An Organizational Study of Mental Health in the Workplace

by

Cynthia K. Malachowski

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Graduate Department of Rehabilitation Science
University of Toronto

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Abstract

Workplace mental health is becoming of increasing importance, in part due to the rising social and economic costs of mental health issues in the workplace. Little is known about how the experience of workers with mental health issues is actively produced through their participation in workplace procedures and associated supports. The purpose of this research is to better understand how employees actively engage in institutional practices and associated social relations that ultimately coordinate and produce their workplace experience. Using institutional ethnography, I take up the standpoint of the employee living with mental health issues to explore the coordinating relations associated with workplace mental health. This approach sheds light on how employees’ experiences are socially produced and coordinated across and between institutional processes and practices. Data collection included over 140 hours of ethnographic observations, the analysis of associated texts and documents, and interviews that were conducted with 17 informants. This research details some of the challenges experienced by one novice health science researcher while conducting ethnographic research, and provides techniques for addressing personal and professional boundaries, negotiating ethical dilemmas, and reconciling the emotional experience of transitioning back and forth between being an ‘outsider’ and ‘insider’. In addition to these insights, the findings explicate the social relations and institutional
processes that coordinate sick time utilization for workers experiencing mental health issues. We revealed that employee’s work of managing workplace absence management programs while negotiating episodes of mental ill health was perceived as overwhelming, unfair, and even punitive. Employees would require formal and informal respite from work, and would often utilized vacation time when unwell in order to avoid institutional processes all together. The biomedical focus of the absence management program created uncertainty about what constitutes a bona fide illness, and caused managers to come to know their work activities as distinctively separate from the work of healthcare practitioners. This research contributes to the literature by highlighting how tensions are created through textually coordinated work activities within and between the corporate and healthcare sector. These insights are important in establishing where and how to enact change from the standpoint of the worker.
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Chapter 1
Introduction

As the impact of workplace mental health is significant for both the worker and the economy, it has become a high priority policy issue for many Western countries. The Organization for Economic Co-operation and Development (as cited in Gabriel & Liimatainen, 2000) reports that the workplace is a priority challenge for the labour market, as poor mental health accounts for between 3% and 4% of the Gross Domestic Product (GDP) in developed countries. Global data ranks depressive disorders as the leading cause of disability days in high-income countries (World Health Organization, 2001). Dewa and McDaid (2011) specifically draw our attention to the epidemiological and economic costs of workplace mental health as mental health issues affect productivity, decrease labor force participation, increase unemployment, and decrease ability to work. In addition to these enormous economic costs, mental health issues in the workplace also carry a significant social burden. Mental health issues are predictive of unemployment and reduced career goals, resulting in a decrease in quality of life and diminished community participation (Stuart, 2004).

Evidentially, quantitative and qualitative research has established the high social and economic costs of mental illness in the workplace. However, despite this growing body of evidence, relatively little is known about how the underlying mechanisms of policies and procedures in the workplace shape an individual’s everyday experience of working with a mental health issue. There is a lack of literature that addresses the coordination of workplace mental health from the standpoint of the worker. Therefore, the purpose of this dissertation is to investigate workplace mental health from a new perspective, and to offer novel insights into how particular practices and processes coordinate the experience of the worker. I will answer the following research
questions: What types of challenges emerge in the workplace for someone experiencing mental health issues? What is the interface between having mental health issues and accessing help in the workplace? Essentially, how do institutional practices and associated social relations coordinate the workplace experience of workers living with mental health issues? By taking up the standpoint of the worker with mental health issues, I shed light on how workers participate in these coordinating processes both knowingly and unknowingly. I use institutional ethnography as an approach to uncover how workers navigate workplace structures, policies, and practices, and how these coordinated activities ultimately shape the workplace experience of individuals with mental ill health.

In this section, I summarize the content of the dissertation. Chapter 2 engages in a discussion and critical appraisal of workplace mental health literature, including a review of foundational theoretical models, and an overview of the development of healthy workplace frameworks. It also provides an in-depth discussion of the origins and foundations institutional ethnography, the influence of feminism and Marxism, and presents several methodical issues and interpretations.

In Chapter 3, I will describe my experience as a novice ethnographer, and utilize Oberg’s (1960) classic culture shock framework to present the ethical, emotional, and practical dilemmas that I faced while conducting fieldwork. I draw attention to these particular aspects of ethnography, as they are not readily discussed in the health science literature. A number of strategies and techniques are provided to effectively navigate the challenges faced in maintaining personal and professional boundaries, negotiating ethical dilemmas, and reconciling the emotional experience of transitioning back and forth between being an ‘outsider’ and ‘insider’.

Chapter 4 examines the coordination of work practices from the experience of the worker with mental ill health, and sheds light on how these experiences are coordinated both locally and
translocally by a “mental illness is an illness like any other” discourse. Because of the highly medicalized absence management process, workers with mental health issues were not able to recognize the ‘work’ or self-management behaviour that they engaged in as legitimate ‘sick’ behaviour. This chapter also draws attention to the fluctuating nature of mental health issues, and workers’ need for immediate and informal respite through flexible work practices. Findings from this research call for the need to position workplace supports to reduce, or address the disjuncture between the workers experience of mental health issues from an experiential perspective (feeling too unwell to work) versus a ruling perspective (the textual practices that coordinate ‘sick time’).

As Chapter 4 explicates how the ruling relations of workplace mental health organize the ‘work’ of the worker, Chapter 5 elucidates the managerial processes and practices of workplace mental health. Here, I show how a medicalized absence management process is perceived as punitive and cumbersome by workers with mental ill health, and how it also makes managers unaware of how to best support their frontline workers living with mental ill health. By shedding light on three institutionally organized processes that coordinate the experiences of employees with mental health problems, we demonstrate: 1) employees’ work of managing and negotiating episodes of mental ill health while adhering to company procedures and doing and keeping the job; 2) managers’ administrative work of maintaining privacy and confidentiality through corporate procedures; and 3) the administrative work of authorizing illness by the employee, physician, manager and wellness team. This research shows how confidential medicalized disability management programs render managers ill prepared and inadequately trained to provide mental health support to their employees, and we make recommendations to facilitate both organizational and policy change to enhance services and supports for workers.
In the final chapter, Chapter 6, I will provide a conclusion and summary of the previous chapters, drawing attention to how all three manuscripts make a unique contribution to the literature. Specifically, I will highlight the implications of my research for the novice health science researcher, the worker with mental health issues, management and human resource personnel, as well as for policy and practice considerations. Lastly, I will draw attention to some limitations of the work, and make recommendations for future research.
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http://economics.ca/cgi/jab?journal=cpp&view=v31s1/CPPv31s1p021.pdf


Chapter 2
Appraisal of Workplace Mental Health, and Philosophical Foundations of Institutional Ethnography

2.1 Workplace Mental Health: Theoretical Models

It is now widely accepted that the workplace is one of the key environments that affects mental well-being and mental health (World Health Organization, 2000). The interface between work and mental health is complex. Under the right conditions the workplace can be a contributing factor to mental well-being; and conversely, if work conditions are not a good fit for the worker, it can be detrimental to mental health (Karasek, 1979; Seigreist, 1996). With increasing numbers of workers experiencing mental health problems and the significant accompanying productivity losses, the employment of individuals living with mental health issues has become a topic of great interest (Organization for Economic Cooperation and Development [OECD], 2013).

Research has shown that most people living with mental health issues want to work (Mechanic, Blider & McAlpine, 2002), and can indeed contribute to the work force (Evans & Reeper, 2000). However, people with mental illnesses may face the highest degree of workplace discrimination of any disabled group, and this can lead to unemployment, diminished self-esteem, and weakened social support (Stuart, 2004). Clearly, increasing our knowledge and understanding of the intersection between the workplace and mental health presents a multi-faceted challenge for both the individual and the workplace. Accordingly, a number of models have been developed to explain the complex relationship between work and health. The first part of this chapter provides a critical review of these workplace models. The second half of this chapter offers a description of the development and application of healthy workplace models, which are holistic
models that address physical, social, personal, and organizational factors to make workplaces healthy and safe (Canadian Centre for Occupational Health and Safety, 2014).

2.1.1 The Relationship Between Work and Health: Foundational Theoretical Models

Our current understanding of work and health has developed from a range of models that demonstrate relationships between job characteristics, psychological processes, and subjective perceptions of stressors (Mark & Smith, 2010). These “stress models” primarily consider the job characteristics, the role of subjective perceptions of stressors, or a combination of both.

Hackman and Oldham’s (1980) Job Characteristics Model is an example of a stress model that focuses on five core job characteristics: skill variety, task identity, task significance, autonomy, and feedback. The authors propose that these five job characteristics influence three psychological states: (1) experienced meaningfulness of the work, (2) experienced responsibility for outcomes of the work, and (3) knowledge of the actual results of the work activities; which in turn, affect work outcomes. Fried and Ferris (1987) performed a systematic narrative analysis on data from nearly 200 studies of the Job Characteristics Model and also conducted a meta-analysis using large portion of the data. They found that job characteristics were indeed related to both to psychological and behavioral outcomes for all five core job characteristics. The authors state that findings imply that organizational goals could align with specific task dimensions (for example to improve performance, the focus should be placed on the development of task identity and job feedback). Furthermore, the authors suggest that there may be too many core job characteristics, and that skill variety, task significance, and job autonomy might be part of the same dimension.
Another well-known stress model, the Effort-Reward Imbalance Model (Siegrist, 1996), places emphasis on reciprocity, indicating that effort at work should be compensated by suitable rewards. Siegrist proposed that high effort, expensed in the form of intrinsic or extrinsic exertion, coupled with little or no reward (such as money, esteem or status control) will result in higher levels of stress and illness. This model provides insights into the psychosocial occupational environment, and the resulting impact on workers’ long-term mental health and wellbeing. In a review of 45 studies on the Effort-Reward Imbalance Model, van Vegchel, de Jonge, Bosma and Schaufeili (2005) provide support that high effort in combination with low rewards does in fact increase the risk of poor health. This model has also been used to understand gender differences in health functioning at work (Li, Yang & Cho, 2006; Siegrist, 2005), and personality factors in employees’ depressive symptoms (Vearing & Mak, 2007). Pikhart et al. (2004) conducted a cross sectional study of workers from Poland, Russia, and Czech Republic, and report that the imbalance between effort and reward is strongly associated with depressive symptoms across all three geographic locations. Furthermore, effort-reward imbalance has been established as a predictor of sickness absence, duration, and frequency (Bakker, Demerouti, de Boer & Schaufel, 2003; Head, Kivimäki, Siegrist, Ferrie, Vahtera, Shipley & Marmot, 2007).

The Demand-Control Model (Karasek, 1979) is considered to be the most influential model of the psychosocial work environment as it relates to stress and health outcomes (Kompier, 2003). Karasek proposed that it is the balance between the level of demand and the level of discretion or control over the job that affects these outcomes; essentially, high job demands and low decision latitude result in mental strain and job dissatisfaction. The demands of the job refer to such factors as workload, stressors related to unexpected tasks, and stressors of job-related personal conflict and skill variety (Karasek, p.291); whereas job control (or discretion) refers to the amount of “decision-making freedom” a worker has over their work (Karasek, p. 287). Job
control can also refer to a lack of perceived job control by the worker (Day & Jreige, 2002). Specifically, Karasek proposed that high job demands in combination with high decision latitude results in an “active” job (p.288), which leads to greater satisfaction and reduced depression. In contrast, a “passive” job, characterized by low job demands and low decision latitude, is theorized to result in dissatisfaction and a decline in overall activity (Karasek, p288).

As the most widely used theoretical framework that relates the characteristics of a job to health and wellbeing (Ibrahim & Ohtsuka, 2012), the Demand-Control Model is supported by much research. Several studies have demonstrated the validity of Karasek’s model, especially for cardiovascular implications. Landmark investigations include Hammar, Alfredsson and Theorell’s (1994) study of 9,295 cases and 26,101 controls in which the authors report an increased incidence of myocardial infarction for men and women in occupations involving low decision latitude at work and psychosocial strain. Kuper and Marmot (2003) provide additional evidence for the model in their prospective cohort study with over 10,000 workers. They found that high job demands were related to the future occurrence of all coronary heart disease for both men and women. In a review of the literature, Theorell and Karasek (1996) found that 16 of 22 studies confirmed a job strain association, including seven of 11 cohort studies, two of three cross-sectional studies, four of four case-control studies, and three of three studies using coronary heart disease symptom indicators. Clearly, the relationship between adverse job conditions, low decision latitude, and coronary heart disease has been well established.

Support for the model is also garnered from longitudinal studies that demonstrate increased satisfaction when job demands were met with a high degree of job control, as well as a reduced sickness absence in the case of high job control in (de Jonge, van Vegchel, Shimazu, Schaufeli & Dormann 2010). With regard to mental health, several studies have demonstrated links between a
lack of control and depression. Specifically, major depressive episodes, depressive syndromes, and dysphoria are strongly associated with the psychosocial dimensions of the Demand-Control Model. These psychosocial dimensions include having enough time to get the job done, the amount of work, and the presence of conflicting demands (Mausner-Dorsch, & Eaton, 2000). This model has also been used to investigate burnout, depression and work engagement (Van der Doef & Maes, 1999). It has also been helpful in examining stress during organizational change such as restructuring and downsizing (Laschinger, Finegan, Shamian & Almost, 2001; Schechter, Green, Olsen, Kruse & Cargo, 1997). Evidently, the Job Demand-Control Model is an influential theory for understanding how work characteristics relate to worker health, performance, and well-being.

As research on the model developed, increasing awareness of the complexity of occupational stress brought new dimensions to it, and in 1988 it was expanded to include social support (Johnson and Hall, 1988). The addition of social support reflected an understanding of work-related stressors and health by suggesting that high job control and high social support at work could buffer the effects of high job demands. However, the literature provides only moderate evidence for this relationship between job control, demand, and social support. For example, in a review of 20 years of empirical research of the Job Demand-Control (Support) model, Van der Doef & Maes (1999) confirmed that high demand and low control over work was associated with lower psychological wellbeing, decreased job satisfaction, burnout, and psychological distress, but that moderating effects of support were only found in cross-sectional studies. More recently Hausser, Mojzisch, Niesel and Schulz-Hardt (2010) systematically reviewed 83 studies investigating the Job Demand-Control (-Support) Model. Again, the authors present consistent findings that demonstrate employees experience both job strain and low levels of wellbeing.
when they experience increased job demands and low job control, but overall, report weaker support for the buffer hypothesis of the Job-Demand-Control-Support Model.

Despite the significant contributions of the Demand-Control (-Support) model, several limitations are identified in regard to its limited set of predictor variables (job demand, control, and social support) and its focus on negative outcome variables (Bakker & Demerouti, 2006). Karasek’s work has been criticized for not giving consideration to personal and non-work factors, such as the impact of personality traits, self-efficacy, self-esteem, socio-demographic status (education, income, and such), and health related behaviours contribute to employees psychological wellbeing (Loretto, Popham, Platt, Pavis, Hardy, Macleod, et al., 2005). Wall, Jackson, Mullarkey and Parker (1996) suggest that the measurement of job demands, which include statements such as “excessive work” or “work hard”, are too broad, and can be affected by self-report biasing factors. The result is a large variance in the main effect of job demands on psychological strain (which essentially impacts the models ability to properly demonstrate the interaction between demands and decision latitude). Lastly, there are conflicting findings about the validity of the model; in a review of 45 high-quality longitudinal studies, De Lange, Taris, Kompier, Houtman & Bongers (2003) found only modest support demonstrating that high demands and low control results in high job strain.

In 2001, Demerouti, Bakker, Nachreiner and Schaufeli addressed some of these issues with the introduction of the Job Demands-Resources Model. The Job Demands-Resources Model introduced a broader conceptualization of workplace mental health, and recognized the importance of resources, such as physical, psychological, social, and organizational aspects of the job that could reduce job demands or stimulate personal growth, learning, and development (Bakker & Demerouti, 2006). Llorens, Bakker, Schqufeli & Salanova (2006) tested the
robustness of the Job-Demand-Resources Model in Spanish and Dutch employees. They found a negative association between job resources and burnout, and that a lack of resources such as poor job control, lack of social support, and inadequate feedback are associated with high levels of burnout. This study provides evidence that supports the structural paths, or relationships, of the model even when they are applied in different national and occupational contexts. Furthermore, the Job-Demands-Resources model has been utilized to understand how worker burnout results from high job demands and limited job resources (Bakker, Demerouti, Taris, Schaufeli, & Schreurs, 2003), offering a basis for workplace interventions aimed at preventing or reducing burnout. One limitation is, however, the lack of empirical cut-off points to distinguish varying levels of risk for burnout (Bakker & Demerouti, 2006).

2.1.2 Healthy Workplace Models

The trajectory towards developing more comprehensive and inclusive models for work and mental health continued with the development of healthy workplace models in the 2000’s. Expanding beyond stress models, several variations of healthy workplace models have evolved. These newer models share commonalities in that they incorporate a holistic perspective of work and wellbeing, and account for factors that extend beyond the impact of work job stress on workers. The focus in these models has shifted from a perspective directed on worker stress to considering how mental health can be positively affected in the workplace. These healthy workplace models integrate a combination of approaches and include multiple avenues of influence on worker well-being (Canadian Mental Health Association, 2010).

For example, the Model of Healthy Work Organization (Wilson, DeJoy, Vandenberg, Richardson & McGrath, 2004) strives to identify the job and organizational characteristics of ‘healthy work organizations’. The authors define ‘healthy work organizations’ in relation to
research on traits of healthy companies and organizations, high-performance work systems; climate and culture factors; and socio-ecological models. Essentially, healthy work organization refers to “the idea that the structure and fabric of the organization, and how it functions can have a wide-ranging impact on the health and wellbeing of employees, and ultimately the effectiveness of the organization itself” (Wilson et al., 2004, p565). Using a questionnaire to survey 1,130 workers, Wilson et al. identified 29 first-order constructs (for example, values, beliefs, communication, role clarity, job security, and employee health) underlying six higher-order domains (for example, organizational attributes, climate, and employee health and wellbeing). Although the authors identify that the constructs for this theoretical model were selected based on evidence from the existing literature, they do not provide detailed explanation of how the specific dimensions were chosen.

Interventions derived from models of Healthy Work Organization have since been applied longitudinally across multiple sites (DeJoy, Wilson, Vandenberg, McGrath-Higgins & Griffin-Blake, 2010). Findings from DeJoy et al. indicate that interventions based on a model of healthy work organization can buffer the negative effects of internal corporate events and economic downturn. DeJoy et al. (2010) report using a five-stage model to work through the intervention process. The five phase problem-solving process consisted of familiarization, skill building, prioritization, action, and reaction. During the intervention process, a variety of structured activities are utilized, targeting improved team communication and cohesiveness (e.g. team mapping, mirroring), the development of problem solving skills (e.g. weighing pros and cons), time management skills (e.g. prioritizing tasks), and conflict resolution skills (e.g. anger control), (p.144). However, the interventions were tailored to 11 different intervention sites in the United States, and the authors did not distinguish which interventions were utilized in which sites. Thus the variability of both the problem identification and the generated solutions were not consistent
across the sites. Despite these promising findings, the non-standardized intervention strategy makes it difficult to reproduce the approach, and challenging to decipher which approach (or combination of approaches) was most effective.

Another leading model, the World Health Organization (WHO) Healthy Workplace Framework and Model (Burton, 2010), focuses on psychosocial issues, work-life balance, mental health issues and their impact on the safety and health of the workforce. By noting the importance of the interrelationships of work, health and community, this model incorporates elements from the physical work environment, the psychosocial work environment, personal health resources, and enterprise community involvement (how the enterprise affects, and is affected by the community). This holistic approach to understanding healthy workplaces includes a variety of psychosocial and physical factors, as well as organizational culture as predictors of healthy workplaces. No formal empirical evaluation of the WHO Healthy Workplace Framework could be found, presumably because evaluations of such frameworks are very challenging. This is because there are typically small sample sizes in evaluation studies, which leads to a lack of generalizability to other organizations (Ozminkowski & Goetzel, 2001).

