often pose a key challenge (Hielscher and Waghorn, 2017). One key challenge is that of the disclosure decision. With links between MI and stigma in the workplace, employees are regularly faced with difficult disclosure decisions, should I conceal or should I reveal?

The complexity of MI disclosure understandably places employees with a MI in a precarious position when it comes to deciding if they should disclose their illness to an employer, along with how much information should be shared and to whom. Given that these decisions can have a significant effect on employees' day-to-day work lives, additional research to explore the fundamental tenets of disclosure experiences is needed, including the antecedents for disclosure and the experiences of the employee post-disclosure. This study aims to improve the understanding of employees' lived experiences of disclosing an MI in the workplace. Specifically, the paper aims to:

1. Access a version of the employee's experience of MI disclosure as they make sense of it through their narrative account
2. Gain an understanding of how employees experience work prior to disclosing their MI
3. Gain an understanding of how employees experience work after disclosing their MI
4. Increase the understanding of how employees with an MI perceive their own disclosure decision post-disclosure.

Previous research points to the challenges for workers in managing information and disclosure and some of the conflicting forces that may shape their experience with disclosure (Moll et al., 2013; Jones, 2011). Studies describing the tendency of workers to hide information from others and the risks associated with disclosure have been countered by other studies, which describe the potential value of disclosure (Jones, 2011; Elraz, 2018). Personal or psychological benefits of disclosure have been identified, including relief from the stress and energy required to conceal information (MacDonald-Wilson, 2005). Although research into the disclosure of an MI in the workplace exists, the available research segments the disclosure journey into its comprising factors and does not investigate the employee's holistic experience and how they make sense of this decision and its outcomes. There is also a limitation in existing research regarding the word disclosure itself and what is meant by this in each individual case. Studies of MI disclosure itself have also been limited, with no known publications of disclosure research coming from Ireland. This study will provide important insights into how employees make sense of their disclosure experiences, allowing for an exploration of idiosyncratic or converging experiences between the participants. It also allows for further understanding beyond the current research on disclosure of MI in the workplace, which has historically heavily relied on quantitative data. Research into mental illness disclosure is also important because it can help promote a more supportive and inclusive workplace for individuals with mental illness.

THE DISCLOSURE CONSTRUCT

Disclosure, as a construct, is not always well defined. Definitions vary across studies, with no consistency across the field. Pachankis (2007) provides an accessible definition, describing it as a decision made about sharing one's hidden status and that by disclosing, individuals are no longer concealing a stigmatised identity. While this definition is helpful as a starting point, it encourages a dichotomous view on disclosure, with employees divided neatly into two categories; those whose MI is concealed deliberately and those whose MI has been disclosed (Brohan et al., 2012; Brohan et al., 2014). However, the complicated nature of disclosure means that it is far more detailed than this dichotomous view indicates. For example, employees may selectively disclose to certain people (Dalgin and Gilbride 2003; Goldberg et al., 2005), or may only partially disclose information about their illness (i.e., “I have an illness” versus “I have schizophrenia”) (Dinos et al., 2004; Bergmans et al., 2009). Employees may also strategically time disclosure, for example, when they have reached a certain level of seniority or created strong relationships with co-workers (Goldberg et al., 2005; Auerbach and Richardson, 2005; O’Day et al., 2006). Disclosure can also be inadvertent, occurring due to observable behaviours and symptoms (Goldberg et al., 2005), or forced, if an employee must disclose due to required hospitalisation or unexpected medical absences (Ellison et al., 2003). Goldberg et al. (2005) also highlighted the concept of *implicit disclosure*, which occurs when individuals gain employment through vocational services or obtain specific employment for those with MIs.

THEORETICAL FRAMEWORKS OF DISCLOSURE

Reviewing the theoretical frameworks of disclosure can help provide a deeper understanding of the disclosure journey. The most common framework is provided by Goffman (1963) through his work on stigma theory. This theory proposed that society is divided into ‘abnormal’ and ‘normal’ groups, where the former can be disparaged by the latter. An abnormal individual carries stigma, does not adhere to conventions of normalcy, and is seen as flawed or deviant (Hastuti and Timming, 2021). Goffman (1963) also explored the concept of “passing”, which refers to the process of concealing a stigmatised identity to pass as normal. “Passing” allows an individual to be treated the same as anyone else (Brohan et al., 2012). From this viewpoint, by engaging in disclosure, it is implied that an individual is choosing to shift from discreditable to discredited, which indicates why employees with an MI would prefer not to disclose to an employer (Hastuti and Timming, 2021).

Although Goffman’s (1963) framework provides a helpful basis for simplifying disclosure, it encourages a dichotomous view on disclosure, with limited parameters. The process-based disclosure theories view disclosure as an ongoing process, not one that is static (Chaudoir and Fisher, 2010). Taking a process-based view, disclosure is seen as a dynamic process consisting of both the antecedents of disclosure, and its outcomes (Chaudoir and Fisher, 2010). It explores how people make decisions to disclose, choose confidants, communicate about their identities, and are affected by disclosure (Clair et al., 2005; Greene, Derlega, and Mathews, 2006; Ragins, 2008). The Disclosure Process Model (DPM) developed by Chaudior and Fisher, (2010) highlights the impact of five main components to this process—antecedent goals, the disclosure event itself, mediating processes, outcomes, and a feedback loop. Antecedent goals explore the approach versus avoidance motivations, which underlie disclosure behaviour. The disclosure event is the verbal communication that occurs between a discloser and a confidant regarding the discloser’s possession of a concealable stigmatised identity. This also takes account of the reaction of the confidant to the disclosure (e.g., supportive versus unsupportive). Mediating processes are multiple potential processes that allow disclosure to affect outcomes; these can include alleviation of inhibition and social support. Outcomes encompass individual (health, wellbeing), dyadic (e.g., liking, trust), and social (e.g., cultural stigma) domains.

Other researchers argue that decision-making can stem from pre-existing disclosure circumstances, including prior experiences, which act as the basis for the disclosure decision (e.g., Brohan et al., 2012). Pre-disclosure interaction occurs between many internal and external factors, which subsequently shape the future disclosure decision. Internal factors include the internal psychological aspects of the individual, along with internal transformations in response to external stimuli that can affect the decision to disclose (Clair et al., 2005, Ragins 2008). The individual then evaluates those internal factors to predict the anticipated outcomes (positive or negative) of disclosure before taking the step to disclose or not (Chaudoir and Fisher, 2010; Jones and King, 2014). Anticipated outcomes are subjective projections of the prospective discloser, attempting to predict support or consequences that could result from disclosure (Jones and King, 2014). These perceptions are influenced by external variables such as environmental and interpersonal factors (Clair et al., 2005) and are also impacted by the discloser’s stigma identity and characteristics (Ragins, 2008). These anticipated outcomes can influence the variables involved in disclosure decisions, which can subsequently influence individual and organisational outcomes - a relationship of cause and effect.