An increased focus on organizational culture has placed emphasis on the values and beliefs that guide workplace behaviours, and has drawn attention to the role of factors such as communication, management practices, leadership style, work-life balance and human resource systems in understanding workplace mental health (Canadian Mental Health Association, 2010). Organizational culture has been identified as a key factor in preventing mental health issues in the workplace. Its inclusion in healthy workplace models and theories provides further context for analysis and intervention (Dextras-Gauthier, Marchand & Haines, 2012). However, there are limitations to research on organizational culture as a factor associated with mental health.
Ostroff, Shin and Kinicki (2005) draw our attention to the subcultures that exist within an organization, which can make organizational-level predictions rather uncertain. Culture strength, which refers to the extent and strength of shared organizational values, may also result in a variance in associations between culture, work organization conditions, and mental health (Gelfand, Nishii, & Raver, 2006). In spite of these challenges, consideration of organizational culture contributes to a deeper understanding of mental health problems in the workplace.

The importance of organizational culture has also raised awareness of the employer’s duty to provide a psychologically safe workplace. This heightened awareness is a result of the increasing number of mental health related legal claims filed under occupational health and safety, human rights laws, and across a broad legal spectrum including labour relations, employment standards, tort law (negligence), and workers’ compensation (Shane & Nassar, 2009). For example, legal liability trends from 2001 through to 2010 have demonstrated an increase in claims regarding harassment, discrimination, bullying, verbal abuse, unfairness, and compassion, which increased the number of cases of workers experiencing clinical depression, anxiety disorders, and demoralization (Shane & Nassar, 2009). These trends have resulted in increased pressures to address mental health issues within the workplace, and Shane and Nassar (2009, p.1) refer to the current state of affairs as “a perfect legal storm”. Psychosocial risk factors, such as workload, social support, recognition and reward, respect, skills, and interpersonal relationships have gained increased importance in workplace mental health (Kelloway & Day, 2005). They are essentially organizational factors that impact the psychological health and safety of employees. In a recent meta-analysis of psychosocial work stressors and mental ill health, there was robust evidence that the psychosocial work environment is important for mental health (Stansfeld & Candy, 2006).
In response to this mounting evidence, Canada has introduced a voluntary National Standard for Psychological Health and Safety to “provide guidance for employers, employees and employee representatives who are interested in protecting and promoting the psychological health and safety of workers” (Mental Health Commission of Canada [MHCC], n.d, p.3; Shane, Arnold & GermAnn, n.d.; Shane & Nassar, 2009). It is an initiative set forth to ameliorate the problem of increasing legal, economic and social concerns regarding mental health problems in the workplace. The introduction of the Canadian National Standard for Psychological Health and Safety in the Workplace identifies 13 organizational factors that impact organizational health. These organizational factors include psychological and social support, clear leadership and expectations, civility and respect, growth and development, workload management, engagement, and balance (MHCC, 2015). The introduction of the Standard represents a shift in thinking in that the protection of workers also includes not only their physical safety, but also attending to their psychological (mental) health and safety (MHCC, 2012).

In summary, these broad healthy workplace models, frameworks, and the standards that are based on these models, bring to light the importance of employees and employers working together to create health promoting work environments. Moreover, they draw attention to the need to protect and promote the health, safety, and well-being of workers through the psychosocial work environment, including the organization of work and workplace culture (Burton, 2010). Although these comprehensive models have been criticized because they are complex, hard to support, and lack predictive validity (Wilson et al., 2004), they also offer new insights into the multifaceted and multilayered nature of workplace mental health.

2.2 An Institutional Ethnography Approach to the Study of Workplace Mental Health
The review of workplace mental health research that has been summarized above has shed light on a series of relevant insights. However, it has also exposed a set of gaps and raised several important questions. The dominant models and theoretical frameworks that address workplace mental health have been based largely on positivist research that has established causal or correlational relationships between person, occupational, and environmental factors. Intervention strategies to improve workplace mental health are based on these theories and models, and utilize various methods and approaches that target individual, group, organizational level, and environmental factors. However, workplace mental health remains of growing concern, in part, because there is a lack of strong evidence shedding light on the human dynamics that support (or undermine) these types of interventions. Furthermore, none of these approaches were developed with consideration as to how the experience of the thinking, knowing, and feeling worker is co-coordinated by their participation within the broader perspective of workplace policies, procedures, and related bureaucratic processes.

The institutional ethnography approach is premised on the idea of providing an alternative to what its founder, Dorothy Smith, argued to be the fundamental ideological practices that grounded traditional sociological perspectives. Through Smith’s personal lived experiences – as a woman and as an academic - she became cognizant that sociological methods, conceptual schemes, and theories had evolved from the (often presumptive) standpoint of men, thus creating a disjuncture between how women experience the world and the associated dominant concepts and theories (Smith, 1990). By reconstructing how she connected with academic life and her everyday life with children, Smith also reconstructed various aspects of sociology in order to “discover how our everyday worlds are being put together within social relations beyond the scope of our experience” (Smith, 2005, p32). It is from this perspective that we elucidate the social relations that organize people’s experiences. Institutional ethnography as an approach to
investigation offers new insights into how the worker’s lived experience of mental health problems are organized in the workplace, and allows us to explore how ruling practices organize those experiences.

In order to explore the evolution of Smith’s approach, the remaining content of this chapter will briefly describe her lived experience and critical stance on traditional sociological practices. I will discuss the origins and foundations of the institutional ethnographic approach, and the contribution of Marxism and feminism by detailing the theoretical underpinning and philosophical foundations of institutional ethnography. I will then discuss some of the methodological issues that are often raised when using institutional ethnography. Finally, I will conclude this section with a summary of the basic tenets of institutional ethnography and their application in practice, and the research practices that were adopted in this study.

2.2.1 Origins and Foundations of the IE Approach

To appreciate the unique goals and purposes of institutional ethnography as it will be applied in this dissertation, it is important to first understand the early influences that shaped Smith’s approach to inquiry. Smith’s unique approach to inquiry was driven in several ways by her experience in the women’s movement and the concept of a dual consciousness; that is, Smith’s own work within the university as a student and teacher was organized by an entirely different mode of consciousness than her work at home as a wife and mother. She noted that her work at home and in the university was connected to, and organized by relations beyond her local setting. These relations were based in and coordinated by texts, thus giving rise to the concern for text-mediated relations as a form through which power is generated and held in contemporary society (Smith, 1996, p176). Material texts organize relations between and within institutions, and they produce both recording and reporting procedures of formal organizations. Smith’s examination
of how texts organize activities locally and translocally endeavour to shed light on the ideological and social processes that produce peoples every day experiences.

Smith’s experience of the contentious upsurge of non-positivist approaches to inquiry in sociology and the social sciences more broadly is also evident in her work. Instead of using traditional sociological approaches that explained or interpreted social interaction, Smith drew from among others Harold Garfinkel and his work in ethnomethodology. Ethnomethodology views people’s mutually-accountable, co-coordination of activities as integral to any account of what was happening, and as central to the active accomplishment of the social ordering of an interaction. As a response to the structuralism that dominated sociological thinking of the period, Garfinkel criticized the apparent autonomy of such structures (an organization or procedure) noting the way in which these dominant schools of thought made the active role of people in creating and experiencing the patterns of activity all but invisible (Garfinkel 1967; Garfinkel and Sacks 1970; see also Heritage 1984; Rawls 2008). In response, Garfinkel used a different approach to social inquiry; he did not use a theoretical lens to view social practices, he observed the world directly and described the methods people used to make sense of their world. The term of ‘ethnomethodology’ comes from Garfinkel’s argument that social orders depend on constant attention to, and display of shared member’s methods, and do not rely on formal structures or individual motivation (Rawls, 2008). As mainstream sociology oriented toward external sources of control, such as institutions, to understand and explain social practices, Garfinkel focused on the day-to-day work of a society’s members. He argued that researchers who entered the field with a predetermined theoretical orientation would ultimately miss out on (and mis-understand) the real world actualities of people’s daily experiences. Therefore, Garfinkel emphasises the details of the co-coordinated accomplishment of work practices as opposed to creating categories
and concepts that, alternatively, organize and subsume how these activities are actually being
done.

Several key aspects of ethnomethodology are reflected in institutional ethnography.
Foundationally, ethnomethodology proposes that facts are treated as social accomplishments, and
studying a member’s knowledge of their everyday activities can be done because their
knowledge has a recognizable order (Campbell, 2003). For example, Garfinkel argued that the
notion of information could not exist without social practices, and emphasizes the importance of
the sequential relationships between items in a social process. He proposed that social
organization and the appearance of social order are in fact produced by shared practices, and it is
the continuity of these practices that leads to objectivity and creates information as a social
object. This concept draws our attention to the challenges of considering information and objects
in abstraction, and highlights the importance of how things are constituted in situated social
contexts, through shared member’s methods (Rawls, 2008). However, despite these insights and
contributions, Smith still sought to further understand some additional dimensions of the reality
constituted by people’s practices. As distinct from the localized co-construction of meaning and
reality, Smith did not want to limit her approach simply to the analysis of discrete events that
represented only a portion of a person’s everyday lived experience. Smith argues that by
assembling the world in an orderly fashion according to these mainstream approaches, it is
wrongly assumed that the actualities of the everyday world are “unformed and unorganized and
that the sociologist cannot enter them without a conceptual framework which selects, assembles,
and orders them” (Smith, 1975, p.368). Objectifying the social relations that organize our lives in
this way, she argues, disregards the embodied experience and actualities of people’s everyday
lives, and in turn leads to a fundamental mis-interpretation of how the social world works.
Smith provides examples of the effects of traditional conceptual frameworks that deal with everyday life through her reading of the work of Goffman (1959). In her critique, she focuses on the distinction between everyday life as resource for studying the social – i.e. as constituting a *problematic* – as opposed to those researchers focused on everyday life as a strictly localized *phenomenon* (Smith 1975, pp.367-368). As an example of the latter, Goffman’s dramaturgical analysis produced a set of categories from which he contends social life can be studied. This framework includes categories such as front stage, back stage, settings, and regions, which present accounts of social interaction in everyday life, thus a method that focuses on the everyday world as a *phenomenon* that can be observed and named. Smith argues that approaches such as Goffman’s leave the broader social organizing of people’s experiences unexamined. Smith states:

> These and other strategies, which focus on the everyday world as phenomenon, serve to isolate it as a discrete focus of inquiry, though the strategies adopted in achieving this effect are various. The concept of a problematic is used in part to bring the sociologist and the sociological inquiry into a different relation to the society by constituting the everyday world as that in which questions originate. The term "problematic" is ordinarily used to talk about matters at the level of concept or theory rather than at the level of experience and action. (It is not incidentally to be confused with the concept of problem). I am suggesting that the social organization and determinations of the everyday world may be constituted as a problematic in the course of inquiry (Smith 1975, p.368).

Regarding the focus of this dissertation specifically, we also gain further insight into the development of Smith’s thinking in her earlier, seminal work. In the article “*K is Mentally Ill:*
The Anatomy of a Factual Account” (1990), Smith demonstrates how the concept of mental illness is socially constructed through the active co-coordination of activities. Drawing from a student paper that was produced to describe how an individual came to be defined by her friends as mentally ill, Smith explicates the interpretation of the text as a method of reading, and demonstrates the social organization of an account. Although Smith contends that there are no clear norms to categorize individuals as mentally ill, she states that there “must therefore be some set of rules or procedures for representing behaviour as mentally ill types of behavior and those procedures must meet the normative conditions for recognizing individuals as members of the class of personal who are mentally ill” (1990, p.15). Smith argues that the features of making sense in ordinary ways are noteworthy in themselves (Campbell, 2003). For Smith, this analysis leads to additional claims as to the importance of texts and textual practices as sources of meaning. It also demonstrated that when the account of mental illness is made visible as people’s practices, we can see how people arrive at particular meanings.

Smith explored how people used concepts, such as the concept of mental illness, to define or more specifically socially establish someone as “mentally ill”. In order to do this, again she made the experience of the individual central to her research approach. Exploring how concepts and ideas had been put together from the inside (as opposed to looking from them both externally as well as non-sequentially) allowed her to transcend the micro/macro divide and exposes the interconnectivity between local and trans-local activity. Furthermore, Smith’s emphasis on people’s everyday experiences directly addresses the issue of interconnectivity, and demonstrates how our lived experiences are connected to, or as she says “hooked up” to complexities and relations that extend beyond our immediate actualities (Smith 2005, p.40). From her approach,

1 This work was conducted in the 1970’s, and not published until 1990.
Smith is able to extend beyond the local and/or face-to-face interactions, and determine how our experiences are shaped by the social relations that are embedded in co-coordinated sequences of action.

In this sense, we can begin to see how information can be gleaned from the established yet interactive collective representation of social norms, resulting in the construction of, or accounting for, an individual’s actuality. And again, as distinct from either Garfinkel’s or Goffman’s approaches, Smith draws political relevance into the analysis by establishing the ruling relations that are likewise responsible for organizing and shaping the experience of the individual (Clough, 1993). Again by example, in *K is Mentally Ill* Smith dissects how a factual account of a mental illness was created within the dominant medical/psychiatric discourse, and she illustrates how alternate interpretations of behavior, including the individual’s own account, are excluded. By explicating the social processes that produce the experience of subordination, Smith developed institutional ethnography as a distinctive sociology for people, not just about them (Holstein, 2006).

### 2.2.2 The Influence of Feminism and Marxism

As noted, the women’s movement heavily influenced Smith’s work as it acknowledged women’s every day experience, thus giving this shared experience a political presence. It created opportunity to explore the subjectivity of knowing, and provided opportunity for the knower’s own, socially-distinguished, experience to become central to research (Campbell, 2003). And as we saw, Smith drew from her own experience in terms of the stark contrast in ‘knowing’ between her responsibilities as a wife and mother at home, and her expectations as a scholar at work. She recognized that she had to suppress the knowledge from her everyday world, and
“contrasted embodied knowing with abstract conceptual knowledge” (Campbell, 2003, p.15). In summary, Smith states:

I had learned from the women’s movement that I was not bound to observe the conventions laid down by men that constructed the relevancies of my thinking. I understood therefore that I could move from what was going on around me to the world of theory and back (Smith, 1987).

Supporting Smith’s feminist position was the work of Marx. Though lacking Garfinkel’s or Goffman’s detailed discussion of specific forms of social interaction dynamics, nevertheless Smith highlighted how it was Marx who located social science in people’s activities, through a central concern for social relations and material conditions (Smith, 1990). This approach placed emphasis on social being rather than simply consciousness or conditions. This paralleled Smith’s concern for the importance of everyday working knowledge, and how people co-coordinate their actions within (and sometimes against) ruling regimes. Building from this, Smith made a material connection for analysis in the course of underpinning her concern for locating visible and invisible expressions of power (Campbell, 2003). Combined with her observations about the link between the local and extralocal coordinating relations within and beyond people’s experiences, it was from this perspective that Smith first sought to to understand how relations between men and women are organized (Campbell, 2003). In order to understand these relations, issues of power and ruling relations, understood from the standpoint of women (and women-workers) had to be taken up in order to build an account of how things actually unfold, thus showing how, with their active involvement, a person’s every day experience was organized across time and space.
Smith’s Marxist feminist approach is grounded in her experience as a woman in the workforce during the women’s movement in the late 1960’s and early 1970’s, however it was also during this time that many other feminist scholars noted that one’s social situation “enables and sets limits on what one can know” (Harding, 1993, p. 54-55). Women’s lives, which were organized in part to maintain capitalist as well as patriarchal social relations, were focused on the work that men did not want to do. This included cleaning and taking care of people and their bodies, thus freeing men to immerse themselves in the world of abstract concepts (Harding, 1993). Smith argued that women’s experience was the foundation of feminist knowledge, and could very much inform a new way of seeing the world. She contended that in order to understand the gendered world from a non-dominant perspective, it was imperative to begin from the actualities of women’s lived experience. This was because the work required in the domestic sphere was all but invisible from the dominant group’s perspective. Therefore women’s lives could provide the starting point for asking critical questions, and to explore relations in a different way.

A detailed review of the history of feminist standpoint theory is beyond the scope of this paper, but it is important to note that the premise of standpoint theory is its claim that:

…in societies stratified by race, ethnicity, class, gender, sexuality, or some of other such politics shaping the very structure of a society, the activities of those at the top both organize and set limits on what person who perform such activities can understand about themselves and the world around them (Harding, 1993, p. 54).

For Smith, it was important that feminist perspectives explored experience as a way of discovering the social from the standpoint of women. Smith did not intend for the standpoint theory to claim that women’s experience was necessarily privileged in some way (Smith, 1997).
Rather, she uses the notion of standpoint to draw our attention to the importance of experience, which is fundamental to the women’s movement:

Experience gives direct access to the necessarily social character of people’s worlds; it is in how people talk, the categories they use, the realizations implicitly posited among them, and so forth, and in what is taken for granted in their talk, as well as in what they can talk about” (Smith, 1997, p. 394).

A standpoint then, becomes a methodological device that helps us view the social organization of a particular institution from outside of it, and allows us to explore the social relations that shape and produce it. It is for this reason that institutional ethnography began as a sociology for women, and then became a sociology for people.

As discussed earlier, Smith rejects the dominance of theory as giving rise to the notion of an autonomous structure simply dictating and ordering what people do, and instead takes the concept of a “standpoint” as a core element of a method of inquiry. Smith’s “standpoint” is unique and pivotal in her efforts to understand the actualities of people’s everyday lives. Specifically, it serves as a point of entry into the social that “does not subordinate the knowing subject to objectified forms of knowledge of society” (Smith, 2005, p.10). In the context of her recognition of issues of power and relations of ruling, Smith’s approach to standpoint is often taken from the perspective of a marginalized individuals or groups of people, and can be used as a tool for advocacy and activism. Institutional ethnography is often undertaken with critical or liberatory goals (Holstein, 2006), and it begins with everyday experience of people. It is a method of inquiry that works from the actualities of people’s everyday lives to discover the social as it extends beyond experience (2005, p.10). It is this politicized aspect of Smith’s approach that indeed sets institutional ethnography apart from other approaches to inquiry. The explication of
ruling relations provides opportunity to generate strategies to enact change, thus conducting research in the interest of people.

2.2.3 An Alternative Sociology

The theory behind institutional ethnography represents an ontological shift in thinking toward what Smith has called “the ontology of the social; meaning that what IE is aiming to discover really happens or is happening, and it can be explored and explicated” (2005, p. 209). Smith argues that the local and everyday lived experience of people are reconstituted as “data” so that they fit into categories or frameworks, thus reducing these experiences to concepts in order to produce generalized statements (Smith, 1975). Institutional ethnography necessitates a shift in perceiving the everyday world as the locus of the problematic, and therefore does not subsume people’s local activities. In order to further demonstrate how institutional ethnography presents as an alternative sociology, this section of the paper will provide a summary of the working principles of institutional ethnography. It will bring to light key aspects that differentiate institutional ethnography from other traditional sociological approaches, including the coordinating practices of ruling relations, the concept of work knowledge, and the importance of mapping.

The overall objective of institutional ethnography is to understand how everyday experiences are determined through the interactions and experiences of individuals and governing organizational regulations (Campbell & Gregor, 2004). Smith describes the process in terms of “a complex of ruling relations” (p.19) that are organized around a particular function; “ruling relations” refers to the multiple activities of individuals, organizations, professional associations, agencies and the discourses they produce and circulate (as cited in Mykhalovskiy & McCoy, 2002). The social relations that organize these experiences at the local level can then be explicated to help
elucidate such ruling relations, which are formally defined as the “…complex of relations that are textually mediated, that connect us across space and time and organize our everyday lives—the corporations, government bureaucracies, academic and professional discourses, mass media, and the complex of relations that interconnect them” (Smith, 2005, p.10). Institutional ethnography is used to investigate how experiences are socially constructed, and how people coordinate and are coordinated in the course of their activities to produce institutional practices.