THE DISCLOSURE PROCESS

The dynamic frameworks above demonstrate that disclosure is not as simple as Pachankis' (2007) earlier definition and goes beyond simply being a matter of revealing one's stigmatised identity to others. Both the mediating and moderating effects of antecedents can predict and influence the disclosure process's short- and long-term outcomes (Jones and King, 2014). Furthermore, the disclosure decisions and outcomes vary across individuals and contexts for each person disclosing (Follmer et al., 2020). By examining these models on disclosure, it is evident that disclosure is not a static choice made in a vacuum but an ongoing process with many influencing internal and external factors. These factors are discussed below.

Disclosure Antecedents

Pre-disclosure, many internal and external factors interact to influence the decision to disclose (Hastuti and Timming, 2021). These antecedents can precipitate disclosure (Follmer et al., 2020) alongside moderating the positive, negative, or neutral outcomes of disclosure (Chaudoir and Fisher, 2010). Countless antecedents have been identified across existing literature; however, common themes have emerged. These are explored below in further detail and include symptomatology, perceived stigma or support, disclosure motives, perception of self, and organisational factors.

Symptomatology

All other things being equal, the severity of MI symptoms can predict disclosure. Studies have shown that if individuals' symptoms are severe, they experience more difficulty and disruption in their day-to-day lives, leading to an increased likelihood of help-seeking in the form of disclosure (Goldberg et al., 2005). This may be due to increased visibility of the MI, with individuals feeling the need to explain unusual behaviour or stop the behaviour from being attributed to a more stigmatising condition such as drug abuse or addiction (Ellison et al., 2003; Banks et al., 2007). Those who display no MI symptoms at work are conversely less likely to consider disclosure (Banks et al., 2007). Disclosure is also more likely to occur if medication or treatment is required during work hours (Munir et al., 2005) or if the employee finds concealing their MI to be a stressful experience (Brohan et al., 2012). Research has also shown that variations in diagnosis of an MI also shapes the disclosure decision, with those with a mood disorder being significantly less likely to disclose than those with a more severe MI such as schizophrenia (Corrigan and Watson, 2002). A potential limitation of this finding is that those with more severe MIs may not be inclined to participate in research on workplace disclosure, leading to insufficient data (Munir et al., 2005).

Perceived Stigma or Support

Unsurprisingly, a key antecedent to disclosure is the individual's expectation of stigma or lack thereof. Research has repeatedly linked the disclosure of an MI to the risk of experiencing stigma (Chaudoir and Fisher, 2010; Jones and King, 2014). If stigma or discrimination appears to be a likely outcome of disclosure, employees are more likely to conceal their MI (Peterson et al., 2011). Anticipated discrimination includes an expectation of being treated differently to other employees (Ellison et al., 2003), fear of a loss of credibility in the workplace or a lowering in expectations about one's capacity to perform well in the job (Brohan et al., 2012), and a fear of experiencing rejection from co-workers (Ellison et al., 2003). Conversely, if the employee feels high levels of psychological safety in their organisation, the fear of stigma is mitigated, and the likelihood of disclosure increases (Kahn, 1990).

Disclosure Motives

Personal motives of the discloser are crucial antecedents of the disclosure decision. Clair et al. (2005) identified several motives to disclose an MI: to acquire accommodations, to create social change, to nurture relationships and gain social support, and to remove the stress of concealment. Due to the potential impact MIs can have on employees' work lives, the need for workplace support and accommodations repeatedly arises as an important indicator of disclosure (Banks et al., 2007), whilst further studies reported that practical work requirements such as requests for workplace adjustments or leave for medical appointments influence decisions to disclose (Peterson et al., 2011). Individuals may also believe that disclosure will provide them with an opportunity to influence their environment through identifying others with a similar illness, nurturing closer interpersonal relationships, and creating a better attitude towards MI in their organisation (Creed and Scully, 2000; Corrigan and Matthews, 2003).

Another positive disclosure predictor within this theme is the individual's motivation to gain social support from colleagues and supervisors (Munir et al., 2005). There is also a belief that individuals will feel a sense of relief and increased psychological well-being by disclosing a stigmatised concealed identity, which explains the drive to disclose (Law et al., 2011; Martinez and Hebl, 2016).

Perception of Self and Self Stigma

Further to these practical needs, an employee's perception of self can indicate if disclosure is likely. Some individuals consider their stigmatised identity core to their concept of self (known as identity centrality) (Swann, 2011). In this case, they are more inclined to see a discrepancy between their self-perception and others' perception of them and, therefore, possess a drive to attain congruence between these (Ragins, 2008). Alternatively, if individuals engage in self-stigma, this is believed to have an impact on disclosure, although exactly how is unclear. Self-stigma occurs when individuals internalise shame and hold prejudices against themselves (Corrigan and Watson, 2002; Corrigan and Rao, 2002). Whilst some studies indicate that higher levels of self-stigma correlate with a lower likelihood of disclosure (Corrigan and Matthews, 2012; Rüsch et al., 2017), others indicated that this leads to a higher likelihood of disclosure (Owen, 2004). These opposing findings highlight an opportunity for future research.

Organisational & Employment Factors

Employment settings can act as a significant predictor of disclosure, with those working in health or social services more inclined to disclose than those in business, technical or education settings (Ellison et al., 2003). A relationship between employee seniority and the decision to disclose has also been referenced, with those who achieve positions of power being more inclined to disclose (Heintz, 2012). Permanent staff are also more inclined to disclose than contract or temporary staff (Follmer et al., 2020).

Organisational support is positively correlated with disclosure, with welcoming and non-discriminatory climates linked to disclosure (Wheat et al., 2010; Follmer and Jones 2018). This support may come in symbolic (e.g., sponsored Mental Health conferences) or instrumental forms (e.g., framework to facilitate disclosure, any actions that aim to support or protect the stigmatised) (Ragins, 2008). Individuals with supportive supervisors are also more likely to disclose and more likely to experience positive disclosure experiences (Ridge et al., 2019). Specific supervisory competencies have emerged as essential factors in successful disclosure, such as the ability to support the discloser on the job and the tendency to encourage self-care and development (Kirsh et al., 2018). Furthermore, positive supervisor attitudes towards providing support and accommodations and proactively facilitating the return-to-work process after medical leave positively affect the disclosure process (Corbière et al., 2018). In some ways, supervisors set the standard for how employees with MI will be understood and treated post-disclosure (Kirsh et al., 2018).

Disclosure Preferences

The disclosure decision itself has also been examined in detail, with decision preferences being the area of focus; whether to conceal or reveal an MI, who to disclose to, and when to disclose.

Conceal or Reveal

Much of the empirical literature focuses on the choice between concealing or revealing an MI. Findings have been mixed, with several papers reporting that the percentage of people who have chosen to conceal their stigmatised identities was higher than those who were willing to disclose (Lucca et al., 2004; Owen, 2004). In contrast, some papers indicate that disclosure frequency rates are higher than rates of non-disclosure (Granger et al., 1997; Banks et al., 2007; Cook et al., 2007), with some researchers reporting figures as high as 87% (Ellison et al., 2003). Several factors could contribute to this, including the various definitions of disclosure mentioned above or the workplace and social context in which the individual inhabits. These inconsistencies indicate that the disclosure decision is a complex process and unique to each individual disclosing, and that further investigations are required.

Recipients

Employees must also decide to whom they should disclose. While the identity of the disclosure recipients varies across studies, disclosure to supervisors is favoured over disclosure to co-workers (Ellison et al., 2003). Gaps do exist here in terms of disclosure to others in the workplace, as most research is currently limited to supervisors or co-workers.

Timing

Several studies have focused on the timing of disclosure. According to Cohen et al. (2016), over 60% of individuals disclose their MI in their first job. This finding contrasts with others that stated that disclosure occurs in the latter stages of careers (Goldberg et al., 2005; Banks et al., 2016). Additional studies focused on revealing an MI in the hiring phase versus employment itself, with many reporting that disclosure occurred during the hiring process (Ellison et al., 2003; Granger et al., 1997).

Disclosure Outcomes

There is criticism in the field on the lack of empirical literature on disclosure outcomes, in particular studies exploring how people experience work after disclosing their MI (Dalgin and Gilbride, 2003). Of the literature that does exist, the findings are conflicting. Some studies have shown positive outcomes associated with disclosure (Rollins et al., 2002; Bergmans et al., 2009). In one study, employees reported that disclosing helped them avoid quitting their job, as their perception of psychological safety and support increased (Gioia and Brekke, 2003). Research conducted by Reavly et al. (2017) found that employees experienced more favourable treatment after disclosure, which supported the study by Ralph (2002), who found that employees believed they had earned respect and admiration from colleagues by revealing their MI. Practical outcomes of disclosure include receiving appropriate accommodations (Banks et al. 2007), having more positive return-to-work outcomes after medical leave (Gates, 2000), and having organisations arrange training courses on disability awareness and allyship (Banks et al. 2007).

In contrast, other research has reported negative disclosure outcomes. Some studies have highlighted individuals who experience negative responses from employers and co-workers in the form of discrimination (Rüsch et al., 2017; Corbiere et al., 2018). Additional research has demonstrated that disclosing an MI can cause adverse career outcomes (Mendel et al., 2015; Rüsch et al., 2017). Ellison et al. (2003) reported that one-third of individuals surveyed regretted disclosing their MI, but further research is required on the reasons behind these regrets. Evidence on the outcomes of disclosure is not unequivocal.

The variety of outcomes and lack of in-depth qualitative research on the employee experiences post-disclosure indicate a need for further research into the phenomenon, a need which has been voiced by many researchers in the area (Goldberg et al., 2005; Brohan et al., 2012; Follmer et al., 2020; Hastuti and Timing, 2021). Specifically, the lack of organisational research contributes to difficulty understanding how these employees should be best supported by HR professionals and policies (Hennekam et al., 2021). Some academics have begun to contribute to the literature, with one study utilising phenomenological qualitative research design to explore experiences into disclosure (Bril Barniv et al., 2017). This study focused on experiences and practices of self-disclosure and concealment among individuals with an MI in Israel and provided an insight into their lived experiences. The study found that individuals utilised both positive and negative concealment practices, alongside identifying the influencing factors on their disclosure decisions. While this study did deepen the understanding of the decision-making process and consequences of disclosing or concealing, unfortunately, it did not touch on its occurrence within an employment setting. Similarly, Brohan et al. (2014) utilised interpretative phenomenological analysis (IPA) as a method of exploring service users' perceptions and experiences of disclosure within the employment context. While the results of this study emphasised the need to focus on the influencing factors that form the basis for disclosure beliefs and experiences, it also had limitations as it focused on disclosure antecedents, lacking insight into disclosure outcomes.

METHODOLOGY

Research Approach

Using a qualitative research approach and interpretative phenomenological analysis (IPA), semi-structured interviews were conducted with three women who had previously disclosed a mental illness in the workplace. IPA is particularly well suited for studying the topics of health and illness (Larkin and Thompson, 2012). The focus of IPA is the in-depth examination of personal experience and how people perceive, give meaning to, and make sense of their experiences (Smith and Osborn, 2008). The core belief behind this is that individuals actively engage with their world, continually reflecting on experiences to understand them. IPA was chosen for this study for these reasons and because it focuses on participants' personal meaning-making, allowing for a detailed exploration of their experiences, perceptions, and views of a phenomenon (Smith et al., 2009). The main theoretical underpinnings of IPA are phenomenological philosophy, hermeneutics and a commitment to the idiographic position. In particular, IPA identifies more strongly with hermeneutic traditions. IPA is not without its critics, however, with Van Manen (2017) arguing it is a psychological "therapy-oriented" research methodology rather than a phenomenological approach. IPA writers disagree, describing IPA as phenomenological since it is interested in developing knowledge of personal lived experience (Smith, 2018). It has been described as "double hermeneutic, whereby the researcher is trying to make sense of the participant trying to make sense of what is happening to them" (Smith et al., 2009, p. 10). By adopting IPA, each participant's experience is rigorously explored in a way that allows for rich detail into the phenomenon under study (Reid et al., 2005; Smith et al., 2009).

Participants

Figure 1 outlines the process used for recruiting participants. Participants were sourced by distributing e-flyers on social media platforms and through online mental health community forums and groups. Potential participants were invited to contact the researcher via email to express their interest in the study. They were then provided with a document outlining the objectives and further details on the study, including the relevant data protection information. Participants who demonstrated interest in participating were then contacted by the interviewer to ensure suitability as per the inclusion criteria detailed in Appendix 1 and to begin the process.