People’s everyday lived experiences are fundamental to the institutional ethnographic approach; therefore, exploring people’s “work knowledge” is the starting place for investigation. Work knowledge is what is produced when the institutional ethnographer collaborates with an informant to explain and describe what people know of their doing, and then explicates what they do that ordinarily remains unspoken (Smith, 2005). This notion is significant, as it will bring to light how institutional processes, known as practices that create and/or disseminate information, are socially organized. Work practices are not reinterpreted in the analysis; instead, it is through the identification of work practices of informants that sequences can be fitted together so that a perspective on the organizational form can emerge (Smith, 2005).

People’s work knowledge and information gathered through interviews, the observation of activities, and texts can be mapped out how work processes and texts are related to each other in the setting. Mapping is an analytic tool, aimed at visually explaining the institutional processes that are uncovered (Campbell & Gregor, 2004, p.34). Mapping reveals institutional processes and actions, rather than providing accounts of individual experiences. This process is much more than producing a chart, as it accounts for a portrayal of both observable work processes and the social organization that connects these processes. Mapping focuses first on activities with texts and then what people do with texts, as a situated account of how a text occurs. Through this
process, it is possible to identify how texts draw in multiple actors, and how work, power, and activities are coordinated across settings and time (Turner, 2006). This perspective will create a map of how things work beyond our everyday knowledge, and explicate how translocal processes are embedded in local experiences (Ng & Mirchandani, 2008).

2.2.4 Methodological Issues and Interpretation: The Difference IE Makes

The methodology associated with IE includes such things as observation, interviews, focus groups, text analysis (paper, electronic file, artistic representation, law, academia, policy) and mapping (Wright & Rocco, 2007). As institutional ethnography requires an ontological shift in thinking from traditional research, many of the standard methodological issues related to qualitative research are reconsidered. The next section of the paper will discuss several aspects of empiricism as it relates to institutional ethnography. In particular, I will discuss the notions of researcher bias, saturation and sample size. I will then provide insights into key approaches that make institutional ethnography unique. This will include the use of texts and mapping as analytic tools.

Traditional sociological approaches treat social order as a fact, whereas alternative approaches such as ethnomethodology and institutional ethnography work to uncover and make visible the work required to produce social order (Heap, 1908). Institutional ethnography draws from ethnomethodology in that it seeks to describe the work required to produce orderliness in activity (Heap, 1980). Because institutional ethnography begins with a problematic and uses the standpoint as the entry point to investigation, as discussed above, the notion of researcher bias is reconsidered significantly. The researcher is not claiming an objective account, and they cannot artificially separate themselves from the research (G. Smith, Mykhalovskij & Weatherbee, 2006). The problematic of the research frames the researcher’s interviews and observations;
therefore, the intent of the research is presented at the outset of the investigation. As far as they involve notions of research bias, subjective feelings do not inform institutional ethnographic research; instead the lived experience of people will explicate the practices and social relations that shape the individual’s experience. Furthermore, institutional ethnography is considered an activist approach, with the practical goal of producing knowledge that can be applied in specific settings. This inherently requires a particular perspective from which the research will be carried out, but this is not the same as conventional notions of researcher bias as such

Concepts such as sample size must also be reconsidered in institutional ethnographic research. There is no sample, as the research is not intended to be representative of a particular population. Instead, institutional ethnographers gather a range of experiences in order to understand how the local is hooked into, or co-coordinated translocally. Institutional processes come to light once the researcher speaks with a number of people about their lived experience and associated work activities. There is no pre-determined or defined set number of people to interview; the institutional ethnographer speaks with the number of informants that are required to explicate coordinating activities, and bring to light how experiences are socially organized. The research is not intended to be generalizable in the sense of representativeness. On this point Smith (1975) states the following:

Explanations are not formal; they are increasingly explications and descriptions of actual processes of social organization. Situations, types, forms of social organization are seen to recur, not as a function of the sociologist’s artful work using social actualities as a resource, but because there is an underlying organization of social and material relations which generates them as “the same” (p. 374).
We can begin to see how institutional ethnography works to understand a total process, examining interdependence across and between local and translocal co-coordinating practices. The organization of the everyday world is social, and not unique to one specific occasion.

Similarly, the notion of data saturation in the conventional sense is significantly reconsidered as well. Data saturation most often refers to “theoretical saturation” or when:

..no additional data are being found whereby the (researcher) can develop properties of the category. As he sees similar instances over and over again, the researcher becomes empirically confident that a category is saturated…when one category is saturated, nothing remains but to go on to new groups for data on other categories, and attempt to saturate these categories also (Glaser & Strauss, 1967, p. 65).

However, institutional ethnography does not employ a summative interpretive framework to data, nor does it seek to generate theory. Instead, it provides an account or a description of how things work. Explanations are not formal; they are increasingly explications and descriptions of actual processes of social organization. Situations, types, forms of social organization are seen to recur, not as a function of the sociologist’s interpretations, but because there is an underlying organization of social and material relations which generates them as “the same” (Smith, 1975, p. 374). Thus, to the degree that notions of saturation are relevant, it is only in this limited (unconventional) sense. And, while topics emerge from the reading of transcripts, we also note that interpretations are not imposed. Instead of trying to find an explanation or cause, institutional ethnography seeks to shed light on how social organization is oriented to, or through, materials such as texts (Heap, 1980).
Texts and documents are important in institutional ethnography as they play a key role in coordinating and organizing the activities of the worker experiencing mental health issues in the workplace. However, texts are not analyzed in a traditional interpretive fashion either; instead they are analyzed for their coordinating actions. For example, recursion, or the replicable nature of activities coordinated by texts, organizes the local experience of individuals while organizing extra-locally through the same texts at other times and places (Smith et al., 1990). Texts “…will make it possible to go from particular events in local settings to a set of general, textually mediated social relations because they have the same social form” (Smith et al., 1990, p. 179).

Once information about peoples’ experience and work is gathered, the institutional ethnographer can explicate how it is sequenced, or socially organized to “…discover how the person positioned next in a sequence picks up and builds on what has been done at the previous stage” (Smith, 2005, p. 211). Findings from the analysis can explicate what is actually happening to the worker with mental health issues, which will then result in the identification of institutional processes that can be enhanced and/or altered to better support workers with mental health issues.

Mapping offers a unique perspective, and is a key analytical tool that can be used in institutional ethnography. It provides a point of entry into the research, and aids the development of an analytic description. Mapping these process identifies how texts are linked, coordinated, and have shaped the social organization and experience of people. Through the mapping process, it is possible to identify how texts draw in multiple actors, and how work, power, and activities are shifted from one source to another and coordinated across settings and time (Turner, 2006).

Recursion, or the replicable nature of activities coordinate by texts, organizes the local experience of individuals while organizing extra-locally through the same texts at other times and places (Smith et al., 1990). The resulting textually mediated social relations can help us
understand local experiences and translocal ruling relations by elucidating how the reading of a
text enters people into particular relations with others in other places.

2.2.5 My Use of Institutional Ethnography in this Study

My personal experience as an occupational therapist working with people living with mental
health problems influenced the questions that have become central to my research. How do
institutional practices and associated social relations coordinate the workplace experience of
workers living with mental health issues? What types of challenges emerge in the workplace for
someone experiencing mental health issues? What is the interface between having mental health
issues and accessing help in the workplace? In essence, what social relations and institutional
practices contribute to the decision not to disclose mental health issues in the workplace? It is
the experience of mental health issues in the workplace, the co-coordination, and the
organization of these institutional structures and ruling relations that is examined in my research.
Therefore, this study explains how social and ruling relations ultimately shape and coordinate the
experience of the worker living with mental health problems. Insights gleaned from
investigating co-coordinating practices from the standpoint of the worker offer new perspectives
into how workers are connected to, and participate in (both knowingly and unknowingly)
institutional practices and associated relations.

To date, there is minimal research that has investigated the social organization in the workplace
to better understand the active co-coordination of worker’s lived experience of mental health
issues, or explored how ruling practices organize those experiences. Although various factors
have been identified in qualitative and quantitative research to inform interventions to address
mental health issues in the workplace, these interventions remain largely unsuccessful in
reducing the social and economic costs of mental health in the workplace (Harvey et al., 2006;
Lyons, Hopley, Burton & Horrocks, 2009). Evidently, the workplace experience for individuals experiencing mental health problems remains a challenge, as mental health issues are not being adequately addressed. Individuals in Ontario experiencing mental health issues in the workplace are protected by legislation (Ontario Human Rights Code, 2009) and now have a variety of resources and supports in place; yet the concerns of mental health issues in the workplace continues to grow. The result is a disjuncture between the institutional relations inside (locally) and outside (translocally) of the workplace, and the lived actuality of the workers’ embodied experience.

It is the experience of workers with mental health problems that has become the problematic of my investigation. The problematic can be described as the question of how such experiences are produced (DeVault & McCoy, 2006). The problematic does not come from theory, but instead the actualities of people’s lives and how they participate in, or are hooked up into, institutional relations (Smith, 2005). In order to investigate this problematic, we take the standpoint of the worker living with mental health problems. As established previously in this paper, taking up a standpoint is a methodological device that helps us view the social organization of work from the outside (Smith, 2005), and this perspective is then used in this research to investigate the institutional relations that create the problematic of my research. By taking up the standpoint of the worker experiencing mental health issues, I claim I am able to begin to offer an important contribution to better understanding of the problems, issues and concerns that these individuals encounter in their everyday working experiences.

Speaking concretely, data from this study came from an institutional ethnography that was conducted at a large industrial manufacturing plant in Ontario, Canada from June 2013 to January 2014. I conducted 140 hours of ethnographic observation over the duration of the
research project. This component of data collection included shadowing trades workers on the job, observing interactions in common areas such as the cafeteria, smoking areas, and staff lounge, and attending various team and organizational meetings such as shift changes and operations updates across all shifts: days, nights, and weekends. This provided opportunity for the researcher to learn about the organizational culture, and the type of language that was used to describe and discuss mental health problems. It also provided opportunity for the workers at the research site to become more familiar with me, and the purpose of my research.

As previously mentioned, the investigation began from the standpoint of workers with mental health problems; therefore I started with the accounts of workers who were experiencing mental health problems (n=4). By carefully listening to the accounts of work activities and processes that these individuals engaged in when they become mentally unwell, we were able to identify additional informants and various texts that coordinate support services and workplace processes and procedures. These additional informants also volunteered to be interviewed, and included employees in managerial-type positions (n=7); and other staff, such as union representatives, physicians, wellness team members, and human resources professionals (n=6). I also asked the human resources contact person for copies of all texts that were implicated in the work processes of the worker with mental ill health. “Texts” refer to words or images that are set into material form that can be read or seen, and as such, become constituents in the co-ordination of sequences of action and work (Smith 2006). These texts included policies, protocols, documents, pamphlets, and forms that informants referred to, used or implicated in their accounts of doing their everyday work.

Unlike many traditional research approaches, the purpose of this study was not to understand the generalized experience of mental health problems in the workplace. Instead, institutional
ethnography was used in this study to shed light on the social organization of mental health problems in the workplace. As opposed to trying to understand why people experience mental health issues in the workplace, I investigated how people’s behaviors and activities produce (and are produced through) institutional processes.
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Chapter 3
Organizational Culture Shock: Fieldwork Strategies for the Novice Health Science Researcher

3.1 Introduction

Ethnography is a both process and a product (Savage, 2000). It has been described as a “style of social science writing which draws upon the writer’s close observation of and involvement with people in a particular social setting, and relates the words spoken and the practices observed or experienced to the overall cultural framework within which they occurred” (Watson, 2011, p.205). The ethnographer spends long periods of time working with people within ‘the field’, or their native environment, in order to observe behaviour in the real-world context (Fetterman, 1998). The researcher is considered to be the primary tool of data collection, and will utilize observations and interviews to collect information about the people they wish to study (O’Reilly, 2012; Schensul, 1999). Deeply rooted in anthropology and frequently used in sociology, this research approach was not introduced into the health care field until the 1960’s and 1970’s (Cohen & Crabtree, 2008). Since that time, ethnography has become increasingly used in clinical and health care research; for example, Myra Bluebond-Langner’s pivotal work on the impact of childhood chronic disease on children and their families (Bluebond-Langner, 2000; 1980).

More specifically, ethnography has been proposed as an approach to investigate healthcare quality and safety (Leslie, 2014), interprofessional care delivery in intensive care (Paradis et al, 2014), and cultures within hospitals around the world (van der Geest & Finkler, 2004). Ethnography has also been used to explore the experiences of families who have kin in hospital...
(Perry, Lynam & Anderson, 2005), as well as how patients engage in healthcare decision-making (Young Garo, 1982). Savage (2006) contends that ethnography offers a holistic way of exploring the relationship between the different kinds of evidence that underpin clinical practice, and several authors advocate for its increased use as a qualitative methodology for the in depth study of health related issues (Parissopoulous, 2014; Savage, 2000; Venzon Cruz & Higginbottom, 2013). I argue that the burgeoning use of fieldwork in health science research warrants increased attention and better preparation of students to become proficient in ethnography as a research method. Specific to the health sciences, there are only a handful of accounts that discuss the logistical implications of conducting ethnographic research (Elsen & Monticelli, 2003; Moll, 2012), and some literature that addresses ethical aspects of conducting ethnography (Goodwin, Pope, Mort & Smith, 2003; Pope, 2005); however, there is a dearth of literature that also addresses the organizational politics and emotional trials and tribulations for researchers conducting ethnographic research within the health sciences field. Furthermore, there is little mention of the management skills that are required to navigate role contradictions in terms of the researcher-clinician role, and balancing the vested interests of primary stakeholders within the research project. Critical discussion of these issues can help to inform the novice health science researcher of the experience of fieldwork, and can be used to better prepare students prior to entering the field.

This article addresses this significant gap in the literature by providing a detailed account of the first author’s research experience of conducting an institutional ethnography (IE) that incorporated 140 hours of fieldwork observations. Institutional ethnography differs from traditional ethnography in that it is an approach used to investigate how our everyday experiences are shaped and produced through the coordination of various social and institutional relations (Smith, 1987; 2005; 2006). Thus, in IE, the coordination of these experiences becomes
the focus of investigation. However, many of the same techniques and approaches that are used in ethnography are also utilized in IE, such as observations and interviews to explicate how people understand, perceive, and negotiate institutional rules. Using Oberg’s (1960) four-phase account of culture shock and adjustment to new cultural environments, I will demonstrate how emotional, ethical, and role contradictions experienced by the novice health science researcher are rarely discussed, yet have a significant impact on the research process. The experience of culture shock and related feelings are considered ‘taboo’ within the anthropology community, as anthropologists are considered to be courageous, prepared, and well equipped to handle such experiences (Irwin, 2007). Alternatively, from a sociological perspective Blackman (2007) discusses the notion of ‘hidden ethnography’, where emotions related to research are readily discussed, though goes on to add that the data does not get published. In my own experience, I quickly learned that accounts of emotion and feelings related to my research cast doubt on the validity of my findings with colleagues. Moreover, if these issues are mentioned in the literature at all, it is often only in the limitations sections of the paper as an accounting for researcher bias.

This methodological reflection begins with my first exposure to ethnography as a PhD student researching workplace mental health in the Graduate Department of Rehabilitation Science at the University of Toronto. I entered into the program with over ten years of clinical experience working as an occupational therapist in mental health. I selected institutional ethnography (IE) as my approach to explore how people’s work activities and the associated texts and documents coordinated the experience of “mental ill health” in the workplace. Several other health science researchers have applied IE to explore social relations, in particular, to determine how institutional forces shape the experience of health care workers with mental health issues (Moll, Eakin, Franche & Strike, 2013), to critically analyse text-based management in nursing practice
(Rankin, 2003), and to examine professional tensions in client-centered occupational therapy practice (Townsend, 2003).

The institutional ethnography that I conducted was within a large industrial manufacturing company in Ontario, Canada. It involved several components, including fieldwork observations, interviews, and a review of relevant texts, documents, policies and procedures. The extensive fieldwork observation period allowed me to gain insight into how the workers talked about mental illness, and provided me with a context in which mental ill health was discussed. This also provided the opportunity for me to better understand how meanings of mental illness are produced and understood within this particular worksite. Additionally, as mental illness tends to be highly stigmatized, the fieldwork observation period provided me with an opportunity to familiarize the workplace with my purpose and objective, and was used as strategy to build rapport and reduce any perceived barriers for workers to share their stories. By using Oberg’s (1960) notion of culture shock as a framework, I draw attention to specific events, activities, and dilemmas that shaped my experience. I provide detailed examples of role contradictions in being both a researcher and clinician, highlight ethical implications for decision-making, and discuss emotional implications of ethnography in efforts to help inform other novice health science researchers using extensive fieldwork methods in their projects. The paper concludes with a set of recommendations for strategies to be used by novice health science researchers to effectively negotiate some of the typical dilemmas experienced in this type of research.

3.2 Ethnography and the Notion of Culture Shock

Although 140 hours of ethnographic observations by no means equates to a significant amount of time in the field compared to traditional anthropological research, it still became apparent to me that I had experienced what Oberg (1960) coined “culture shock”. The concept of culture shock
originated in the mid-20th century, and the term is still used to describe the state that is “precipitated by the anxiety that results from losing all our familiar signs and symbols of social intercourse” (Oberg, 1960, p142). Originally considered a phenomenon that anthropological researchers experienced in far away and/or remote research locations, literature is now beginning to acknowledge that culture shock can also occur when people enter into other new environments such as school, work, towns, or organizations (Cushman, 2007; Griffiths, Winstanley & Gabriel, 2004).

Consequently, I will use Oberg’s (1960) classic four-stage model of culture shock to describe both my adjustment to the research site - a North American industrial manufacturing plant - during my ethnographic fieldwork experience, and the research process. These four stages include: (1) the initial Honeymoon Stage, where individuals are fascinated by the new environment/culture; (2) the transition to the Negotiation and Hostility Stage, where individuals experience difficulty in the process of adjustment to the new environment; (3) the Regression Stage when the individual develops a sense of disappointment and critical views; and (4) the Recovery Stage when the individual starts to experience adjustment and acceptance. I will then provide suggestions to aid other novice health science researchers in the use of ethnography within new organizational or workplace cultures.

3.3 Stage 1: The Honeymoon

Oberg (1960) states that the honeymoon stage of entering into a new culture may last from a few days or weeks; to up to six months but that the duration is shortened if one is forced to cope with challenging conditions. In the case of my research, there were many challenges in securing a site for my investigation, as most organizations I approached were not interested in engaging in research related to workplace mental health. I was ecstatic when I finally received an expression
of interest from a potential research site. My honeymoon period began with the news that I had been given approval by the corporate head office and the local site to proceed with the research. An ethics application and legal agreement were soon underway, and I was very excited to start my research project within this industrial manufacturing company that employed over 200 employees. After following recommendations from published literature on how to best negotiate and maintain access to the research site (Bondy, 2013; Moll, 2012), I felt well prepared. A research advisory committee (RAC) was assembled to help devise an entry strategy and provide ongoing support. The RAC was compiled of representatives from human resources (HR), each of the two unions, various levels of management, and frontline staff. After discussing my research proposal, the entire team was on board, and everyone appeared to be very supportive of the initiative.