A total of three volunteers were selected from the pool of potential participants. See descriptions in Table 1. IPA studies are conducted on relatively small sample sizes, with a default size of n=3 recommended for Masters-level IPA studies (Smith et al., 2009). Small sample sizes allow for the researcher to conduct a detailed analysis of each case and a subsequent micro-analysis of similarities and differences across the subjects (Smith et al., 2009). A small sample size reinforces the idiographic nature of IPA research with its focus on concern for individuality and a commitment to a rigorous finely textured analysis of contingent, unique, and often subjective phenomena (Eatough and Smith, 2008). Furthermore, Pietkiewicz and Smith (2012) argue it is inappropriate to use larger sample sizes within IPA studies purely because it is more common in psychological studies. The aim of IPA is also to find a relatively homogenous sample so that within the sample, convergence, and divergence can be examined in detail (Smith et al., 2009). The sample contributed to data richness or 'information power' (Malterud et al., 2016).

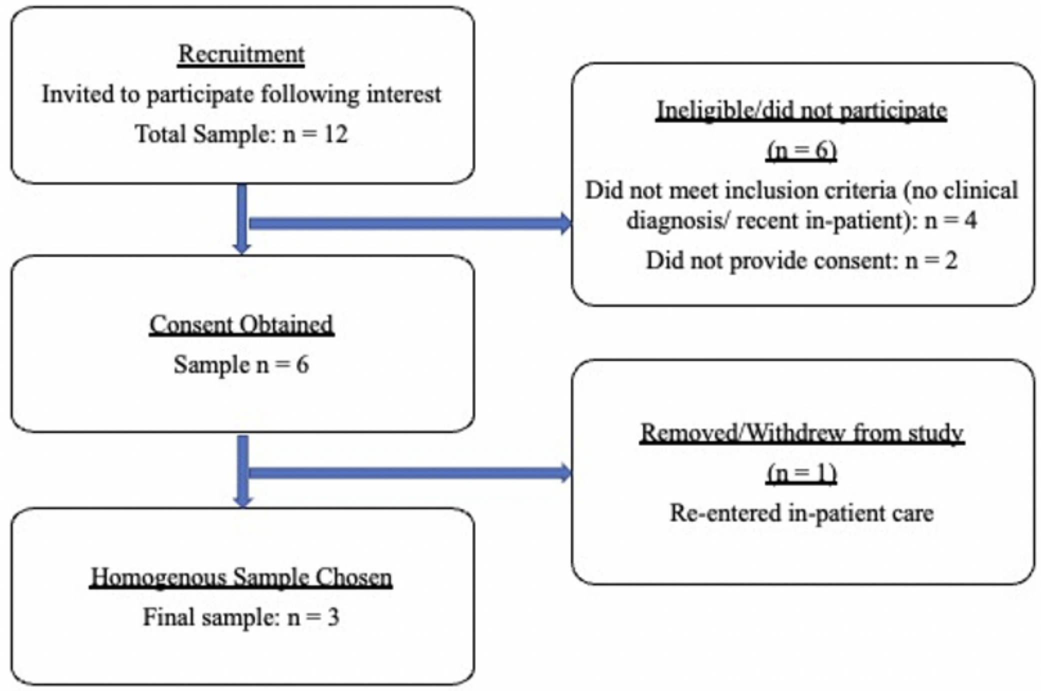

Figure 1 Recruitment Process

Table 1: Demographics of Study Participants

Pseudonym	Age	Gender	Occupation	Diagnosis
"Kate"	34	Female	Director of Risk in Financial Organisation	Major Depressive Disorder Traits of Generalised Anxiety Disorder
"Orla"	29	Female	Research Assistant & PhD student in Educational Organisation	ADHD (Attention-Deficit/Hyperactivity Disorder) Traits of OCPD (Obsessive-Compulsive Personality Disorder) EDNOS (Eating-Disorder not Otherwise Specified)
"Laura"	60	Female	IT professional and educator in Educational Organisation	Bipolar II Disorder

Information power indicates that the more information the sample holds, relevant to the actual study, the lower number of participants is needed. As such sampling strategies in qualitative interview studies would benefit from a move away from "numerical input of participants to the contribution of new knowledge from the analysis" (Malterud et al., 2016, p. 1759).

All three participants who volunteered were female. This was not a deliberate choice, but it provided an opportunity to explore female experiences specifically. Evidence from epidemiological and clinical research has indicated that women tend to have higher rates of common MIs (Sullivan et al., 2000; Rosenfield and Mouzon, 2013; Allen et al., 2014). In addition, among employed individuals, women are more likely to experience lower earning trajectories and job losses because of mental illness (Marcotte and Wilcox-Gök, 2001).

Data collection

In-depth semi-structured interviews were conducted to learn about the participant's lived experiences of disclosing their MI in the workplace, as per specific IPA guidelines (Smith and Osborn, 2003). The interview guide was framed to answer the main research objectives in a way that also captured the meanings individuals attributed to their disclosure journey. The guide was based on themes identified in the literature review and the meta-ethnographic element of Brohan et al.'s (2012) systematic review. The schedule centred on the following key areas: (1) personal experience of a mental health problem; (2) experiences with paid employment; (3) personal experience of disclosure of a mental illness; (4) opinions about disclosure; (5) experiences of mental health stigma or discrimination post-disclosure (Brohan et al., 2012). These interviews were approximately one hour in duration, which allowed for an appropriate amount of time to explore the topic in-depth (Smith et al., 2009). Due to the Covid-19 pandemic, face-to-face interviews were not feasible during the time of interviews. All interviews were conducted via video conferencing using the Zoom platform. The benefits of using Zoom for qualitative data collection have been highlighted in previous research (Archibald et al., 2019; Khan and MacEachen, 2022). Due to the sensitive nature of the study, particular attention was paid to ensuring all ethical implications were considered. A risk management protocol was established regarding online interviews and data privacy to ensure anonymity was protected and ensure data protection. This protocol also focused on how to limit and respond to interviewee distress with steps outlining how the potential for distress was reduced, alongside appropriate responses and resources for responding to distress. A risk management protocol was also developed to minimise researcher risk. This included conducting a debrief with the supervisor immediately following each interview and leaving sufficient time between interviews to process any information that may have been harmful.

Data analysis

The transcripts were then subject to IPA analysis as outlined by Smith et al. (2009). Thematic connections between transcripts were noted, along with evidence of contradicting experiences. Each theme was given a document with participant identifiers and verbatim quotes recorded. The selection of themes was built on Smith et al. (1999) recommendation that the themes captured in IPA should be chosen for their richness and ability to highlight the respondents' beliefs on the topic. Where themes appeared to be connected, they were grouped to produce a list of super-ordinate themes (See Table 2). Some initial themes emerged as isolated as the analytical process progressed

Table 2: Superordinate and Subordinate Themes

	Superordinate themes	Sub themes
1	Antecedents of Disclosure	Working with an MI – Silence and Impression management
		Moving Towards Disclosure
2	Disclosure and the Organisation	Work & Relationship Outcomes
		The Organisation: Myth, Reality, & Supports
3	Disclosure and the Self	Self-Management: Changing behaviour & Perceptions of Stigma
		Opinions on own disclosure

and were disregarded. The process went through many iterations before the final themes were solidified.