An email introducing my project was sent from HR to all staff. It contained a brief biography, an overview of the research project, and at the request of Human Resources, a personal photo so that the staff would recognize me and be able to ‘put a face to a name’. I strategically chose a photo taken with my newly rescued dog, a 170lb St. Bernard, hoping it might invite informal conversations with the workers. My first few days onsite were pleasant. I received an extensive tour of the facility, and was personally introduced to most of the workers by HR staff or team leaders. A lot of workers either commented on, or asked about my dog and shared stories about their own dogs. I also had formal orientation, which included health and safety training. I was provided with my own private office, which caused some initial confusion about my role as many of the workers thought I was offering in-house psychological counseling services. One worker commented, “When are you getting your therapy couch delivered to your office?” I used the question as an opportunity to clarify my role at the site, and to describe my research. For the most part, everyone was cordial and friendly. I started attending various meetings to talk about
my research to further increase my visibility. I also took advantage of the opportunity to work out in the on-site gym. This presented as another opportunity for the workers to get to know me, and to further generate informal discussion and conversations with staff.

I associate this ‘honeymoon’ phase of my research with becoming somewhat of a ‘temporary’ insider (Mullings, 1999, p349). Adler and Adler (1994) discuss the various roles that researchers assume, which range in degree from complete membership within the group being studied (an insider) to complete stranger (an outsider). Shortly after entering the field, I felt that I was being welcomed and accepted within the organization; thus moving along the continuum toward becoming more of an ‘insider’. Workers became less guarded around me, and they started to share more and more of their personal stories. I had a genuine interest in learning about their job duties, their roles, and perspectives on the workplace. They also asked me many questions about academia and the research process. I became aware of many of the workers’ personal and work-related struggles, frustrations, emotions, and perceptions. I ate dinner with them on the evening shift, and ‘hung out’ in the kitchen while preparing brunch on the Sunday morning shift. I was developing a deeper understanding of the everyday challenges of their work and home lives as I listened to stories about lay-offs, divorce, illness, families, hobbies, vacations, shiftwork, and job security.

The initial stages of my fieldwork were going very well; I was building rapport with the workers, a key priority for researchers in the field (Gaglio, Nelson & King, 2006; Pitts & Miller-Day, 2007). I had spent time learning industry acronyms, work processes, and terminology used within the plant. I was able to converse in their ‘work language’, and felt integrated and accepted into the community. I could not foresee any major challenges regarding the research
process, and I began to focus on my recruitment for interviews. Undoubtedly, the time I spent building rapport with the staff facilitated this process. Everything was going according to plan.

### 3.4 Stage 2: Negotiation and Hostility

Not knowing it at the time, I soon found myself in the ‘adjustment’ phase of my new cultural environment. Oberg’s (1960) second stage of culture shock is characterized by difficulties with the process of adjustment; a series of ‘troubles’ arise, and there is much frustration and disdain. I was becoming more and more aware of the workers’ stigma toward mental illness, the blurring of relationship boundaries, and how gender issues played out in this particular workplace.

Similar to other ethnographers (Dennis, 2009), I began asking myself a series of questions: Should an ethnographer intervene in the activities of the community/organization? Had I compromised my personal values and integrity by not addressing stigmatizing and discriminating comments? What are the boundaries between researcher, advocate, and ally? The following examples will shed light on how active involvement with research participants can challenge research ethics, and create significant ethical dilemmas for the researcher who faces tensions around choosing whether or not to intervene.

Although my initial orientation and observations in the plant went well, there were still a few workers who refused to speak with me, and others who remained extremely guarded in my presence. Colleagues of these workers had informed me that they had previous negative experiences with management within the organization, which caused them to distrust anyone who was not a frontline worker. I tried very hard to be respectful of the workers’ space, and in situations where I felt I was not welcomed I would often relocate to another area to avoid intruding and inconveniencing the workers. As workers became more comfortable around me, they started using terms such as “crackpots”, “nuts”, “crazy”, and “insane” to describe
individuals living with mental illness. I frequently heard comments such as “You’ve come to study the insane asylum”, “Have you found any crazies yet? You’re not looking hard enough, they’re everywhere”, “If you interviewed me, I’d end up in a straightjacket” and “If we see any crazies, we’ll let you know”. Even though the purpose of my fieldwork was to better understand the culture and context in which the workers understood and spoke about mental illness, I found myself getting agitated and irritated by the workers’ recurrent derogatory comments and blatant expressions of stigma towards mental illness. I politely tried to provide information to these workers in a non-patronizing way, but they did not appear interested or invested in learning about mental illness. I considered the amount of time I could spend on trying to educate the workers versus the purpose of my research, and quickly came to realize that I could not single handedly provide an anti-stigma mental health campaign within the organization. I made a conscious effort to not intervene, thus potentially contributing to my difficulties in adjusting to the new environment by not taking measures to address my discomfort with their use of derogatory language and terminology.

Yet, on another level, once the people at the workplace became accustomed to my presence and more familiar with the purpose of my research, boundaries quickly began to blur. A new set of ethical dilemmas was introduced when I began interviewing workers; I struggled to maintain my position as a researcher and fought the urge to enact my clinical training during interviews. Many of the workers shared their personal experiences with mental illness, and it became increasingly difficult not to probe and question from a clinical perspective. Despite this instinct to enact my clinical training, I had to intentionally avoid engaging in counseling techniques, and reserve comments and advice about navigating resources within the community. Instead, I strictly adhered to the guidelines outlined in my ethics protocol and I provided the informants with a handout of local mental health resources that they could contact for further information. But I
had a nagging feeling that there was more I could do, rather should do, for these informants. I felt that I had failed some of the informants, as I knew many would not want to publically disclose their mental health issues or contact community resources for fear of stigma. They entrusted me with their stories and I had regular interaction with them in the workplace setting; yet I couldn’t do anything further to support them. Again, I found myself questioning my decision to not intervene.

Gender issues and conflicts between blue-collar and white-collar workers at the plant added another dimension of tension to my experience. As one of the few females onsite I was routinely made very aware of the hyper-masculine work environment. Safety and risk issues were often brought to my attention in a manner that emphasized the strength and bravado that was required to do the job. There was also a very clear chain of command that organized the workers according to their level of power and authority; this hierarchy of status was attained through training, credentials, or position title. In addition to these tensions, I also began to struggle with how to maintain my neutrality within the site. The management and administrative staff had generously allowed me access to their organization and seemed confident that I would present a favourable perspective of workplace mental health within their organization. However, I was orienting my research from the standpoint of the worker experiencing mental health issues. I had spent many hours and days alongside of these workers, learning of their daily routines and everyday struggles. I became caught between two opposing forces; being empathetic to the workers’ plight, but also feeling that I was indebted to senior management and administration for letting me into the plant. This put me in an extremely awkward situation. I was in a position where I would jeopardize my research if I ostracized either party.
Maintaining this delicate balance became harder as the workers began to relate to me as an advocate and an ally in their struggles with co-workers and management. I found myself making a critical error in judgment: I had finally decided to intervene. I relayed a female staff member’s concerns about working with a particular male coworker to management at her request. Despite my suggestion that she advocate for herself, I was empathetic to her plight of being one of the only females on staff. Because the nature of the concern involved staff safety, management had to take formal steps to address the issue, and word of my actions quickly spread throughout the plant. The dynamics of my relationship with all staff significantly changed; some for the better as I was seen as an advocate acting with integrity, but many others for the worse as my actions were also interpreted as intrusive and inappropriate with my role as a researcher. I had been completely ignorant of the impact this disclosure would have on my relationship with both the frontline workers and the management and administrative staff who had provided so much support for my research endeavor. My field notes reflected this sudden shift in dynamics:

Shortly after being informed that a formal process now had to be enacted to properly address the issue, [my primary contact] asked for my office key back. It was very awkward and uncomfortable for me as it felt like I wasn’t welcome there any more, and that I was being shoved out the door or punished in some way by having my privileges revoked. It was very demoralizing and demeaning…I left shortly after with a very heavy heart as I felt I had disappointed everyone at the site.

I was angry for being put in such a position, irritated and bewildered by the response I received from many staff, and felt discontent towards the organization as a whole. I was overwhelmed, and didn’t want to cope with the fallout of my misguided actions; I just wanted to walk away from the research altogether.
Difficulties experienced with adjustment in this stage of the research project are not uncommon, neither are the ethical or political dilemmas faced by the researcher as to whether or not to intervene. An extreme example is provided by Vanderstaay (2005) when he describes how his attempts to intervene inadvertently led to a murder and the arrest and imprisonment of a research participant, a teenage drug dealer. Not all ethical dilemmas are of this magnitude; as I discovered, even dilemmas that seem minor by comparison can place the researcher in a compromising, or uncomfortable position. To facilitate an understanding of the dilemmas an ethnographer faces around the issue of intervening, Dennis (2009) describes three specific processes by which ethnographers might examine their ethical practices. The first process discussed by Dennis (2009) includes identifying modes of intervention, which could be interpersonal, administrative, enactment, and modeling interventions. Prior to relaying the staff’s concerns to management, I could have considered other means of intervention, such as encouraging the female staff member to write a letter to her manager if she wasn’t comfortable meeting with him in person to express her concerns. The second process that can be used to examine ethical practice would be articulating elements associated with the decision to intervene or not, which include reflection of researchers values, structural, and hermeneutic elements (institutional power relations among participants, goals of the project, trust/responsibility, egalitarianism, and inclusivity) (Dennis, 2009). Had I spent more time reflecting on the hierarchical nature of the organization and the limited number of women in the plant, I would have had a greater appreciation for the extent and nature of the concern that was expressed.

The third and final process is to articulate underlying ethical principles and critiquing practices by locating contradictions in one’s ethical claims. Dennis presents a complications and contradictions “BUT” formula (2009, p.144) which is very helpful in critically reflecting on these dilemmas. The formula first identifies the ethical practice, and then points out
contradictions inherent in our ethical principles by using “BUT” statements to highlight contractions and limits in the ethical practices of intervening. Had I used this formula, I could have located the contradictions in my ethical claims and critiqued the associated practices. For example, the statement “I should remain neutral in regard to my research site participants BUT when a female worker expressed concerns I took it upon myself to advocate on her behalf” would have drawn my attention to the contradictions and limitations in intervening. Upon reflection of these principles, I should have contemplated alternate modes of intervention, and given greater consideration to the institutional power relations among the staff.

3.5 Stage 3: Regression

Just over four months into my data collection I had completed almost all of my interviews, and gathered all of the texts and documents that I required for my analysis. I started to sincerely regret the decision to engage in such a high level of intimacy with the workers at the plant. I no longer wanted to physically go into the plant, and I certainly did not want to interact with the staff. Oberg’s (1960) notion of regression is characterized by extreme disappointment and a highly critical view of the new environment, which is exactly what I was feeling. Even despite the fallout from the incident that had changed the trajectory of my research process, I reflected on the amount of time, energy, and emotional investment I had put into my data collection. I began to contrast my experience with that of my academic peers who were using quantitative research, and I became very envious of their clear-cut, straightforward, and predetermined protocols. The amount of energy invested in negotiating interpersonal relationships felt overwhelming.

As I had already collected most of the data that was required for my project, it was no longer necessary for me to be immersed in the day-to-day activities of the worksite. Therefore, I
decreased the frequency and duration of my visits. At this stage of my research I no longer felt like an insider, and by all accounts I had found myself as an ‘outsider’. An example of this emotional shift along the continuum of insider and outsider is described in my notes:

At the start of the night shift, the first thing that was made VERY clear to me was that I was no longer welcome by the team leader. He pulled me aside and said “you know everyone leaves here by 4, there’s no one left, just [this trade]; everyone else is gone”. I suddenly felt that I was in uninvited space and/or intruding …that it was unacceptable for me to be there. Some of the other workers started making small talk with me, but the team lead remained very removed and ignored me for the most part. I left early because it just felt too awkward to stick around.

Understandably, I had the perception that I lost the trust of some of the workers; therefore, I was treated with a more formal and detached approach. These types of shifts along the continuum of insider and outsider in the research process are commonplace, and they can be described as a common back and forth process that occurs when situations involving different values arise (Mercer, 2007). However, the experience was still unpleasant. As an outsider, I was no longer privy to candid conversations or informal discussions with staff at the plant.

My newly acquired outsider status brought to light the fact that I had never really contemplated an exit strategy upon completion of my research. I had worked so long and hard on “getting in”, that I didn’t have a plan for “getting out”. Recent events had precipitated a forced closure of my research and although I was preparing to leave, I wasn’t prepared for the sudden disengagement. As the frequency of my visits had decreased, I simply left on my final day as if it were any other, without any final goodbyes to the workers. I was able to formally thank the few management and administrative staff that were present on my last day. As part of the initial research strategy
devised by the RAC included my ‘summary of research findings’ or a debriefing about the project, some of the workers may have been left with the impression that I would be returning. But this would no longer be the case as I had created tensions within the organization, and enthusiasm about my presence had faded significantly. Similarly in her methodological reflection, Watts (2008) shares her experience of exiting from ethnographic research, and notes that the issue of unexpected departure raises emotional concerns for both the researcher and the research subjects. The exit phase can be emotionally trying for the researcher, and draws attention to the need to contemplate a strategy for it early on, upon entering into fieldwork.

3.6 Stage 4: Recovery

Fortunately, I had completed an adequate number of interviews to for the purpose of my research, and I had collected enough data to remove myself completely from the research site, and move forward with my study. Only then was I able to reflect on how differently the organization functioned from the healthcare environments in which I practiced. Industrial manufacturing in general, and my research site specifically, had their own culture and customs, including a hypermasculine work environment and a stanch hierarchical structure. Being a newcomer in the organization meant that I initially didn’t fully understand or appreciate the rationale behind certain actions and behaviours. Upon reflection I was able to better able to situate my experiences within the context of the organizational culture, and reactions of staff and management began to made more sense to me as I started to recognize that they were acting within their own customs and organizational traditions. As Oberg (1960) notes, this fourth stage is about acceptance, and adjusting to the new culture as ‘just another way of living’ (p.143).

The final data analysis and write up of my findings also provided some clarity and closure. Aside from a few minor issues with proposed publications (all work had to be vetted through the
company), the process was moving forward. I came to understand certain issues were flagged within the proposed publications, and the rationale made sense from the company’s perspective. I was concerned with advocating for change, and the company was concerned with protecting staff, and their confidentiality. We were able to negotiate these differences in a fair and timely manner. I would occasionally reminisce about new things that I had learned about the industry during my time at the plant, such as how certain equipment was maintained, or how particular products were manufactured, regulated, and marketed. I genuinely missed many of the workers that I had gotten to know, and I wondered how they were managing with their personal and professional undertakings.

3.7 Discussion

In a narrative review of ethical decisions he had to make in his fieldwork research, Vanderstaay stated: “While no recipe for ethical fieldwork can be written, a review of dilemmas faced by previous ethnographers can enable researchers to anticipate difficulties and to establish useful guidelines before entering the field” (2005, p.372). The present paper combines the ethical, emotional, and practical experiences of a novice researcher in an effort to support health science students in preparing for ethnographic research. By using Oberg’s (1960) account of culture shock as a framework, I provide a detailed explanation of my experience of collecting fieldwork data. I will now provide a summary of key ethical, emotional, and practical reflections for future consideration.

The first recommendation is to recognize that most researchers in the field will be faced with ethical dilemmas at some point in their data collection. Most likely, the researcher will be basing their actions on the well being of research subjects, and probably within the context of researching vulnerable or exposed populations. The researcher must consider how they will react
when faced with the decision to intervene (or not intervene) in the ongoing activities of the site. However, the researcher should note that their decisions may not be solely based on the objectives of the research project, but instead may arise because of personal investment in the people being researched, or because of the researchers own personal standards of behaviour (Dennis, 2009). This may lead to blurred lines between personal and professional boundaries. Researchers need to reflect on their own personal values at the outset of the project, and remain cognizant that their actions out of concern for some will also have an impact on others.

Before acting, the researcher would be wise to consult with their supervisor or advisory committee to attain expert opinion and guidance. It is important to consider what is within their control to change and affect, and consideration should be given to alternate ways in which intervening may be possible. Using a process such as Dennis’ (2009) “BUT” formula to examine ethical practices will provide an approach to critically reflect on contradictions between our ethical principles and our actions. Furthermore, time should be spent anticipating typical dilemmas that may arise, and consideration should be given to what potential responses or options may be. For example, I had obviously expected to interview people with mental health problems, and after the interview I had planned on providing them with an information sheet on community supports and resources for mental health issues as per my ethics protocol. But I hadn’t anticipated building relationships with these informants, spending time interacting with them on a daily basis, or having to negotiate how I could best provide support for them when limitations in practices for marginalized workers were exposed.

There is an inherent unavoidable emotional component within the ethnographic experience. Establishing rapport requires some level of emotional commitment to those being researched. Moreover, it is important for the researcher to recognize that there will be times of transition
across the continuum of being an outsider and then insider (and possibly back again) during the
time spent immersed in the field. I had mistakenly interpreted the movement across the
continuum as a failure, instead of a normal and ongoing back-and-forth process. These
transitions require constant adaptation and adjustments in the researcher’s social interactions, and
thus, they also take an emotional toll on the researcher. Depending on emerging situations, the
researcher will also experience a variety of feelings from their fieldwork. Koning & Ooi (2013)
discuss what can be learned from “awkward encounters”, Blackman (2007) discusses fear, and
romance, whereas Warden (2012) talks about trauma, and Vanderstaay addresses shock, fury,
anger, bitterness, and despair. As many of these authors suggest, these feelings should not be
ignored and can be used as data to gain insights into key issues of the research. Koning and Ooi
(2013) recommend the use of ‘inclusive reflexivity’ to enrich our understanding of the
ethnographic experience. Inclusive reflexivity incorporates everyday experiences (inclusive of
emotions, anxieties and agendas of researchers and research participants) into reflective
practices. It provides a means for ethnographers to reflect on interpersonal exchanges in the
field, how these interactions can enrich an understanding of the field, and how reflection can
direct how much of oneself to reveal in the field (Koning and Ooi, 2013).

On a practical level, it is prudent to ensure that the role of the researcher, the scope of the project,
and the timeline for data collection is made very clear to all stakeholders at the beginning, and
consistently throughout all stages of the research. Despite an informative email sent to all staff, it
was obvious that there was a lot of misunderstanding about my purpose for being onsite. It
became apparent that the type and amount of information, as well as how that information was
delivered to the organization had a significant impact on how it was understood by the workers.
For example, as my research was intended to take up the standpoint of the worker I tried to align
myself with their interests and experiences; thus they saw me as a vehicle to advocate for their
cause. Therefore, it is also important to engage in regular contact with all stakeholders throughout the research process to maintain perspective of the project, provide updates, and seek guidance on any issues that may arise.

An additional strategy that may facilitate the fieldwork process is the comprehensive recording of ethnographic field notes. Field notes not only serve as a dataset, but can also help the researcher make sense of their experience and record changes over time (Emerson, 1995). Establishing an academic mentorship/working group or support outside of the research site would be helpful to have a safe place to confide in and disclose personal experience. For example, I was an active member of a working group specifically for students conducting institutional ethnographic research. Engaging in these regular exchanges, or simply reporting on experiences provides the researcher with an opportunity to debrief and check in with someone who is external to the immediate ethnographic process. Lastly, we need to recognize that these experiences and challenges can be considered a ‘right of passage’ (Irwin, 2007), and are a necessary part of the transition to becoming a proficient researcher. The lessons learned through these challenges are invaluable, and will continue to inform future practice if researchers are given the opportunity to critically reflect on their decisions and emotions during the fieldwork experience. Discussions of ethical dilemmas, emotions, and practical considerations are important to uphold the integrity of fieldwork research, and to present a more holistic (and realistic) account of what happens in the field.
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Chapter 4
The ‘Work’ of Workplace Mental Health: An Institutional Ethnography

4.1 Introduction

The economic and social costs related to poor mental health in the workplace are growing rapidly. This trend is reflected in American data that links absenteeism and poor work performance to major depressive disorder (Kessler, 2006; Wang, Simon, & Kessler 2003) at a cost between $30.1 and $51.5 billion USD (Greenberg, Kessler, Birnbaum, & al. 2003; Stewart, Ricci, Chee & al. 2003). In addition to these enormous economic costs, mental health problems in the workplace also carry a significant social burden. Poor mental health is predictive of unemployment and reduced career goals, resulting in a decrease in quality of life and diminished community participation (Stuart 2004).

Many workplaces in North America have responded to this pressing issue with a variety of programs that target both physical and mental health. Workplace health promotion and wellness strategies often include programs that aim to enhance employees’ physical, psychological, social, spiritual, and economic potential (Michaels & Greene 2013). These strategies have demonstrated some positive outcomes such as an increase in productivity, improved morale (Berry, Mirabito, & Baun 2010), enhanced quality of work life and reduced worker compensation expenses (Michaels & Greene 2013). However, these initiatives are difficult to assess because of a lack of clarity and standardization around organizational intervention methods (Harvey et al. 2006), as well as difficulties measuring outcomes such as presenteeism (Cancelliere, Cassidy, Ammendolia, & Cote 2011). As there continue to be numerous struggles within the workplace for individuals living with poor mental health, a series of questions guide
our research: What types of workplace challenges do individuals experiencing mental health problems encounter? What is the interface between having mental health problems and accessing help in the workplace? How does an employee navigate support systems in the workplace, and what characteristic problems emerge? The purpose of this research is to explore the social relations and institutional practices in one Canadian organization that provide the context for employees who are both dealing with episodes of mental illness, and attempting to stay employed.

To explore these relations, our research takes up an ontological shift from traditional qualitative and quantitative research in order to investigate social relations in which the workplace is situated. In order to do this, we employ Smith’s (1987; 2003; 2005) institutional ethnography to better understand how the experience of the employee with mental health problems is shaped and coordinated within the workplace setting. Institutional ethnography starts in the everyday lives of people, and explores the forms of organization and relations that produce their experiences (Smith 2003). Making these coordinating relations visible provides opportunity to investigate them, and describe analytically how they operate.

This paper begins with a brief overview of stigma towards mental illness to provide the social context of workplace mental health. This overview will be followed by a summary of institutional ethnography and a description of our methods and the research setting. It then goes on to describe the research process, which begins from the standpoint of employees with mental health problems, and explores the institutional processes that organize their workplace experience. Our findings shed light on the social relations and institutional practices that produce a disjuncture between attendance management practices in the workplace and the actuality of the employees’ embodied experience. Through this process we are able to reflect on
the employee’s experience of negotiating mental health, and the time and resources needed for
self care.

4.2 Stigma Towards Mental Illness

Stigma has been defined as “an attribute that is deeply discrediting” (Goffman, 1963, p3) and the
concept dates back to the Greek symbol designed “to expose something unusual and bad about
the moral status of the signifier” (Goffman, 1963, p1). Stigma can be described in terms of four
interrelated components: distinguishing and labeling differences; associating human differences
with negative attributes; separating “us” from “them”; and status loss and discrimination (Link &
Phelan, 2001). In relation to mental illness, it has been proposed that stigma can be understood
as a combination of ignorance, prejudice, and discrimination (Thornicroft, Brohan, Kassam &
Lewis-Holmes, 2008). Stigma is devastating in the lives of individuals who experience it as it
prevents people from seeking support and contributes to significant social and economic loss
(Stuart, 2004).

Stigma and discrimination towards mental illness are particularly destructive as they impair
social roles, social integration and diminish an individual’s quality of life (Stuart, 2005). Stigma
and resulting discriminatory behaviour have been shown to contribute to social exclusion and
marginalization, resulting in income deprivation, restricted career development and hopelessness
(Canadian Mental Health Association, 2007, para. 4). One out of every four to five employees is
affected by mental health issues every year (Mental Health Commission of Canada, 2011) and
many workers choose to go untreated rather than risk being labeled as “unreliable, unproductive,
and untrustworthy”.
Public stigma has been defined in terms of three components that have a negative impact on the lives of individuals living with mental illness: stereotypes, prejudice, and discrimination (Corrigan, Markowitz, Watson, Rowan & Kubiak, 2003). Harmful stereotypes include beliefs that individuals living with mental illness are dangerous and/or unpredictable (Crisp, Gelder, Rix, Meltzer & Rowlands, 2000). Prejudice occurs when these negative stereotypes are endorsed and result in prejudicial attitudes that perpetuate these negative attitudes (Corrigan et al., 2003). Lastly, discrimination may include coercion, segregation, or hostile behaviors directed towards individuals living with mental illness. Stigma carries significant negative consequences, and can often be “…more destructive than the mental illness itself” (Canadian Mental Health Association, 2011, para. 5). The identification of these constructs has helped to inform intervention strategies in attempts ameliorate the growing costs of mental illness in the workplace. However, workplace mental health is a phenomenon that remains a high priority issue because of the complexity and continued prevalence in the workplace despite these efforts.

4.3 Institutional Ethnography

Institutional ethnography does not start with a theoretical perspective, but begins with the actualities of people’s lives, as they are experienced (Smith 2005). It is based on the understanding that peoples’ individual experiences are organized by, connected to, and shaped by larger power relations (Smith 2005). By investigating the ‘work’ that people do, one can begin to explore the ways that people are ‘hooked into’ relations that are not readily visible (Smith 2003). Smith’s generous concept of ‘work’ includes a broad data set of everything that people know how to do, and that their daily lives require them to do (Campbell & Gregor, 2002:72). Therefore, the objective of institutional ethnography is to make visible how everyday
experiences are determined through the actions and interactions of individuals and governing organizational regulations.

In order to investigate the coordination of ‘work’ activities that are of concern to employees in their everyday lives, institutional ethnography begins by taking up their standpoint. A standpoint is a methodological device that helps us view the social organization of a particular institution from outside it (Smith 2005). Smith describes the processes and institutional relations that shape the experience of the individual in terms of a “complex of ruling relations” (p.19) that are organized around a particular function; these “ruling relations” refer to the multiple activities of individuals, organizations, professional associations, agencies and the discourses they produce and circulate (as cited in Mykhalovskiy & McCoy, 2002). For example, by ‘taking up’ the standpoint of the employee experiencing mental health problems, we can shed light on their activities or ‘doings’ that are related to managing mental health episodes and workplace procedures. This approach allows one to better understand the issues and concerns that these individuals encounter in their everyday work experiences, and to explicate the organization of work practices and related activities associated with the coordination of employee supports and services. The experiences and everyday activities of employees with mental health problems serve as our entry point, and lead to an understanding of how their experiences are “hooked into”, or shaped by the institutional relations and dominant work practices that we explore (DeVault & McCoy 2006). The intent of institutional ethnography is not to generalize the experience of the individual(s) per se, but instead to demonstrate how the experience of the employee with mental health problems is socially constructed, produced, and reproduced in the workplace setting.
4.4 Methods

4.4.1 Informants and Procedures

Data from this study came from an institutional ethnography that was conducted at “ABC” (pseudonym), a large industrial manufacturing plant in Ontario, Canada from June 2013 to January 2014. Ethics approval for the study was received from the University of Toronto Research Ethics Board. The primary author was responsible for all data collection. Early in the research process, we established a Research Advisory Committee (RAC) with the company. This committee consisted of senior management staff, human resource professionals, union representatives, and front-line staff from the research site. The RAC was created to build relations, facilitate strategic access to the plant, and aid in developing a dissemination plan. Members of the RAC were integral to the entry strategy and focused on ensuring transparency, and aligning goals and processes. The RAC held several meetings prior to data collection, and individual RAC members provided support as needed throughout the research process.

All employees were invited to participate in the research project via a recruitment email drafted and sent from Human Resources. To maintain anonymity of our standpoint informants, we simultaneously invited employees who were a) living with mental health problems, b) working with a colleague experiencing mental health problems, and c) involved in the support or management of employees with mental health problems to participate in interviews. By inviting these three groups, concerns about being seen with the researcher were alleviated, as people both with and without mental health problems were included. We intentionally scheduled interviews with standpoint informants first, and arranged interviews with other informants as applicable.
4.4.2 Data collection

The primary researcher conducted 140 hours of ethnographic observation over the duration of the research project. This component of data collection included shadowing trades workers on the job, observing interactions in common areas such as the cafeteria, smoking areas, and staff lounge, and attending various team and organizational meetings such as shift changes and operations updates across all shifts: days, nights, and weekends.

Prior to the interview process, each informant reviewed and signed a consent form, and was provided with opportunity to ask any questions about the research. Interviews were audio recorded and transcribed verbatim. As previously mentioned, the investigation began from the accounts of the “standpoint informants” (Bisaillon & Rankin 2012) or employees who were experiencing mental illness (n=4). Each of the four standpoint informants personally disclosed to the researcher that they were living with depression. By carefully listening to the accounts of work activities and processes that these employees engaged in when they become mentally unwell, we were able to identify additional informants and various texts that coordinate support services and workplace processes and procedures. These additional informants had also volunteered to be interviewed, and included employees in managerial-type positions (n=7); and other staff, such as union representatives, physicians, wellness team members, and human resources professionals (n=6). We also asked our human resources contact person for copies of all texts that were implicated in the work processes of the employee with mental illness. “Texts” refer to words or images that are set into material form that can be read or seen; they coordinate sequences of action and work (Smith 2006), and included policies, protocols, documents, pamphlets, and forms that informants referred to, used or implicated in their accounts of doing their everyday work.
4.5 Analysis

All data were analyzed with the aim of locating and describing how people coordinated the work of managing mental illness across settings and time. Interviews were audio recorded and transcribed verbatim. We read and re-read transcripts from interviews with employees working with mental health problems in an iterative and recursive fashion in order to identify common work activities. This in-depth review elucidated several institutional coordinating practices, policies and procedures; we were then able to track a sequence of socially coordinated activity, which was mediated by the employees’ engagement with texts. We traced how various informants, such as managers, healthcare staff, and physicians, were drawn into the coordination of work practices that support employees experiencing mental health problems. This process involved situating an identified text back into the action and activities in which it was produced, circulated, and activated (Turner 2006). It is a process that allowed us to identify how texts enter into, and consequently coordinate sequences of action, thus identifying determinants of life conditions (Campbell & Gregor 2002).

Central to our research was the notion that texts can be used to help analyze how coordinating activities reach beyond the local, into translocal social relations (Turner 2006). Specific texts and documents that were gathered included items such as the Collective Bargaining Agreement, corporate documents on health and safety, site-specific policies and procedures, medical absence forms, attendance management procedures, medical appointment request forms, and so on. Once collected, we analyzed the employees work activity with the coordinating text in order to identify how texts were responsible for organizing and standardizing work in multiple local settings, thus uncovering the textually mediated coordinating practices of the attendance management program (Turner 2006). This process allowed us to explore how these texts ultimately shaped the
employees’ experience by coordinating their ‘doings’ with the ‘doings’ of others elsewhere (Smith 2005).

4.6 Findings

By examining the experiences of employees with mental health problems and the associated social relations, we identified a disjuncture between attendance management processes and the employees’ embodied experience that is produced and reproduced through three workplace practices: the work of managing episodic mental health problems, the work of protecting privacy and confidentiality, and the work of establishing a bona fide illness.

4.6.1 Employees’ work of managing and negotiating episodes of mental illness

Informants living with mental health problems reported challenges in arranging time away from work due to the intermittent absences they required to manage their illness. The day-to-day work activities of employees experiencing mental health problems at ABC are organized through the coordinating practices outlined in two primary texts: the Collective Bargaining Agreement and the Company Policies and Procedures, which are posted on the Corporate Portal intranet. The Collective Bargaining Agreement outlines the terms and conditions of work, duties, and responsibilities for both the employee and management, and is negotiated between the company and the trade union. It primarily outlines the practices of such things as hours of work, wages, vacation allowance, disability benefits and income protection, whereas corporate policies and procedures provide guidelines for job descriptions, work duties and responsibilities, communications and reporting structures, training, and health and safety.

We learned from informants living with mental health problems that they would occasionally require time away from work when unwell, be it for a few hours, a few days, or weeks at a time.
In order to arrange time away from work at ABC, there are two relatively new and distinct absence management procedures that the employee must be ‘hooked into.’ These procedures were agreed upon within the Collective Bargaining Agreement, but the company manages the program.

The first procedure, the Attendance Management Program (AMP), is activated when an employee is absent from work on three or more occasions in a rolling six-moth period (regardless of duration of absence). The employee enters into a series of well-defined activities that advance through four progressive stages if the employee attendance remains challenging: (1) an initial interview or informal meeting between the manager and the employee (and union representative if requested) to discuss the impact of the employee absence; (2) counseling, which re-emphasizes attendance expectations, and provides other resources, such as Employee and Family Assistance Program; (3) counseling, which confirms attendance issues and expectation for improvement, and also mandates a visit to the company doctor; (4) counseling, where the employee is advised that if there is no improvement in the next three months, the employer will be required to take further action. The employee is also placed on a “Note Program” (where the employee must produce a doctor’s note after every absence).

The second procedure, which addresses a major medical absence (MMA), is activated when an employee is absent for more than four consecutive days. This procedure requires that the employee provide a Medical Absence Form (MAF) signed by their physician prior to returning to work.

Both of these procedures follow highly detailed processes that are clearly defined, and outline the roles and responsibilities of the employee, the management staff, human resource professionals, and health service workers when an employee is away from work. The rationale...
for both procedures is clearly outlined in the Corporate Policy: “to define the procedure required concerning sick leave usage” in order to “ensure consistent treatment of employees” and to “protect base salary or wages” to employees who “are absent due to bona fide illness” while “eliminating unnecessary use of sick leave”. Managers at ABC are responsible for administering the Absence Management Procedures, but are not privy to any of the employee’s personal healthcare information. The Wellness Team, comprised of the corporate nurse and corporate physician, is responsible for collecting the required confidential medical information from the employee to verify the illness or medical condition.

When employees become unwell and are not able to work, they are ‘hooked into’ these textually mediated Absence Management Procedures that pull in the professional work and procedures of physicians. The AMP requires the employee to contact their manager directly, prior to the start of their shift. The employee is also required to call in on a daily basis and advise their manager of their expected return to work date and any restrictions. The work in fulfilling the steps outlined in the AMP becomes challenging for employees living with mental illness, as the requirements can be overwhelming; particularly for someone whose mental status is fragile. One employee experiencing a mental health problem stated:

You must call your [manager] every morning at 7am, and you must make verbal contact; you must do this. You know, in a perfect world, maybe that’s great. But if it is somebody that’s suffering depression, or suffering something, you are not helping the situation any.

Establishing ‘consistent treatment’ for the employees meant that those who called in ‘sick’ on account of their mental health problems had to engage in a work process that was perceived as unfair, and even punitive. As one informant explained, “they had to clamp down on [sick time
usage]. It was being abused; but it just makes it worse for the legitimate cases”. The AMP procedure was intended to proactively identify employees who may need support in “returning to work as early as possible”. However, due to the episodic nature of mental health problems, this becomes challenging for the employee. Employees with mental illness may require more frequent absences that are shorter in duration, and following the AMP each time required a lot of coordinating work on the part of the employee:

So I came back to work on Monday, so I missed 4 hours. And another time, I had missed another day, so that was 8 hours...I was on 8-hour days at that time. So that was two absences. So, I got hauled in because I had 2 absences within 3 months. And I was saying that’s 12 hours, and they said, that’s right. And I said at the time, I could take four 12-hour shifts off and I wouldn’t be in the office getting chastised; which is like 48 hours right? Because that would be one occurrence, and I tried to reason with them, and that didn’t work. So they were going to put a letter on my file. So I had to go to the union and explain to them that I didn’t want a letter on my file because I wasn’t abusing sick time. So, I think the union persuaded them not to put a letter on my file. But that’s how they look at it still. They still look at it the same way.

The work of managing mental illness in the workplace created more stress and pressure for the employee with mental health problems. The standpoint informants show us how calling in sick more frequently, but for shorter durations of time, resulted in what they perceive to be as a punitive process. They revealed that rigid procedures meant to ensure ‘consistent treatment’ were used to deal with all illnesses, including mental health problems that tend to fluctuate. The procedure did not recognize the differences in support that may be required for individual
variation in the experience of mental health problems. The standardized process essentially subsumed the individualized experience of mental health problems in the workplace.

In order to avoid the AMP procedure all together, employees enacted strategies to navigate these procedures when they became unwell. For example, one employee would begrudgingly access his vacation time as opposed to utilizing sick time when unwell, and stated, “At the time I was doing it, I was thinking, this isn’t right, I should be taking sick time”. Another informant used vacation time instead of sick time “to avoid triggering another [absence management] interview”. Employees are granted a limited number of vacation days (accrued with years of service). The number of vacation days utilized for sick time would significantly reduce access to vacation time; yet vacation time is essential for engagement in recreation, relaxation, and rejuvenation (Stein, 2012). When employees use vacation time in lieu of sick time, it creates a cycle that reduces the use of vacation for leisure, rest, and relaxation, and thus can potentially lead to an increase in stress, burnout, and contribute to a general state of unwellness.

4.6.2 Managers’ Administrative Work of Maintaining Attendance Management Protocols

When discussing the ‘work’ activities of taking time away from the workplace on account of mental illness, employees stated that they would call their manager and simply report that they were ‘sick’, without providing details. This practice is consistent with a recent systematic review that reported employees are more likely to disclose a physical illness than a mental health illness in the workplace (Brohan et al, 2012). Tracing the coordinated work activities from the standpoint of the employee with mental health problems revealed that employees prioritized their privacy and did not want to disclose their mental health problems to their managers: I would never tell [my manager], I would never call in and say like ‘Oh today I’m not feeling [well], I’m not coming in because I’m sad or anything.” Informants also reported, “I don’t disclose what’s
going on, or why I’m sick or anything like that”, and “it’s none of their business”. Employees at ABC are not obliged to disclose their reason for taking a sick day off, and none of the employee informants disclosed to their manager that they took a sick day on account of their mental health problems.

According to formal company policy, the employee only has to disclose whether or not the illness is work related (the absence will be handled differently if it was a work-related illness as it could fall under the jurisdiction of the Ontario workplace safety legislation [Workplace Safety and Insurance Act 1997]). However, this practice of non-disclosure, which ‘protects’ the employee, also compromised the availability and the quality of formal and informal supports and accommodations for employees throughout the implementation of both the AMP and MMA procedures. Formal supports refer to company-sponsored programs or assistance, such as flexible scheduling; changes in supervision practices and training; modification of job duties, work space, or location; and job coaching that are systematically developed and accessed, Informal supports evolve out of the daily workplace activities and routines and occur on a more random or ad hoc basis for example, unplanned accommodations or social supports (Unger, 1999). As one manager reported:

[We’re] not entitled really to any information. You have to interview people for being sick but not really know why they were sick, and you have to encourage them to be here. You know, it’s important that they’re here, but [we don’t] really know anything about their wellness, or their sickness because it’s confidential, all that stuff, right? So it’s a tricky thing, because you know, the company line is ‘you need to take care of yourself”, but I’m not allowed to know what it is that is wrong with you. So I really don’t know how to help you because you don’t even have to tell me. So it’s a bit tricky from [the
Managers are not privy to their employees’ healthcare related information. The employee or the physician forward all required forms and documentation directly to the company Wellness Team. The company Wellness Team is comprised of a corporate nurse and a corporate physician who is available by consultation when required. The corporate nurse is responsible for ensuring the confidentiality of medical information received from the employees’ family physician, and must also act as a resource to management and unwell employees regarding the medical absence and return to work (RTW) process. The nurse’s communication with management regarding RTW discloses only the amount of information that the employee chooses, and most often this does not include information about mental health.