FINDINGS

The key findings are presented as though through the chronological process of the disclosure journey in an attempt to guide the reader through the participant's journeys and experiences. Within the findings, three superordinate themes emerged: (1) Antecedents of Disclosure, (2) Disclosure Outcomes and the Organisation (3) Disclosure Outcomes and the Self. It is important to consider each theme holistically and in relation to hermeneutic circle.

Antecedents of Disclosure

This superordinate theme conceptualises participants' experiences and beliefs prior to disclosure. All participants discussed the antecedents of their disclosure decision and how this impacted their journey toward disclosure. Three main sub-themes conceptualise this: working with an MI, illness as secret, and moving towards disclosure.

Working with an MI – silence and impression management

All participants discussed the impact of living with an MI whilst being an active member of the workforce. All reported that mental health issues were surrounded by secrecy and silence whilst dealing with their MI. "*I get a lot of fulfilment from work, but it can be very difficult to have the balance of feeling like I'm doing a good job in a role that is fulfilling, at the same time as being able to manage my mental health. Those two things seem to conflict at times* (Kate)."

Kate's comment suggests that those with an MI may experience difficulty staying well while working at a performance level they deem is required of them. All reported that their silence served to protect their worker image as a healthy, competent worker. This pressure to keep a façade of normalcy even though they were struggling inside can be linked to organisational norms and work culture, "*we have a culture that can make it very difficult for people with mental health issues* (Kate)". Another participant echoed this sentiment, "*We hit this kind of tipping point; I can't weather it [work life] anymore"* (Orla). This difficulty was also expressed referencing times in which participants' symptoms were more severe, "*when the depression began to return on a regular basis, I became more fearful of not being considered good enough for the job or for promotion…. I hid my mental illness for the most part during these years, rarely taking sick time even if I needed to*" (Laura). Participants mentioned that they continue working whilst unwell, and while it does not impact others in the workplace or group projects, their personal work performance can suffer, "*I will do everything that is required, so I'll show up at meetings, I'll do everything that is for other people, or ticking boxes... but my work, the stuff that is the only kind of my self-motivated stuff, that all goes by the wayside*" (Orla).

The struggles participants felt whilst working with an MI led to initial silence and secrecy around their condition. "*I did not immediately disclose my mental struggle. I continued to be fearful that I may not be accepted or considered good enough to hold my position in the organisation*" (Laura). Laura became quite ill due to her MI in the early days of her career, and although she took a long leave of absence, she concealed the details of her illness, "*I hid my illness for many years. In 1995 I became very ill and was out of work for six months. In my return I found my colleagues not knowing how to react to my absence. It was not discussed or talked about at the time*." This theme of silence was echoed across the other participants' accounts, "*there would be a lot of kind of don't say anything, just mask and get on with things"* (Orla). Uniquely in Orla's case, who entered the workforce for the first time immediately after university, some secrecy also came from a belief that functioning adults did not suffer from MIs. Here it was an internalised stigma that prompted the silence, "*I would have known among the student population that mental illness was huge. It being something that a functional adult could have? No, no example*s." This lack of visibility of others with an MI created a lot of fear around disclosing, "*before my interactions with psychiatrists and stuff, I would have thought it was like the movies and worried they'd [the organisation] section me if I was honest about having suicidal ideation"* (Orla). Previous experience with stigma and disclosure also impacted silence and a decision to disclose. Kate's initial concealment resulted from negative experiences of disclosure in other organisations, "*I've disclosed it previously, but not really through choice. I've felt like I've been forced to disclose it because I've needed time off*" (Kate).

Moving towards disclosure

Whilst all three participants willingly disclosed their MI in their current roles, their journey towards this choice, their motivators, how, and what they disclosed highlighted the variety of variables within the disclosure process. Specifically, they differed in their preferences surrounding the choice of whether to disclose or not, the timing of the disclosure, recipients of the disclosure, and the circumstances.

Kate disclosed once she had reached a position of seniority, which equated to safety, in her opinion, "*the role I'm in is quite senior… and I felt once I got to this level, I could disclose in a way that wouldn't affect my career trajectory."* This need to achieve seniority before disclosing came from a place of fear, "*I was very conscious of bias, and I wanted to prove myself in this role for a period of time before I disclosed anything*." Her triggering event, and motivation for disclosure, was experiencing negative workplace attitudes towards individuals with MIs, "*I've seen inappropriate behaviour around mental illness in the workplace. I've seen how some people with mental illness are talked about, while I've been in the room and people haven't been aware that I have mental health issues. So I felt like an ethical responsibility to disclose and be seen as an example of someone who is doing well in their role while having a mental illness."* For Kate, the motivation to disclose was to create social change by allowing herself to serve as an example for others with mental illnesses.

Getting to a place of safety before disclosing was also crucial to Laura, who kept her MI a secret until she felt like her illness was under control, "*around the early 2000s I disclosed my mental illness… having an excellent psychiatrist taking excellent care of me, I felt more confident to disclose."* In contrast, whilst Orla disclosed willingly, it was under the recommendation of her psychiatric care team for her to get access to accommodations and reasonable adjustments from the company, *"[I disclosed] only because I was an in-patient and had to take a medical leave period. And so when I came back, it was recommended to me that I linked in with the disability services."*

The disclosure recipient and the content of disclosure varied across each participant, highlighting the unique nature of each disclosure experience. Laura disclosed only to HR in an annual survey on employee disabilities, keeping the detail of her MI to herself, "*I disclosed that I had a depressive illness… I never disclosed my illness to my manager."* Orla also disclosed solely to the disability service, providing consent for them to share a summary report to her supervisor, "*I went through the official process of having it added to my like record or whatever. And like a profile was done up, and I knew and had to consent to that being visible to my supervisor*." In contrast to the other two participants, Kate disclosed all details of her condition to all members of her organisation through a disability group blog series, "*I disclosed what my mental illness struggles are, how they kind of originally were diagnosed, how that manifested themselves, how it affects me day-to-day, the kind of coping mechanisms I use… I spoke about my medication and the type of therapy I get… So yeah, well kind of, the full list of things you can pretty much disclose*."

Disclosure and the Organisation

This super-ordinate theme summarises participants' experiences of their organisation following disclosure. All participants discussed the perceptions they held of organisational responses to MI and to their disclosure. This is comprised of two sub-themes: work and relationship outcomes, and the organisation: myth, reality, and supports.

Work & Relationship Outcomes

The accounts of the participants all touched upon the organisational reaction to their disclosure, with most explaining that their work experience was largely unchanged due to their disclosure, "*there was no change in my experience of work after I disclosed*" (Laura). Some even felt as though there was no reaction whatsoever to their disclosure, "*the process was a bit so-whatty and it's kind of one of those where I suppose… I have it hanging over me in the sense of it's now there to be used against me, arguably. But I didn't really get any benefit from it"* (Orla). While Kate also did not experience any huge work-day changes as a result of her disclosure, she reported receiving a positive response to "*coming out"* about her MI in quite a public way, "*I had an overwhelmingly positive response to the article."*

Responses differed when it came to the impact of disclosure on relationships. Some participant experiences are worth noting, with varying responses when it came to the impact of disclosure on participant's relationships with direct supervisors. While Orla's supervisor was aware of her MI from the summary report received from the organisation's disability services, the supervisor never discussed it, "*[I] had to consent to it being visible to my supervisors. It was never mentioned there was never any… [long pause] Nothing really followed up from that. So. Yeah."* This is an example of a management practice of silence where a manager ignores the presence of mental health issues and appears to be actively discouraging full disclosure.

Contrary to this, Kate experienced a positive impact on her relationship with her supervisor following disclosure, "*she was very very positive about it and I actually think we probably have a better relationship because of it, because funnily enough, I think she has more respect for me now."* Kate is unsure of the reasons behind this but believes it could be due to her ability to manage a MI and the high-pressure work environment simultaneously, "*I don't know if that's as a result of disclosing and her realising, actually, how much is on my plate, you know personally and professionally."* She also added that it could be due to her "*proving herself*" before disclosing, "*by the time I disclosed it, I'd already been in the role for a period of time, and she was you know happy with my work, so I think it then came as a surprise, oh you've managed to do all this and you have depression*?" Laura's MI was never disclosed to her supervisor, only to HR, "*I never disclosed my illness to my manager… I continued to be very fearful and did not feel I could share details to my manager to obtain supports or accommodations."*

There were also some reports of disclosure resulting in impacts on the participants' relationships with others. Orla, who participates in a disability forum in her organisation following her disclosure believes that MI is not as readily acceptable as a physical disability by others on the forum, "*me being there [the forum] on a mental health basis is kind of pushing the boundaries."* She also mentioned a fear that disclosing has had impacts on other relationships, "*I can't say for sure, but it would be a concern."* In contrast, Kate has experienced an increased organisational network following disclosure, "*a lot of people commented on it, and a lot of people privately messaged me to say they've experienced similar things that didn't [sic] feel like sharing it in sort of a public domain."* She has had others in the organisation disclosing their MI directly to her. She believes this is down to a humanising factor linked to her disclosure, "*I think they see me as more approachable or more empathetic. I think also putting myself out there as someone who was open to disclose this and give personal information, make people feel like I can be a safe space to talk to."* She sees this as positive and believes that disclosing has provided her with an opportunity in terms of building relationships, "*it's allowed me to build more relationships with people in the workplace and definitely people I wouldn't have interacted with before or had the opportunity to make relationships with."*

The Organisation: Myth, Reality, & Supports

Access to workplace accommodations has been identified as one outcome of disclosure. All participants report dissatisfaction with the organisational supports on offer following disclosure. Some found the options were more suitable for those with physical disabilities and did not feel like MIs had been considered, "*they went through all the options with me, most of it was completely irrelevant"* (Orla). Participants also believed the relevant supports on offer were insufficient for their needs, "*there's an option to have counselling, and counselling is always offered as a like "it'll help you, this ought to do well', but counselling isn't always the answer to the problem*" (Laura). This view was supported by Kate, who shared, "*my leadership has sort of mentioned to me that we have an internal phone service that you can and get free therapy on that service. So that's been mentioned but that therapy is five sessions a year. And I already, you know do far more than that. Beyond that, no I haven't really received any support."*

Some participants reported that the responsibility came to them to organise their own accommodations, "*it's a possibility that, you know, funding will magically turn up if you ask for it [accommodations] and make a case for it.*

But that is placing a lot of onus on you to kind of, you know, state that case" (Orla). Laura supported this, "*I had asked to have accommodations made, I had to, you know, organise the plan of action and you know, then I passed it over to the organisation to ask if it could happen. So the organisation isn't proactive, it's reactive."* This comment suggests a perception that the employer is shifting responsibility for mental health issues from the organisation to the individual worker. Silence, in this case, could be considered functional for the employer as they appear to abdicate responsibility. In Laura's case, supervisors refused her request for accommodations, "*in our area the holiday policy had been that everyone had to have their annual holidays between June and August. If I had an option to have holidays at other times, I could have, you know kind of maybe planned days to help me cope better. But I asked actually, to have that accommodation, and I couldn't have it, it would impinge on the annual holiday policy*."

All participants also reported a dissatisfaction with the discrepancy between the organisations' public attitudes towards MI, versus how MIs are dealt with in practice. Orla shared her feelings on this, "*I feel like there's a lot of, em… kind of this nicey-nicey PR stuff. So they'll do a lot of mental health kind of spiels about various things or you know, there's Mental Health Awareness Week, and there's this, and there's that, and there's the other. But when you fundamentally get down to it, it's [the response] not fit for practice*." Similarly, Kate highlighted the disparity between the organisation's tone versus reality, "*I would say the tone is very different to what happens in practice. So the tone from the top and across the company is that mental illness is something we need to talk about… we have a workplace that, on the surface seems to be very very supportive. So that's the tone. However, in practice, that's not what happens and that is not what I hear from colleagues*." Finally, while Laura reported that the organisation can have a good policy in place, the reality comes down to the individual supervisors as to whether appropriate support is provided to employees. She attributes her early retirement to her unsupportive experience following disclosure where her request for accommodations regarding holidays were dismissed and she was unable to continue to work, "*I ended up actually coming out of work, because of illness. So, if I had the, you know, flexibility and help, I actually could have maybe kept going."*

Disclosure and The Self

This superordinate theme explores participants' beliefs surrounding their own disclosure, and how their relationship to self has been impacted.