Two sets of texts were identified in coordinating these social relations. The first was the Ontario Personal Health Information and Protection Act (S.O. 2004). This Act outlines the rules regarding the use and disclosure of personal health information by the healthcare system, and also applies to individuals and organizations that receive personal health information from the health care system, such as insurance companies, and employers. These texts are responsible for protecting the privacy of healthcare information in order to avoid possible harm or embarrassment of those with mental health issues (Singleton & Kalra, 2009). In regard to the disclosure of personal health information, it is important to note that there is also arbitral jurisprudence relating to Canadian workplaces that are unionized that provides direction as to the handling of information such as mental illness (Hughes & Dickson, n.d.). The major difference is that grievance and arbitration exists as an adjudicative model only in unionized workplaces; by
contrast, only non-union employees will have access to the courts (Knight & Dockendorff, n.d., p2)

We can further map the processes that the company puts in place to protect the confidentiality of employee healthcare information to a second set of regulatory texts. Both the Canadian Human Rights Act (R.S.C., 1985, c. H-6) and the Ontario Human Rights Code (R.S.O. 1990) prevent discriminatory practices towards employees based on disability; therefore, socially coordinated practices of confidentiality are also organized around the legal aspects of workplace mental health. The employer has a legal duty to accommodate disabilities or illnesses, for example, by providing formal supports as mentioned above. However, it is difficult to enact these accommodations if the manager is not made aware of the employee’s functional limitations, and is unable to provide input and recommendations to how the employees work can be accommodated. However, in protecting the employee from potential harm or embarrassment we can see that a lack of information-sharing and the withholding of pertinent medical information poses challenges to managers who are responsible for ensuring appropriate workplace accommodations and supports for the employees living with mental illness.

Union representatives, by virtue of their positions within the organization, are seen to be supportive of employee rights and thus employees may choose to disclose confidential info. These staff view the limited information provided to management as quite concerning:

I’m the person sitting at the table that understands why somebody is off, but nothing is being discussed at the table. So, it makes it complicated sometimes. And because of that, a lot of issues come up where individuals develop their own opinions, or why somebody is off, or how they can fix it. But they’re not privy to any of the information, which can make things worse.
These informants reflected that although the Absence Management Procedure had clearly defined processes for both the manager and employee, the actual practices of ‘maintaining employee confidentiality’ through reporting procedures became an obstacle in the company’s provision of optimal accommodations for, and transition to maintenance of regular work attendance. According to these managers, the absence management process prioritizes the privacy and confidentiality of the employee, but created a significant barrier in providing workplace supports and accommodations for the employee with mental health problems.

Legally, the manager’s work is also organized through legislation that protects against harassment. If the employee feels that they are subjected to unwelcomed conduct or comments about their illness. Manager informants strictly followed the AMP protocol, as they were very concerned about being held liable for any actions that could potentially be interpreted as harassment if the employee feels that they are subjected to unwelcomed conduct or comments about their illness. For example, if managers expressed concern over inquiring about an employee absence or requesting meetings with employees without following proper protocol. One manager stated that s/he strictly adhered to the procedure because:

If things branch off into an investigation of a poisoned work environment, or if the harassment-bomb comes out, or whatever, I think it’s just human nature, whether you’re a manager or not, is to cover your own tracks.

Another manager informant disclosed “That’s [mental illness] probably one of the circumstances where if there is an issue, I will revert to policy and procedure”. Because of previous incidents involving human rights complaints at the plant, managers were aware of the potential for
negative and/or legal implications of their involvement with employees who are experiencing mental illness, and therefore, did not feel comfortable offering informal accommodations for fear of negative repercussions.

Although not formally addressed in the local corporate procedure or the Collective Bargaining Agreement at ABC, practices of protecting privacy and confidentiality are coordinated through the Canadian Charter of Rights and Freedoms, the Ontario Human Rights Code and international human rights law such as the United Nations’ Convention on the Rights of Persons with Disabilities (CRPD). ABC’s local practices regarding privacy and confidentiality are also aligned with seven major legal trends in Canadian law which include changes in (1) human rights, (2) law of torts, (3) workers’ compensation, (4) occupational health and safety, (5) the employment contract, (6) employment standards legislation, and (7) labour laws, all of which draw attention to the increasing liabilities placed on employers regarding workplace mental health (Shain 2010).

As a result of these broader coordinating practices and sets of documents, managers must reconcile the institutional priority of reducing sick time utilization with the management of employee illnesses that they do not know about, and cannot fully understand. This work is done in a complex balancing act where managers must legally protect the privacy of employees, but must also uphold Human Rights legislation by ensuring accessibility measures are put in place for those employees who require accommodation. Because of these challenges, managers are largely made unaware of the daily, lived experiences of these workers, and are thus rendered unable to understand the individualized needs of employees working with mental illness.
4.6.3 The Work of Authorizing Episodes of Mental illness

If absent longer than three days, employees living with mental illness at ABC are responsible for establishing that they do, in fact, have a “bona fide illness”. Establishing a bona fide illness, or a legitimate illness, lies at the core of activating several textually mediated activities. It brings to light two significant challenges: first, the difficulties of how the ‘illness’ is to be managed between the workplace and healthcare system; and secondly, how the confirmation of a bona fide illness is established through a confidential medicalized process. This medicalized process is one that is at arm’s length from the manager and the workplace. Because it is a medicalized process, it falls outside of the traditional duties required by management, thus managers feel ill prepared and inadequately trained to provide mental health support to their employees.

A bona fide illness in regards to absenteeism issues related to mental illness is formally recognized by a physician’s signature on the Medical Absence Form (MAF):

I went to the doctor and he said take time off. Before I left that appointment I would say, I need to see you again shortly there’s going to be some paperwork; and he’d say okay I’ll book you in, bring your paperwork I’ll sign it

After three days, you need to have a [MAF] form. And you have to have a doctor fill it out saying basically when you’re going to return to work. So anything after three days; so if you take three sick days, you’re okay, but if you take four, then you need a doctor to fill out a form

Once authorized by a physician’s signature, the employee or physician must return the MAF to the Wellness Team, who then verifies the illness on behalf of the company if they deem the
report valid and appropriate. The MAF can be authorized by any medical physician, but is most often signed by the employee’s family doctor, a general practitioner.

In Ontario, nurse practitioners and physicians are the only registered healthcare practitioners that are given complete authorization to perform the act of communicating a diagnosis of a physical or mental disease or disorder (Regulated Health Professionals Act 2013). Therefore, for work-related absences, the physician is most often the healthcare practitioner who determines if an employee has a ‘bona fide illness’. The MAF designates space on the form to record the “primary diagnosis”. However, the form also indicates that the diagnosis may be withheld at the employee’s discretion. Essentially, the physician does not have to record a specific diagnosis in order to establish a bona fide illness; the physician signature alone is the only requirement. For example, one physician informant stated that it is his practice to identify general ‘health reasons’ for authorizing absence from the workplace, and described stigma towards mental illness as his/her rationale for not disclosing the employee’s mental health problems:

I initially just put ‘they need to be off work for health reasons’. Just health. I mean there’s still such a stigma with [mental illness], that I don’t want them facing that, and you know, being the ‘oh, this is the crazy person at work’, like ‘they’re going to come in and shoot up the office’. Stigma is there still, especially in [a town like this].

The same physician informant shared his approach in determining whether an employee has a bona fide illness, making visible that there are no processes in place to guide physician decision-making:

I’m very lenient with the patient side. So for the most part, I’m kind of like, where are you at, what do you think you need? And if it’s reasonable, then I’ll give it to them. So I
mean, it works, but it definitely opens me up to someone saying, yeah, I need to be off for the rest of my life. So obviously, I have to really work that out.

The Ontario College of Family Physicians, the Ontario Medical Association, and the College of Physicians and Surgeons of Ontario report that there are no formally established guidelines, protocols, or procedures in Ontario to help guide family physicians make decisions about determining work absences with regard to mental health problems (R. Pita, E. Veca & P. Hurst, personal communication May 30, 2014). The physician is given absolute authority to determine the health status of an employee, which situates the manager outside of the medicalized process. As one informant stated, “Accountability of the medical profession is lacking. We don’t take them to task, and we hesitate to challenge doctors. If somebody makes a statement, they should be prepared to stand by it.”

The emphasis on ‘bona fide illness’ also compelled some employees who were too unwell to work to access vacation time, as they had difficulties reconciling the disjuncture between taking sick time and legitimizing their mental illness:

And I took it as a vacation day because I couldn’t justify in my heart, as a sick day. Which is wrong, because it was a sick day. I was not at work because I was sick, but I didn’t sit at home and wallow. I went on a hike and did all of the stuff to help me. So I thought to myself, how can you be on a sick day if you’re out hiking in the woods? But really, it was a sick day because I wasn’t capable of working. Sitting at home would have been worse.
I probably would have used vacation time and other time for stuff like that [mental illness] but, it wasn’t so much of a conscious thing, it was kind of like…I would just wake up and I just, I wasn’t so much like upset and I didn’t want to go into work that day, I just didn’t want to go to work that day, so I would call in a vacation day.

Employees’ narratives show that the lived actualities of having mental illness in the workplace are not recognized by the AMP, a program put in place to eliminate unnecessary sick leave. Highly structured workplace-reporting procedures created doubt for employees about whether their mental health problems are actual health problems. Such policies and practices that create uncertainty about what constitutes a bona fide illness may restrict employees from attending to their mental health problems, as they must navigate the space between wellness and unwellness within a context of uncertainty. Most importantly, rigid practices may not properly accommodate for the fluctuating nature of mental health problems. As a result, employees pursue alternative means to avoid these reporting structures while managing their mental health problems.

The establishment of a bona fide illness between the physician and the Wellness Team is arranged in isolation from the management staff. It renders the managers at ABC unable to understand their employee’s challenges, and make it difficult for managers to support employees in their absences as well as the return to work processes. As established earlier, managers are not privy to any healthcare related information, and have come to know their own work activities as distinctly separate from the work of the healthcare practitioners. Therefore, because they have no ‘medical’ training, managers perceive that they are not adequately prepared to provide such ‘medicalized’ support.
Despite well-established organizational policies, procedures, and computer assisted learning modules at ABC that target workplace mental health, managers perceive that the coordination and delivery of supports for employee mental illness falls outside of their scope of duties. As a result, managers have established a clear division between “the role of a manager” and managing mental illness in the workplace. Three different informants in management positions shed light on how they defer the work of supporting employees with mental illness to healthcare professionals:

[Mental health] really is an area that should be left for people who have the necessary skills or capabilities to deal with that—physicians, doctors, psychiatrists, and psychologists.

So I’ll suggest that maybe they should go to their physician. I’m not a physician myself, and I don’t try to be a backyard doctor (laughter), as they say a backyard mechanic. I don’t want to be, and I would never want to suggest that I am.

Unfortunately in those circumstances, [dealing with mental health] is an area where I have little to no expertise, knowledge, or capabilities. I will defer to medical professionals and that sort of thing.
The institutional work of establishing a bona fide illness positions mental health outside of the responsibility and/or scope of the managers’ duties. These coordinating relations make managers unaware of their employee’s health conditions; and furthermore, because managers do not have medical training they do not feel qualified to provide support for mental health problems. For managers, these separate coordinating work practices cause significant challenges in developing competence to manage employees with mental illness, and therefore compromise the delivery of appropriate front-line workplace supports. For example, despite policies and procedures to promote and support mental health, one manager informant expressed frustrations regarding his/her inability to support his employees with mental health problems, “you don’t get any training for that really, to speak of. We’re trained to supervise and keep [the plant] going, that’s the bottom line.”

4.7 Discussion

The analysis of informants’ personal accounts resulted in the explication of work activities and coordinating processes that create a significant disjuncture between the intent of the “absence management procedures” and the employees’ actual experiences. Institutional ethnography enabled us to shed light on the social organization of the absence management program. We have elucidated three textually mediated coordinating practices that became challenging for employees with mental health problems: (1) practices and procedures for reporting frequent absences from work for mental health reasons; (2) the legally required procedures for maintaining privacy and confidentiality of healthcare information; and (3) the administrative and professional policies for providing workplace supports, including procedures for establishing bona fide illness.
Enhancing our understanding of the work practices of employees experiencing mental illness sheds light on how standpoint informants experience the work processes in the AMP as both overwhelming and punitive. The standardized AMP did not accommodate for frequent, short-term sick time use by employees experiencing mental illness. Therefore, these workers would use vacation time as opposed to sick time when unwell in order to avoid getting hooked into managerial processes that require extensive reporting and monitoring. However, the importance of vacation time used for vacation cannot be overstated. Instituting strict absence management procedures may serve as a disincentive for employees who abuse sick time (McGrory-Dixon 2012), but it also acts as a barrier to recovery for those employees who are experiencing mental illness. In fact, the benefits of vacation time are so far reaching, that time for restoration via vacation can be considered a general determinant of health (Hartig, Catalano, Ong, & Syme 2013). Employees who use their vacation time when experiencing mental illness potentially jeopardize their wellbeing further by preventing future access to restorative time when they are well.

Our study also demonstrates how workplace-coordinating practices, intended to protect employee confidentially, make managers feel unable to provide support for employees with mental health problems. Protecting personal health information in the workplace is of paramount importance for both the corporation and the employee. Employees avoid disclosing mental health problems in the workplace for fear of stigma and discrimination (Brohan & Thornicroft 2010; Krupa, Kirsh, Cockburn, & Gewurtz 2009; Stuart 2004). Confidentiality in the local context of a company’s absence management procedure puts managers in the position of having to enact contradictory practices; they must provide support, while only knowing their employees’ illness as “a general health issue”, or “stress”. Managers’ thus give accounts of workplace mental health that speak from the institutional or organizational position of having to reduce sick time
utilization and they cannot know, and thus do not take into consideration the actualities of employees experience and their front-line support needs of their employees with mental health needs.

Manager informants also revealed that they do not feel adequately prepared to support employees with mental illness within this highly medicalized absence management program. As physicians are given absolute authority to establish a bona fide mental illness, managers establish their role as external to that of the healthcare system and consequently, outside of the realm of providing informal support for mental illness. Despite well articulated policies and procedures that demonstrate a strong commitment to workplace accommodations for their employees, the formal and medicalized process of accessing time away from work often acted as a barrier to the successful workplace management of mental illness.

Restrictive absence management programs have spurred some companies to implement a demedicalized disability management process that utilizes a flexible approach to disability management. Such programs include a facilitated dialogue with employees on a “case-by-case” basis, and focus on what the employee can do instead of what they cannot do (Davis 2006). Employees are not required to prove that they have a disability; instead, this approach focuses on three ability-based approaches: (1) the ability to do job tasks, (2) creating a culture of accommodation, and (3) the employee-manager relationship (Davis, 2006). Within the first year, the implementation of this program reduced one Canadian company’s lost days by 30%, which translated into a savings of $6.5 million per year (Davis 2006). It presents a significant contrast to the traditional medical approach, as it does not require the authorization of a bona fide illness as to why a given employee is off from work. This alternative approach to disability management has certain advantages, as the results from our research demonstrate that employees living with
mental health problems may perceive engagement in formal medicalized absence management programs as cumbersome and punitive. Policy makers need to consider that the duration of mental illness over time might necessitate shorter more frequent absences from the workplace.

Limitations of this study are common across all institutional ethnographies, and are well articulated by Zurawski (2012). ‘Institutional capture’ occurs when both the informant and researcher are familiar with institutional discourse and know how to speak it (Smith 2005:156). Because of the primary author’s previous clinical and scholarly work related to mental health, it is possible that CM could have made assumptions or drawn conclusions about the employees’ experiences based on her previous knowledge. Alternatively, CM may have missed out on being told certain information because of the informants’ perception of her knowledge as a clinician. To avoid this risk CM followed recommendations set forth by Campbell and Gregor (2002), DeVault and McCoy (2006), and (Smith, 2005); care was taken to focus on the work processes that the informants engaged in, as opposed to the informants’ subjective feelings or perceptions.

Clearly, the complexities of confidentiality and the management of episodic mental illness pose many challenges in ensuring that appropriate supports and accommodations are put in place for the employee. Our study contributes to the literature on mental health in the workplace by bringing to light how individuals manage the actualities of working with mental illness. It is unique in showing how some institutionally organized sickness absence programs do not account for the embodied experience of the episodic nature of employees’ mental illness. Future research needs to investigate the impact of privacy and confidentiality on employee with mental illness, and to determine the most effective way of empowering managers to provide ongoing support for employees working with mental illness.
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Chapter 5

The Social Organization of Mental Ill Health in the Workplace Setting: Local and Translocal Ruling Relations

5.1 Introduction

The direct and indirect costs of mental ill health in the workplace continue to rise, despite recognition and attempts at remediation of this growing epidemic. Data from the United States (US) indicate that the cost of depression is approximately $52 billion in absenteeism and reduced productivity (Fogarty, 2006). The economic costs of presenteeism, defined by Lack (2011) as being present at work but unable to be fully engaged in the work environment, are significantly higher. In the US, it is estimated that presenteeism costs over $180 billion dollars annually (Health and Human Resource Management, 2008). These trends show no evidence of slowing; in any given year, one in 20 Americans will be depressed, making major depression the second leading cause of disability by the year 2020 (Kahn & Langlieb, 2005). Workplace specific interventions have been developed to address the issue (Hurrell, 2005; Rick et al., 2002; Schaufeli & Kompier, 2001), but there is not enough research to form firm conclusions regarding the effectiveness of such organizational interventions (Harvey et al., 2006; Szeto & Dobson, 2011). In addition, barriers to accessing services for mental ill health in the workplace are numerous, and include stigma surrounding worker competence and the legitimacy of the illness (Krupa, Kirsh, Cockburn, & Gewurtz, 2009; Stuart, 2004), as well as a lack of worker motivation to seek support because of shame about needing care (Cross & Sipkoff, 2006).

As a result of the growing awareness of the relationship between employment and mental ill health, the workplace has become a site for mental health promotion, illness prevention and intervention (Barkway, 2006; Dietrich et al., 2012). To understand how a person’s experience is
organized in the workplace setting with regard to mental ill health, it is necessary to locate the broader practices, ideas, and knowledge that workers participate in. Dominant discourses organize institutional relations and coordinate the practices of individuals who participate in, and reproduce them (Smith, 2005). These discourses surface in the experiences of the worker.

Historically, the concept of mental ill health entails a central discourse that suggests that people with mental illness are different from mainstream society because they are unpredictable, impulsive, and never recover from their disorder (Tartakovsky, 2009). This dominant discourse is grounded in a biomedical perspective, which suggests that behavior deviating from a “normal” presentation is viewed as pathological and requires medical intervention to become “normal” (Fee, 2000). This deviation from ‘normal’ lays the foundation for the concept of stigma towards mental illness. Link and Phelan (2001) describe stigma in terms of four interrelated components: distinguishing and labeling differences; associating human differences with negative attributes; separating “us” from “them”; and status loss and discrimination. In relation to mental health, it has been proposed that stigma can be understood as a combination of ignorance, prejudice, and discrimination (Thornicroft, Brohan, Kassam & Lewis-Holmes, 2008). Because individuals living with mental illness are not seen as “normal”, they often do not disclose that they are living with mental ill health for fear of the stigma that may result.

Research suggests that it is an increasing trend for the general population to adopt attitudes that embrace a biological framework for understanding mental illness (Schomerus, 2012). People are now more apt to relate to mental illness in terms of a biological or chemical imbalance, and have a more biomedical understanding of mental ‘disease’ (Blumner & Marcus, 2009; Prescosolido, Martin, 2010; Schomerus, 2012). Because of this perspective, efforts to reduce stigma had been positioned to promote mental illness as a “brain disease”, despite evidence that demonstrates this
approach may actually increases stigma towards mental illness (Albee & Joffe, 2004; Corrigan & Watson, 2004; Estroff, Perm & Toporek, 2004; Lincoln, Arens, Berger & Rief, 2008; Pescosolido, Martin, Long, Medina, Phelan, & Link, 2010). Notwithstanding the potential adverse affects of increasing stigma towards mental illness, conceptualizing mental illness as a brain disease led to many anti-stigma programs promoting the concept of ‘mental illness is an illness like any other’ within their approach (Reid, 200). This approach has significant consequences for individuals living with mental ill health, as it places a very individualistic perspective on the experience of mental ill health, and presents it as a condition or disorder that needs to be treated or cured.