Opinions on Personal Disclosure Experience

Although participants believe that outcomes have been mostly neutral or positive, their opinions on their disclosure experiences and whether they would repeat the experience were not encouraging. While one participant believes that the benefit of disclosing outweighs the negatives, she believes that her life is now more difficult as a result of disclosing, "*if anything, its made things more challenging for me,"* believing that she has lost an element of control over her life due to disclosing. This appears to be linked to a fear of stigmatisation, "*if I hadn't chosen to disclose I wouldn't potentially face criticism… for something that is outside of my control… I wouldn't if I'm upset on a particular day that it's going to be potentially linked to my mental illness and therefore perceived as an inability to do my job or an inability to be rational*" (Kate). This was echoed by Orla who fears discrimination and stigma following her disclosure, "*I think that you end up carrying a lot of strain… I think there's probably some things where the stigma possibly outweighs the benefit*." Similarly, Laura did not necessarily recommend disclosing to others who were in her situation, "*I actually, you know, think that if a person who has an illness, and can happily not disclose, there isn't any need to disclose*."

Self-Management: Changing Behaviour

Another key theme to emerge was how disclosure had a more significant impact on their actions than the actions of others in their organisations, "*If anything, probably the main change has been with me"* (Kate). Orla supported this, "*I think it has a lot of impact on how I conduct myself*." Both participants shared that they are less inclined to share thoughts and feelings in the workplace, "*I'm much less inclined to share any illness with leadership, because I'm concerned that if I do say I'm sick for anything then, their assumption might be because its depression*" (Kate). Fear of being disregarded was also apparent, "*I suppose I'm very aware, and very wary of, being written off as mental illness, therefore like, doesn't get taken seriously, shouldn't get taken seriously*" (Orla). Due to disclosure, they perceive there is now more pressure on them to maintain an image of professional competence. There was also a perception that their illness could be used as a method to undermine them, "*I feel that now when I say something* *that would have been taken as quite innocuous before such as, I'm having a bad day, it now seems to have an association with it (MI) like, oh, she's depressed, or you know, she's stressed*" (Kate). This self-monitoring behaviour can be linked to a fear of stigma that remains following disclosure. Although no participant has had direct experience of discrimination following disclosure, some believed they had experienced microaggressions towards them in the form of assuming their capabilities are different due to their MI, "*I felt like that's (disclosure) been used against me a little bit. There was a voluntary position I was going for, and I got told the other candidate would be really organised, and I kind of felt a bit like that the only thing that they would have to consider me unorganised was my ADHD… like I'd never missed an email, never missed a meeting*" (Orla). Kate elaborated on feeling a loss of control following her disclosure, "*there are assumptions over what I can and can't do*," and references being given different types of tasks due to the assumptions of others surrounding her capability and competence to perform at work.

DISCUSSION

This study sought to gain an understanding of the phenomenon of the disclosure of mental illness in the workplace from the perspective of the employee disclosing. The key findings were presented through the chronological process of the disclosure journey in an attempt to guide the reader through the participant's journeys and experiences. Overall, we find that disclosure is not an "all or none" event but is rather much more complex. The view of it being the outcome of a decision whether or not to share information with others is overly simplistic (Goldberg et al., 2005). Another assumption is that disclosure is about personal agency where the worker chooses to disclose or not disclose, based on consideration of both the costs and benefits of sharing information (Corrigan and Matthews, 2003). This research challenges some of these assumptions. Rather than an "all or none" event, variations in practices of disclosure were evident across the three participants, with selective and strategic information sharing being noted. Study participants recounted stories of selective disclosure where only partially disclosed information was provided (e.g., detail on their illness) or chose to tell HR but not their supervisor. Selective disclosure is often used to access protections whilst minimising the risk of stigma (MacDonald-Wilson, 2005). We also had evidence of strategic disclosure where disclosure was done as part of advocacy efforts for MI for others or to negotiate accommodations and supports. This example was also evidence of timed strategic disclosure where the participant waited until they were at a senior stage of their career before making a disclosure.

All participants highlighted the experiences and beliefs that they had prior to disclosing their MI. Initially, all had kept their illness a secret, which links to Goffman's theories on "passing", which holds that stigmatised individuals will attempt to pass as normal, or as those without a stigmatised condition (1963). The motivation for passing appears to come from mostly a place of fear for these participants, with various discussions on a lack of knowledge on MI limiting their openness, a fear of judgement from co-workers, and a need to feel in control. These beliefs do not appear to be uncommon, with others echoing the same sentiments throughout the existing literature (Brohan et al., 2012, Peterson et al., 2011).

An important concept identified in this research is the multiple patterns of silence visible across the main stakeholders – the workers, the manager and the organisation. Silence has been conceptualised as information, which is consciously held back by employees, rather than an unintentional failure to communicate or simply having nothing to say (Tangirala and Ramanujam, 2008, Wilkinson et al., 2018). In this study, silence was not simply an absence of voice, but rather an active practice adopted by key stakeholders that can be termed fear-driven silence (the desire to speak up as well as the fear of doing so, see Kish-Gephart et al., 2009). Workers actively engaged in practices of silence when they engaged in strategies to conceal their mental health issues from others. This was evidenced by their efforts to maintain an image of competence in the workplace whilst struggling with their MI. This is consistent with the practices of impression management described in Goffman's (1963) work on stigma. Goffman (1963) proposed that a stigmatizing condition such as mental illness meant that individuals affected by the illness were potentially "discreditable". Silence practices such as impression management therefore may have been produced by discursive constructions of what it means to be a "good" worker (Moll et al., 2013). Silence was not simply a choice of whether or not to disclose, it was also closely tied to stigma in that it was influenced by what norms constitutes a healthy and competent worker. Managers' practices of silence included a) not talking about or acknowledging issues, b) dismissing concerns, or c) facilitating impression management. Managers did not initiate a discussion about them or act when problems were evident. Finally, institutional silence refers to differences between the public image of the organisation and the private struggles of employees with a mental illness within the organisation. This came through in all participants' stories. Whilst their organisations appeared to be supportive of MI and conducted initiatives for wellbeing, the reality of organisational responses to MI was far from this. This pre-disclosure belief is interesting to note, as research indicates that employees with unsupportive and psychologically unsafe work climates are less inclined to disclose their MI (Wheat et al., 2010; Follmer and Jones 2018). The participants in this study did not appear to factor in the unsupportive work environment into their decision.

Several findings regarding the disclosure decision-making process arose throughout the interviews. The disclosure decision was reached at separate times in people's careers prior to disclosing. Kate and Laura's narratives support the claim that disclosure occurs in the latter part of a career (Goldberg et al., 2005; Banks et al., 2016), with Kate confirming that she had waited until she reached a position of seniority prior to disclosing as per research by Heintz (2012). Kate's motivations for disclosing at that time also corroborates with Brohan et al.'s (2012) research on "proving yourself" first within an organisation prior to disclosure. This strategy is based on an employee's belief that they can reduce the potential for stigma prior to disclosing (Brohan et al., 2014). For Kate and Orla, disclosure motivations appeared to be functional, hoping that it would allow them to influence their environment (Kate), and access supports and accommodations (Orla). Disclosure as a functional behaviour was first discussed by Derlega and Grzelak (1979) who believed that disclosure only occurred if individuals feel it is an effective tool to obtain something (Quattrone and Jones, 1978). This appears to conflict with Laura's disclosure motivation, which appeared from the findings to be simply because she was in a position to do so.

One of the findings regarding disclosure outcomes was the lack of reaction from the participants' organisations and supervisors to their disclosure. There is growing research that suggests that the reaction of the discloser recipient is one of the most vital factors in indicating whether disclosure will be beneficial or not (Chaudoir, 2010; van Beukering et al., 2022; White et al., 2023). Furthermore, participants are said to not experience any benefits to disclosure if the reaction of these recipients is neutral or negative (Lepore et al., 2000; Rodriguez and Kelly, 2006). In some ways, the findings of this study corroborate this, with two participants receiving neutral reactions to disclosure, and both feeling disillusioned as a result. However, the third participant received a positive reaction to her disclosure yet was still uncertain about her overall disclosure experience. The only participant in the study who disclosed to a supervisor experienced quite a positive external reaction to their disclosure. As mentioned in the literature review, it is believed that supervisors set the standard for how employees with MI will be understood and treated post-disclosure (Kirsh et al., 2018). The findings from this study corroborate research from Dewa et al. (2021) who indicated that over 64% of employees who disclose to supervisors have a positive experience. Unfortunately, the small sample size here indicates that further research is needed. The lack of knowledge and provision of supports for those with an MI from the participants' organisations appears to be commonplace, particularly with regard to how to implement accommodations for this population (McDowell and Fossey, 2015). Additionally, the experience of those who mentioned that they were offered the same accommodations as those with physical disabilities has been referenced previously by Unger and Kregel (2003). These accommodations for employees with MI can often seem less tangible than those required by employees with more physical disabilities.

An important outcome to note is the increase in self-stigma following disclosure. Whilst there have been a number of studies examining the perception of self prior to disclosure, most outcome-focused disclosure studies look to external reactions (e.g., co-workers, supervisors). Two out of three participants believed that the biggest impact of their disclosure decision came from within, referencing increased self-monitoring behaviour and self-discrimination. Some of this might be linked to the various reports of micro-aggression that participants perceived towards them, as there have been links between micro-aggressions and increased self-stigma (Corrigan and Rao, 2012). However, disclosure has also been cited as a strategy to reduce self-stigma (Rüsch and Kösters, 2021), so this finding leads to many additional questions. For example, a question that has not been thoroughly examined in this study is, when do the impacts of disclosure stop impacting the work life of the individual who has disclosed, if they do at all?

RESEARCH LIMITATIONS

This study complements previous research on mental illness disclosure and contributes significantly to the understanding of the employee experience and beliefs surrounding the process and its outcomes. A number of limitations were identified. The authors acknowledge that this study took place at one point in time and participants were reflecting on processes as they happened in the past. One of the main methodological limitations of this study is a weakness inherent with most IPA research. Although this study contributes to the richness of information on the topic, broad conclusions about the population cannot be drawn due to the size and homogeneity of the sample. Patton (1990) states that this problem commonly occurs in qualitative research, and whilst these methods produce detailed information which increases understanding; generalisability is decreased (Patton and Westby, 1992). As the focus of IPA is increased understanding of individual experiences amongst relatively homogenic groups, it is not intended for wide generalisation. The specific sample also contributed to ‘information power’ (Malterud, 2016). However, further research should explore wider sample sizes, to explore if this experience is shared. The sample selection itself also posed a limitation. Whilst homogeneous groups are recommended for IPA studies (Smith et al., 2009), having only female, white-Irish respondents limits the generalisability of the findings. The consequences of MI stigma have been shown to be worse for racial and/or ethnic minorities compared to racial and/or ethnic majorities indicating a lack of shared experiences (Eylem et al., 2020). There is a need therefore for more high-quality research on MI stigma and minority groups. Finally, as a result of the Covid-19 pandemic, all interviews were conducted via videoconferencing. Due to the nature of the topic, achieving the same level of honesty and openness from participants over video can be challenging to achieve, and the communication channel used may have negative influences on the level of sharing (Sedgwick and Spiers, 2009). Given the topic’s sensitive nature, validity may have been compromised if participants did not honestly and openly share their experiences.

FUTURE RESEARCH

Although this study contributes to a conceptual understanding of MI disclosure, there are several areas of research that would contribute to the further development of these ideas. The issue of silence emerged as a major issue in this research, which involved all stakeholders in an organisation. Future research should try to understand how individuals in organisations make the decision to be silent about MI issues that concern them, and about which types of issues employees are likely to be silent about within the context of mental illness disclosure in the workplace. The response of the discloser recipient was also critical in understanding MI disclosure. Future research should examine both discloser and recipient evaluations of disclosure strategies, response, and predictors of interaction success, recognising multiple perspectives of the same interaction. Finally, longitudinal studies would also be beneficial in order to study the longer-term impacts of MI disclosure on the individual’s work life.

CONCLUSION

While this study merely provides a brief insight into the lived experiences of three individuals with MI, its complexity and variety of responses highlight the nuanced nature of MI disclosure and emphasises a real need for further in-depth qualitative studies. Using the novel approach of IPA, we find that disclosure is much more complex than an “all or none” event. We add to the limited research on MI and work by taking an emic “insiders” perspective by focusing on invisible human characteristics that are not easily identified (as opposed to gender, age or race). By doing so, we address Ruggs et al.’s (2013, p. 39) call to include minority perspectives in work and psychology research as we are “missing an opportunity to be at the forefront of understanding and instigating changes that would result in maximizing the fairness and optimization of these often forgotten employees and their experiences in the workplace.”

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APPENDIX 1

Inclusion criteria for participation in this study were as follows:

- Participants were required to have the capacity to give informed consent.
- Participants had to be 18 years or older.
- Participants will have received a diagnosis of an MI classified in the DSM-V (American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders).
- Participants will have been treated for this MI over a 6-month period.
- Participants will have disclosed their MI in their current or previous workplace.
- Participants will not currently be undergoing treatment for a severe episode (i.e., will not currently be an in-patient of a psychiatric facility, or have received treatment as an in-patient in the year preceding the interviews).
- Participants will consider themselves either recovered, or in the process of recovery.
- Ongoing out-patient care or being on medication did not pose an obstacle to participation.

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