Further adding to the complexity is a paradigm shift in psychiatry that has now also positioned mental illness as a psychosocial issue (Ramon & Williams, 2005). This parallel discourse sees the concept of mental health recovery as a personal journey and is now at the forefront of mental health policy across English speaking countries (Oades, 2012). A recovery approach to mental illness is an alternative to a biomedical perspective. Anthony (1993) and Deegan (1988) describe the meaning of recovery as a shift in thinking from clinical pathology to a strengths-based approach, placing emphasis on building self-esteem and finding a meaningful role in society as opposed to focusing on the eradication of or relief from symptoms. Furthermore, it is now possible for individuals living with mental ill health to lead "meaningful community lives in spite of the presence of intermittent or even pervasive and continuous mental illness" (Krupa & Clark, 2004, p. 69). As a result of the recovery movement, the notion of mental illness now transcends the healthcare setting, and has entered mainstream society within communities and workplaces.
There are significant tensions created between these two dominant discourses; the biomedical discourse places responsibility on the individual to become treated or cured of their mental ill health as with any other illness, and the recovery discourse embraces a more socially integrated view of mental ill health, and focuses on participation despite symptoms. Clearly, there is a need to better understand the systems, structures, and social relations that contribute to the experience of mental ill health in the workplace within this context. Therefore, the problematic of our research arises from the disjuncture between efforts to alleviate mental illness in the workplace, and the lived actualities of the worker experiencing mental ill health. Within this context, many questions arise that serve to guide our research process: How does an employee navigate support systems in the workplace, and what characteristic problems emerge? What social relations and institutional practices contribute to the decision to access (or not access) supports and services for mental disability in the workplace? To the best of our knowledge, no literature to date has adequately explored these questions from the standpoint of the worker in order to determine how the experience mental ill health is coordinated in the workplace setting.

Our research takes up the standpoint of the worker experiencing mental ill health as a location from which to explore the social and institutional relations that ultimately coordinate and produce their everyday lived experience. First, we will provide an overview of our research approach, institutional ethnography, and offer a brief description of our research study. After an explanation of our analytical strategy we will demonstrate how texts shape what workers think and do, and discuss the social coordination of formal and informal respite from work. We will then demonstrate how this coordination extends beyond the local and into the actions of the worker (both knowingly and unknowingly), thus allowing us to better understand why workers do, or do not access available supports. Last, we will conclude with a discussion of our findings, and make recommendations for change.
### 5.2 Methods

#### 5.2.1 Institutional Ethnography

Our research draws on data collected from an institutional ethnography that was conducted to better understand how the experience of mental ill health in the workplace is organized, connected to, and shaped by larger power relations. Based on a social organization of knowledge perspective (Smith, 1987, 1990), this approach allows us to explicate the complex set of ruling relations from a particular standpoint or location. The standpoint refers to the experiences of specific individuals whose everyday activities are in some way “hooked into”, shaped by, and coordinated by the ruling relations under exploration (Smith, 2006). Ruling relations are defined as the “complex of relations that are textually mediated, that connect us across space and time and organize our everyday lives- the corporations, government bureaucracies, academic and professional discourses, mass media, and the complex of relations that interconnect them” (Smith, 2005, p.10). Therefore, institutional ethnography allows us to make visible how texts, in the form of documents, policies, and procedures, ultimately shape and determine what workers think and do. IE will help us reach beyond the local to examine how the coordination of texts shape peoples’ consciousness by hooking them into translocal, or broader ruling relations, that extend beyond their local experience (Smith, 2006).

In essence, institutional ethnography as an approach to inquiry enables us to study the activities of people in order to understand the social organization of mental ill health in the workplace. Instead of trying to understand why people experience mental health issues in the workplace, we will be investigating how people’s behaviors and activities produce (and are produced through) institutional processes. Unlike many traditional research approaches, the purpose of this research
is not to understand the generalized experience of mental health problems in the workplace. Rather, our study explains how policies, processes and procedures ultimately shape and coordinate the experience of the worker living with mental health problems. This innovative approach offers insights for employers, policy and decision makers as it provides a unique perspective on how common workplace policies actually work for employees with mental health problems, as opposed to how they are supposed to work.

5.2.2 The Study

Our site of investigation was a large industrial manufacturing plant in Ontario, Canada, hereafter referred to as ABC Corporation (a pseudonym). There are approximately 200 employees and two unions. Ethics approval for the study was obtained through the University of Toronto Health Sciences Research Ethics Board. The primary author (CM), an occupational therapist with over ten years of clinical experience working with people living with mental illness, completed all data collection. Information was collected over a seven-month period, and consisted of ethnographic observations, interviews, and the collection of relevant documents and texts. Approximately 140 hours of onsite ethnographic observations occurred across all shifts (day, night, and weekend). Observations were recorded while job shadowing various workers as they completed their tasks, spending time in common areas (e.g. lunchroom, designated smoking areas, centralized work areas) and attending various meetings such as shift change, managerial meetings, department meetings, and health and safety meetings. Open-ended semi structured interviews were conducted with 16 informants who were recruited via email from the Human Resources department, and one physician informant that was recruited externally to the organization.
5.2.3 Analytical Process

The findings of this paper are based on analysis of data from four standpoint informants, or individuals working with mental ill health. It is important to note that institutional ethnographers are not concerned with sample size, summarizing workers’ subjective perspectives, or creating generalizability across subjects. Instead, we analyze how texts enter into and organize work activity. As texts organize sequences of action across multiple different sites, they can be used to elucidate the ruling practices and relations that help form, shape, and otherwise structure the workers’ experience. This approach produces an understanding of how things work beyond our everyday knowledge, and explicates how translocal processes are embedded in local experiences (Ng & Mirchandani, 2008).

Our investigation began from the accounts of the informants living with mental ill health. Our analytic strategy focused on Smith’s notion of a “generous concept of work”, which refers to “what people do that requires some effort, that they mean to do, and that involves some acquired competence” (1987, p165). The standpoint informants’ accounts bring to light how institutional processes and practices socially organized, thus leading to an understanding of how worker’s activities are coordinated. The interviews enabled us to uncover multiple standardized institutional texts, policies, and procedures that were responsible for organizing and coordinating the workers’ experiences when they became mentally unwell. One key text, for example, is the attendance management program for sick time utilization; discussed at length later in this paper.

When reading and re-reading the transcripts, we paid particular attention to the activities of the worker, and how specific texts entered into and coordinated sequences of activity. Smith (2006) refers to this as the Act-Text-Act Sequence, and emphasizes the notion of texts as “happening in time and place and as integral to organized sequences of action” (p67). Therefore, we analyzed
the texts that were implicated by the informants according to how they were responsible for coordinating, organizing, and sequencing activity in relation to the experience of the worker with mental ill health.

5.3 Findings

The accounts of four standpoint informants provided our entry point into uncovering how ruling relations coordinated their everyday experience of working with mental ill health. The informants consisted of three males and one female, ranging from approximately 20 to 55 years of age. They also occupied a range of positions, from front-line to administrative and management staff. All four informants reported that they lived with “depression”. It is important to note that it is not the workers’ mental illness that is the focus of the inquiry but how the experience of the worker with a mental ill health in the workplace is organized.

Each of these informants described the work that they engaged in when becoming unwell in the workplace. This work was primarily centred on accessing time away from work when unwell via attendance management program protocols (AMP). The informants were hooked into these textually mediated coordinating practices, and we can locate the social relations within broader, translocal texts and discourses. We argue that these textually mediated coordinating practices shape the workers experience in such a way, that they begin to question their experience of mental ill health in the workplace. The workers engage in formal and informal strategies to negotiate the disjuncture between their embodied experience of mental ill health, and the textually mediated process for accessing time away from work.
5.3.1 Formal Respite From Work: The “Work” of Mental Ill Health

The AMP dictates a particular corporate protocol for calling in sick at ABC Corporation - the worker must notify their supervisor when unable to report to work for medical reasons. If the worker utilizes three or more sick days in a rolling six-month period, they enter into a complex set of procedures that may progress through various stages, which might include meetings with their supervisor, documentation of their absence on their employee file, a mandatory visit to the company doctor, and eventually placement on a “note program” where every future absence has to be substantiated with a note from their physician.

The second protocol, a Major Medical Absence (MMA), is enacted if the workers are absent for longer than four consecutive days. At this point, workers are responsible for establishing that they do in fact, have a “bona fide illness”. Proof of a bona fide illness can only be attained by a physician’s signature on a corporate form. The MMA form requests specific information from the physician, such as: the identification of a “primary diagnosis”, “underlying or relevant medical conditions”, and “prognosis”. The only information related to mental status on the MMA was one question that asks “Do you require further information concerning the cognitive and physical demands of the job in order to provide restrictions” (emphasis added). The restriction section on the form provides space for the physician to indicate only physical restrictions, which include: limits to lifting, pushing, and pulling; restrictions for bending, twisting (back or neck), repetitive motion or stresses to extremity against resistance; tasks to be avoided; work restrictions above shoulder level; no climbing ladders or scaffolding; avoiding environmental extremes; restrictions due to medications or treatment; restrictions for operating motorized vehicles; no prolonged standing or sitting; and inability to wear protective equipment (including respirators, plastic suits, etc.). Clearly, we see that the MMA is a text that is grounded
firmly in a physical and medical-based discourse. By virtue of the type of information it gathers, the MMA positions mental illness as “an illness like any other”, but it does not take into account the everyday lived experience of mental ill health in the workplace.

The type of information requested on the MMA was largely in terms of functional limitations, which presents a bona fide sickness only in terms of physical limitations and/or restrictions. There is no formal category that captures any of the emotional, psychological, or cognitive states described by the standpoint informants. As engagement with texts coordinates the actions of people and organizes activities locally and translocally in specific ways, we have made visible how the MMA coordinated the physicians’ work process. The text did not provide opportunity to easily identify emotional, psychological, or cognitive work limitations in the physicians’ documentation, thus coordinating the physician’s work in a particular way. Moreover, the MMA establishes what constitutes a bona fide illness, and it did not contain words, categories, or other items that reflected the everyday lived experience of the worker with mental ill health. The understanding of a bona fide illness is shaped by the MMA, and the standpoint informants come to understand what a legitimate illness through this textually mediated process. Because they could not identify with any items in the content of the form, they came to question the legitimacy of their mental ill health.

Both of these absence management processes posed a major challenge for the standpoint informants; namely, coming to know their mental ill health as a bona fide illness in the medicalized sense. Each standpoint informant spoke of the disjuncture between their embodied experience of mental ill health, and the textually mediated processes of accessing sick time when they became unwell. Our first informant disclosed that he regularly utilized vacation time when
experiencing mental ill health. Through his account, we can see how the textually coordinated practices for taking sick time positions having a bona fide illness in a particular way:

And probably what I’d do is I’d come to work and take two hours vacation time […] but I’d use up all of my vacation time. I don’t think it’s right, but for me to get sick time off in the afternoon, you’d have to, I guess give them a reason. What am I going to say, I’m kind of depressed right now and I’m feeling tired?

There is a clear disjuncture between the informant’s embodied experience of his mental ill health, feeling depressed and being too tired to perform his work duties, and the textually coordinated practices of attaining time off for a bona fide illness. Another example is drawn from an informant who struggled to reconcile the disjuncture between her embodied experience of her mental ill health, and the associated practices in the workplace:

I took a day off when this episode hit, I took the Monday off. And I took it as a vacation day because I couldn’t justify in my heart, as a sick day. Which is wrong, because it was a sick day. I was not at work because I was sick, but. I didn’t sit at home and wallow. I went on a hike and did all of the stuff to help me. So I thought to myself, how can you be on a sick day if you’re out hiking in the woods? But really, it was a sick day because I wasn’t capable of working but sitting at home would have been worse.

Here we see a disjuncture between the actual “work” of tending to mental ill health (engaging in activities that are health-promoting), and the workplace coordinating relations of what constitutes a sick day (inactivity and “sitting at home”). The embodied experience of the worker does not match the workplace requirements of being unable to work “for medical reasons”. These ‘medical reasons’ are constructed in the physical presentation of sickness, and focus on
functional limitations to work activities only. Evidently, we see how the texts related to accessing sick time align workers’ consciousness and actions with organizational expectations about the extent to which their mental ill health “deserves” attention and time away from work. We also begin to see how a bona fide illness should, or alternatively should not, impact their ability to work. When moving between the ruling perspective of what constitutes a “bona fide illness” and the experiential perspective mental ill health, the standpoint informants’ experience a significant disjuncture between workplace requirements and the actualities of their everyday life. We see that when experiencing mental ill health, workers did not recognize the ‘work’, or self-management behaviour that they engaged in as legitimate “sick” behaviour. This is because the behaviour did not conform to the textually mediated limitations in activity produced when establishing a bona fide illness.

These textually mediated workplace social relations shape how workers come to know what the employer expects of them in regard to sick time utilization. Another standpoint informant who accessed sick time for her mental ill health stated: “But when I think, and when managers see that you’re taking a sick day, they expect you to be like, puking, or like you can’t get out of bed. But sometimes, it’s like…I honestly think we should have mental health days […] I know some companies do have mental health days”. Here we see how workplace social relations organize the ‘work’ of being sick with a bona fide illness in a particular way. Moreover, we see how this notion of ‘sickness’ is grounded in a biomedical presentation of what it means to be too sick to work: being physically incapable of performing or fulfilling work duties. The informant suggests that a distantly separate textually-mediated process would be appropriate for workers with mental ill health, as symptoms experienced in mental ill health are not congruent with those outlined in sickness absence management processes.
We have made visible how the textual account of a bona fide illness is taken up in a generalized form so that it can be recognizable and accountable across the local settings of institutional work (Smith, 2005): the workplace and healthcare setting. Sickness absence texts coordinate activity between the work sector and the healthcare system to establish a bona fide illness. Because the foundation of the healthcare system is firmly grounded within the medical model, we begin to see how the workplace texts positions mental ill health in a certain way; primarily in that it indicates the presence of a diagnosis, physical limitation, and/or visible restriction with regard to work activities in order to establish a bona fide illness.

5.3.2 Informal Respite: The “Work” of Hiding When Unwell

To avoid getting hooked into any formal textually coordinated processes, our informants also engaged in work activity that afforded them informal respite from their work duties. This coordinating relation was uncovered through the informal work activities that informants engaged in when experiencing mental ill health, particularly when the need for immediate respite emerged. One informant was able to construct privacy without disclosing his mental illness:

   And I would tell my boss. I’d go and lay down; I’m going to hide. There are days here when I would go, that if I would have been caught, they wouldn’t have understood. If [senior management] would have caught me sleeping somewhere, and if I would have said to him/her, I need this, or I have to do this, they wouldn’t have understood.

Over time, this informant established the activity of finding a place to rest as an effective and routine coping mechanism. As ‘napping’ could not be justified as a bona fide intervention for illness, the work of ‘hiding’ to manage his emotional state became a recognized and mutually agreeable practice between the informant and his manager. According to the ABC Corporation
policies and procedures, this activity would have otherwise been identified as an attendance management issue or a performance management problem, and would have resulted in the organization of a completely different set of coordinating social relations. This informant was able to effectively hide his state of being unwell; therefore did not have to disclose personal information to his colleagues or Human Resources, nor did he have to engage in extensive, formally coordinated management protocols (disability-related or otherwise).

Another informant was in a position that enabled her to regularly engage in flexible work practices when she required informal respite. She would seek support from another colleague who was also able to be flexible with their work time and activities:

What I found too was when I was really in the dumps; I would spend a fair bit of time with [coworker]. Like more than a lunchtime. Like longer into the work time. I’m not so sure that [just any] worker can do that; it’s a little tougher there, because some people probably should call in sick because they can’t come in and not work. Whereas I have that little bit of latitude and will get the job done.

This informant was able to adjust her work in various forms; she could choose the time and space in which she conducted her work duties, and was also able to negotiate between a public, private or semi-private space in the workplace. This flexibility, and being able to “get the job done” provides ‘justification’ for her taking time away or hiding from the general workforce, that is, using work time to get support from her coworker. But we note that she identifies that other workers could not come in to the workplace and “not work”, thus providing a rationale for them to use sick time. This informant was able to resourcefully complete her work duties by flexing her work time to “get the job done” when she was experiencing mental ill health; therefore, she did not see the need to utilize sick time. The flexibility of being able to complete her work tasks
in the evening, while at home, or on the weekend, meant that she could actively dodge institutional control and avoid being drawn into textually mediated absence management processes. Clearly, there was a disjuncture between her embodied experience of not being able to concentrate and perform immediate work duties because of mental ill health, and the textually coordinated sick leave process that accounts for what constitutes a bona fide illness in the workplace.

When describing strategies for dealing with the immediate need for respite from work, one informant simply stated that in order to make it through the day she would “go to the bathroom and cry a lot”. Here too, the act of hiding for relief is employed as a strategy - she coordinates her activities when unwell in such a way that she can take a reprieve from her work duties without having to justify or explain her absence to anyone. This strategy enables her to avoid entering into a textualized or complex set of coordinated practices (such as sick time) for a brief reprieve from immediate work practices. Like others, her mental ill health is shaped by organizational policies and procedures that in turn coordinate her bodily experience of her mental ill health in a particular way.

5.4 Discussion

5.4.1 The Ruling Relations of Workplace Mental Ill Health

Our study shows how the work of the informants’ with mental ill health becomes organized locally and translocally around the discourse of ‘‘mental illness is an illness like any other’’. This presents a profound disjuncture between the embodied experience of being too unwell to mentally perform work duties, and the textually coordinated practices of what it means to access sick time for a bon fide illness within a biomedical based attendance management protocol. As
the generalized texts that are used to record sickness absences are framed within a physical and biomedical perspective, they align workers’ consciousness and actions related to sickness with organizational expectations about what a bona fide illness is, and by omission of certain symptoms, what it is not. This inadvertently delegitimizes mental ill health, and leads to the experience of some workers’ mental ill health to become constructed as a much broader and more complex issue. The use of vacation time could have been avoided if workers were able to identify their mental ill health as a form of bona fide illness, or if other less bureaucratic processes were in place to access formal respite from work.

Because of the disjuncture created between the lived experiences of mental ill health and the formal textually coordinated process of accessing sick time, we also uncover how workers with mental ill health often engage in informal respite from work. This informal respite from work was coordinated around the concept of ‘hiding’ and was evident in numerous ways, including ‘hiding’ the expression of emotions, physically ‘hiding’ from coworkers, and ‘hiding’ the need for respite. Indeed, this concept of ‘hiding’ and invisibility was shaped and coordinated by various texts that hooked the worker into broader organizing relations such as the notion of a ‘bona fide illness’. As access to sick time for mental ill health is taken up in a generalized and medicalized textually coordinated process, workers do not ‘fit’ into a particular category that substantiates a bona fide illness. As Smith (2005) poignantly states: “Agency is assigned to institutional categories. Someone who can’t be subsumed under the institutional categories assigning agency has no agency” (pp117). As the standpoint informant was neither “well” nor “unwell” by the textually coordinated establishment of a bona fide illness, they disappear as a living subject in the institutional procedure.
As the aim of our investigation was to better understand the social relations and institutional practices that contribute to the workplace experience of people living with mental illness, we began by remarking that our approach differs from mainstream studies of mental health problems in the workplace. The alternative perspective offered by institutional ethnography is, in our view, crucial. At the same time, we are not entirely alone in our efforts to explore mental illness through the lens of institutional ethnography (e.g. Jakubec, 2004; Lane, McCoy & Ewashen, 2010); nor are we alone in exploring mental ill health specifically in the workplace. For example, drawing on institutional ethnography, Church, Frazee, Panitch, Luciani and Bowman (2007) carried out studies of disability in the workplace also commenting,

> [w]hether the condition is visible or invisible, disabled employees learn how to “hide” in the workplace. They do so to facilitate their own integration, and to prevent negative reactions but also to secure privacy against unwelcome curiosity. Practicing concealment is a “second job” layered onto their work. Concealing can be elaborate, a choreography of invisible microdecisions within each transactional workplace moment. (Church et al. 2007, p.7)

More recently, Moll, Eakin, Franche and Strike (2013) also raised the issue of the institutional coordination of silence, disclosure and privacy as a form of hidden work. We add to the literature by shedding light on the disjuncture created between the embodied experience of mental ill health and the ruling perspective of what constitutes a bona fide illness, adding a unique focus on how people’s uptake and utilization of attendance management related supports in the workplace.

Limitations to this study include those common to institutional ethnography as an approach to inquiry. As data analysis techniques for this approach are not standardized, there are some
limitations to how the observations and analytical approach are organized to conform to this interpretive frame (Walby, 2006). While institutional ethnographers strive to be people-centred instead of theory driven (Walby, 2006), some may criticize IE for situating the research in the context of discourses, thus influencing the analysis by the subjective bias of the researcher. The ontology of the social configures what the objects of inquiry can be; therefore framing the organizing discourses as ‘mental illness as any other illness’ essentially creates a lens from which the informants’ work activities may have become filtered by the primary researcher.

Our findings have several implications for emerging initiatives to mitigate the challenges associated with mental ill health in the workplace. The textually mediated process to access sick time in the workplace is firmly grounded in a biomedical discourse. This aligns workers’ consciousness with organizational expectations about what constitutes a bona fide mental illness. For example, there is a clear distinction between the textually organized practices of sick time versus vacation; however, according to the informants, these texts coordinated their experiences in such a way that their actions regularly blurred the division between categories. Workplace supports need to be positioned to either reduce, or address the disjuncture between the worker’s experience of mental ill health from an experiential perspective (feeling too unwell to work) versus a ruling perspective (the textual practices that coordinate ‘sick time’).

The need for informal respite also requires attention. Interventions that challenge the prohibitive distinction between physical and mental ill health are needed, and consideration must be given to mental ill health as a continuous spectrum of states. Lastly, the informant accounts shed light on the work processes that are required to effectively manage exacerbations in their condition. With this in mind, we argue for increased attention toward the active
accomplishment of institutional coordination of periodic mental ill health at work as an under-appreciated starting point for organizational change.
References


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Chapter 6
Conclusion

6.1 Conclusion and Implications for Practice

Workplace mental health is of growing concern, and a number of initiatives are being introduced in attempts to ameliorate the related economic and social costs (Harvey et al., 2006). This study set out to add to this body of literature by exploring the social and institutional relations that coordinate and produce the everyday work experience of people living with mental health issues. By using institutional ethnography, I have elucidated the practices, processes, and procedures that shape the experience of the workers. Developed by world-renowned Canadian sociologist and theorist Dorothy Smith (1987, 1998, 2005) institutional ethnography (IE) has been established as a formal empirically based scholarly research methodology (Mykhalovskiy & McCoy, 2002).

IE is based on the notion that peoples’ individual experiences are organized, connected to, and shaped by larger power relations (Wright & Rocco, 2007). People “see that exercising control over the form that knowledge takes is central to their own experiences and their own success as well as the troubles they identify in doing their work.” (Campbell & Gregor 2002, p.25).

Campbell and Gregor (2002) further explain that power is embedded in the written material, and the organizational talk and actions around texts. We can begin to see how people from different locations are tied together and act in concert with each other, thus revealing the social organization of our work and associated activities.

This study sought to shed light on the following research questions: What types of challenges emerge in the workplace for someone experiencing mental health issues? What is the interface between having mental health issues and accessing help in the workplace? Essentially, how do
institutional practices and associated social relations coordinate the workplace experience of workers living with mental health issues? In this final chapter, I will first offer a brief summary of the main findings of each of the three empirical chapters included in this dissertation, and highlight the key results. This overview will then be followed by a discussion of how my research makes an original contribution to the field. I will summarize the main findings from my study, and discuss implications for research and practice. I will conclude with a discussion about the limitations of this research, and offer suggestions for future research.

6.2 Summary of Main Findings

In Chapter 2, entitled “Organizational Culture Shock: Fieldwork Strategies for the Novice Health Science Researcher”, I explore my learning as a novice health science researcher. This chapter speaks to my methods while it draws attention to the typically unspoken aspects of ethnography by providing insights on role contradictions, and ethical, emotional, and practical issues that are not readily addressed in traditional methodological descriptions of ethnography. In a reflexive account of my experience conducting an institutional ethnography, I use Oberg’s (1960) stages of culture shock as a framework to draw attention to some of the challenges and dilemmas that I faced in my research. This chapter better prepares novice health science researchers for the experience of conducting ethnographic research by providing examples of the lived contradictions in ethical principles and actions faced by health science researchers, and noting some of the emotional challenges faced when moving back and forth along the continuum of being an insider and outsider.

Chapter 3, “The ‘Work’ of Workplace Mental Health: An Institutional Ethnography”, explicates three institutionally organized processes that coordinate the experiences of employees with
mental health problems: 1) employees’ work of managing and negotiating episodes of mental ill health while adhering to company procedures, and doing and keeping the job; 2) managers’ administrative work of maintaining privacy and confidentiality through corporate procedures; and 3) the administrative work of authorizing illness by the employee, physician, manager and wellness team. This chapter draws attention to the coordinating practices of maintaining employee privacy and confidentiality within a comprehensive biomedical-based sickness management process. I elucidate why employees utilize vacation time instead of sick time when they become unwell, and show how managers must enact contradictory practices in light of the highly medicalized process of establishing a ‘bona fide’ illness. These findings have significant implications for the impact of privacy and confidentiality of employee health, and calls for a more integrated approach to employee care.

The last empirical chapter, Chapter 4 “The Social Organization of Mental Ill Health in the Workplace Setting: Local and Translocal Ruling Relations”, describes the social organization of mental ill health in the workplace setting, and specifically locates the coordination of this experience within local and translocal ruling relations. In this chapter, I demonstrate how workplace expectations of a bona fide illness are textually mediated by biomedical and physical work restrictions, and as a result, create a significant disjuncture between an experiential and ruling perspective of mental ill health. I show that workers come to learn what a bona fide illness is through the textually mediated process of what constitutes a sick day, and I draw attention to the need for immediate and informal respite for workers who experience mental health issues while at work. These findings have implications for how we coordinate workplace supports for periodic mental ill health, and also draws attention to the need to support workers who require immediate informal supports.
6.3 Contributions to the Field

6.3.1 Implications for Novice Health Science Researchers Conducting Health-Related Ethnography

By drawing attention to the ethical, emotional, and practical issues of conducting an ethnographic study, I hope to support novice health science researchers to better prepare for their investigations. Although a variety of disciplines have addressed challenges related to conducting ethnography, I combine several key issues within a framework that is relevant for the health science context. For example, the nursing literature has addressed the issue of emotions and rapport (Pellatt, 2003; McGarry, 2013), and ethical issues are addressed to some extent within the sociological literature (Goodwin, Pope, Mort & Smith, 2003; Vanderstaay, 2005). More recently, publications have begun to describe the logistical challenges of conducting ethnographic research conducted within healthcare from a pragmatic perspective (Moll, 2012; de Melo, Stofel, Gualda, Antunes de Campos, 2014). Through one experiential, reflexive account, I address a number of trials and tribulations that the novice healthcare research may encounter, and provide real-world examples to make the material inclusive and easy to relate to.

This contribution is timely, as there are a number of emerging studies addressing the importance of qualitative research in the healthcare setting, and particularly, the value of ethnography (Reeves, Peller, Goldman & Kitto, 2013; Rahman & Majumder, 2013; Savage, 2006). This paper adds to the literature by providing a rich, comprehensive description of challenges faced across disciplines, and is specifically intended to inform novice health science ethnographers. This contribution to the literature strives to enhance the quality of the experience of the novice health science researcher by providing examples of contradictions in ethical principles and our
actions, and by drawing attention to various emotions and logistical challenges faced by the ethnographer. By enhancing the research experience, the overall research product can be strengthened and improved.

6.3.2 Implications for the Literature and Workers

As established earlier in this dissertation, there is a growing body of literature that addresses mental health in the workplace. However, the majority of these intervention efforts target changes at the individual or organizational level. Psychosocial interventions target engagement and well-being, and focus on an individual’s participation, communication, and social support (Parks & Sparkes, 1998). Other interventions at the level of the organization address job related or environmental stressors, and include socio-technical interventions that target modifications in job design, work load, or work schedules (Parks & Sparkes, 1998). This dissertation offers a unique perspective by investigating the ruling relations of workplace mental health from the standpoint of the worker living with mental health issues. This standpoint approach embedded in IE allows us to make visible how the everyday experience of workers living with mental health issues is shaped, coordinated, and actively produced by people through texts, documents, policies, and procedures.

The work of Eakin (2010) and Moll (2013) highlight the importance of a standpoint approach in workplace mental health. Eakin (2010) specifically draws our attention to the invisibility of workers in occupational safety and health research. She further argues for the analytic integration of multiple standpoints in order to enhance our understanding of systems as a whole, and to identify possibilities for change. In her research on health care workers with mental health issues, Moll (2013) refers to the worker’s disclosure of their mental health issues as a social process. She describes the practice of impression management as an interactive, socially
produced process of what it means to be “a good worker” (p.176). Moll sheds light on how the active practice of silence maintains institutional order and serves a range of functions for both the individual and the organization.

This present study, from the standpoint of the worker with mental health issues, further contributes to this body of literature in that I demonstrate how institutional practices and workplace social relations establish what is, and what is not a bona fide illness from the perspective of the worker. By shedding light on how sickness management policies and texts align workers consciousness and actions to organizational expectations about what constitutes a bona fide illness, this study demonstrates how workers themselves come to learn and play an active role in the institutional coordination regarding what a legitimate illness is. Krupa, Kirsh, Cockburn & Gewurtz (2009) report that one of the assumptions underlying stigma towards mental illness in employment is that mental illness is not viewed as a legitimate illness within the workplace setting. This study supports those findings, and further explicates the textually mediated process by which workers begin to question the legitimacy of their own illness. The institutionally coordinated relations for sickness absences drew heavily on a biomedical discourse; thus the coordinated self-management activities that workers engage in when experiencing mental ill health were not perceived as ‘sick’ behavior, and therefore challenge the legitimacy of their illness. This finding has implications for the way in which mental health and mental illness are presented within the workplace, and what types of illness behaviour constitutes a legitimate, or bona fide illness.

Furthermore, as with any chronic disease, symptoms related to mental health issues tend to fluctuate and cause periods of decreased functioning in workers (Honey, 2003). This study shows how workers’ with mental health issues require immediate and informal respite while at
work, calling attention to the importance of flexible work practices. The standpoint informants would engage in a variety of ‘hiding’ tactics, or restructure their work processes in order to accommodate for exacerbations in their mental health issues. The experience of episodic mental health issues also caused workers to avoid regimented institutional practices altogether when unwell. Contrary to literature that reports the workforce in the USA utilize sick days for vacation days (McGrory-Dixon, 2012), this study demonstrates that workers will access vacation days instead of sick days when they become unwell in order to avoid absence management protocols that they perceive as overwhelming and punitive.

Moreover, workers come to know what a legitimate bona fide illness is within the workplace not only by the words that are present in texts and documents, but also by the omission of other indicators and/or symptoms that are not present in these texts. Furthermore, this study highlights the need for greater attention to be paid to the management of periodic states of mental unwellness in the workplace. This includes giving a distinctive form of consideration to flexible work practices, as well as the need for and availability of privacy when a worker becomes unwell while at work. It also shows how workers’ use vacation time when unwell to avoid entering into formal institutionally coordinated sickness management processes; thus suggesting that the rationale behind some workers use of vacation time be considered in order to mitigate practices that contribute to mentally unwell states.

6.3.3 Implications for the Work of Managers and Human Resources Personnel

This study has several implications for managers and human resource personnel. The importance of management style on mental health is well established in the literature, demonstrating that poor management practices can lead to a decrease in workers’ mental health (Danna & Griffin, 1999). As managers have multiple responsibilities such as achieving
productivity quotas, maintaining safety requirements, and navigating diverse personalities within the workforce, it is logical to have well-articulated policies and procedures to manage sickness absences. However, this study shows that despite clear and robust policies and procedures, engaging in the sickness absence management process had the unintended effect of being perceived as punitive and cumbersome by workers with mental health issues. Although the procedures were implemented with the intention of providing enhanced support through early identification, workers with mental health issues reported that they found these processes overwhelming, and occasionally perceived them as unfair.

The absence management procedures were standardized in efforts to uphold consistency and fairness, and encompassed both physical and mental illnesses within the same process. This study shows that treating mental health issues the same as physical issues may not be beneficial for the worker, as their embodied experience is not reflected in the categories or wording of sickness absence documents. The notion of “mental illness as an illness like any other” has been employed in anti-stigma campaigns (Reid, 2000); but similar to findings from other studies (Ablee & Joffée, 2004; Corrigan & Watson, 2004; Pescosolido, Marin, Long, Medina, Phelan & Link, 2010), we provide evidence that has demonstrated that it may actually increase stigma towards mental illness. Therefore, human resources and management must consider the implications of a bio-medically based sickness absence management program that is not congruent with the experience of workers with mental health issues.

Many of the standpoint informants prioritized their privacy, and did not disclose their illness to the worksite. The implications of this nondisclosure are twofold; it renders managers unaware of the daily, lived experiences of these workers as they were unable to understand the individualized needs of these workers, and it also draws attention to several legal implications
for the manager and the workplace. First, the practice of non-disclosure puts managers in a position to enact contradictory practices of wanting to provide support, but not knowing what type of support to provide. They put themselves at arms length from the problem by referring to mental health issues as falling within the domain of medical practitioners. Managers were able to separate their role from that of healthcare practitioners, essentially placing providing support for mental health issues outside of their realm of workplace duties. Paradoxically, the healthcare practitioner that most often authorizes a bona fide illness for longer-term sickness absences is the workers’ family physician, a general practitioner; it is well established in the literature that general practitioners are not proficient regarding the detection and management of mental health issues (Croudace et al., 2003; Dezetter et al., 2013; Hyde et al., 2005). The resulting challenges in communication, coordination of support, and return to work practices draws attention to the need for a better integration between the healthcare system and the workplace, and greater cohesiveness in the roles and responsibilities of all stakeholders involved in the process, including the healthcare practitioner, managers, and human resources. The coordination of processes between these two distinctly different sets of institutional practices requires a common underpinning in order to better reflect the actualities and every day lived experience of the worker with mental health issues. A more unified, cohesive approach must be established between healthcare and corporate sectors in order to address managers’ concerns regarding liability issues, and also to bridge the gap between perceived medical expertise and scope of job duties to ensure that workers return to work in a timely fashion with proper sustainable supports.

Second, the legal implications of workplace mental health are growing and becoming of increasing interest (Shane, 2010). Shane and Nassar (2009) report a rising number of mental health related legal claims filed under occupational health and safety, human rights laws, and across a broad legal spectrum including labour relations, employment standards, tort law
(negligence), and workers' compensation. This research demonstrates how work activities are coordinated within this litigious environment. Managers must navigate worker mental health, and balance both the liabilities related to mental health issues and the risk of being accused of harassment for being over involved in a worker’s mental health. I demonstrate that managers must also abide by legislation regarding the duty to accommodate, even when they cannot understand the embodied experience of workers with mental health issues. Therefore, this research highlights that in addition to workplace mental health initiatives targeting mental health literacy and stigma reduction, there is also a need for managers to better understand their legal liabilities and responsibilities in supporting workers with mental health issues. Managers must also learn how to best integrate their corporate management practices with these legal responsibilities in order to provide optimal support for workers with mental health issues.

6.3.4 Implications for Policy and Practice

This study has demonstrated how the experience of workers with mental health issues is coordinated in the workplace setting. This coordination occurs locally through organizational policies, procedures, and text based sequences of activity. It also occurs translocally through dominant discourses and institutional relations that sequence textually mediated activity between the workplace, healthcare system, and government legislation. Findings from this study indicate that there are considerable tensions between the biomedical and recovery-oriented discourses of mental illness, which created a significant disjuncture for workers with mental health issues. This disjuncture occurs between the workers’ embodied experience of their illness, and the medical-based textually mediated practices and process that they engaged in when becoming mentally unwell.
This finding demonstrates the challenges in implementing a recovery-oriented approach within a biomedical discourse. Although a recovery-oriented approach prioritizes inclusion, diversity, and engagement and is promoted within many Western nations (Mental Health Commission of Canada, 2009; Oades, 2012), the biomedical discourse remains prevalent, and posits that mental illness is a brain disease requiring pharmacological treatment to heal presumed biological abnormalities (Deacon, 2013). This poses several challenges for the workplace setting as it brings to light the difficulties in integrating these two prevailing discourses. Biomedical perspectives of illness may not reflect the experience of workers with mental health issues; therefore, this study emphasizes the need to improve communication and coordination between the workplace and healthcare sectors. It also brings to light the social aspects of recovery-oriented practices, as workers experiencing exacerbations in their mental health issues do still want to work, but may need intermittent or informal respite while in the workplace.

Similar to Corrigan, Markowitz and Watson (2004) who draw attention to the impact of structural stigma from a sociological paradigm, this study explicates the broader practices that coordinate the experience of the worker with mental health issues. By addressing the impact of structural stigma on individuals with mental health issues, Corrigan et al. (2004) highlight how structural, or institutional discrimination includes policies of private and governmental institutions intentionally restrict the opportunities of people with mental illness (p481). This study moves beyond why policies and institutions intentionally restrict opportunities for people with mental health issues, and instead explicates how the experience of workers is actually produced through textually mediated sickness absence processes. It raises awareness not only of how these activities are coordinated in the workplace setting, but also to how social relations, or sequences of actions are coordinated with others both locally and translocally. This has implications for sickness management processes as it brings to light the importance of reviewing
accommodation practices and procedures to ensure they meet legislative requirements, but so
that they also account for the everyday experience of the worker with mental health issues.

6.4 Limitations and Future Directions

This institutional ethnography took up the standpoint of the worker experiencing mental health
issues. From this standpoint, additional informants were identified if they were implicated in the
processes that the worker engaged in when managing their mental health issues. Therefore, other
organizations may have different nuances in their policies and procedures that would coordinate
a disparate sequence of activities, thus producing a different experience for the worker.
Furthermore, this study explicates local and translocal ruling relations within one industrial
manufacturing company in Ontario, Canada. It sheds light on how the experience of workers
with mental health issues is coordinated through textually mediated work activities. Considering
the workforce was predominantly male, the gendered nature of the expression of mental illness
may have influenced some workers decision to access (or not access) services and supports, and
may have influenced the type and amount of information that was provided to the researcher

As this study shed light on the disjuncture between an individual’s everyday experience of
working with a mental health issue and the associated workplace policies and procedures, it
opens many opportunities for further research. It draws attention to the need for future research
to be conducted from the standpoint of the manager, as individuals in management positions are
responsible for actively coordinating distinctive sets of processes that are often incongruent with
one other. By highlighting the textually mediated interactions between the worker and the
workplace, I draw attention to the importance of sickness absence documents in coordinating
care for the worker across and between the healthcare and corporate sectors. Establishing best practice guidelines to facilitate and maintain the work participation of workers’ with mental health issues is crucial. This could be a starting point for facilitating effective communication and information exchange in order to ensure that the worker experiencing exacerbations in their mental health issues is receiving the appropriate supports both inside, and outside of the workplace. Also, it would be beneficial to explore how non-traditional approaches to mental healthcare, alternate service providers such as psychology or psychiatry, and Employee and Family Assistance programs can be integrated within the traditional healthcare system.

Further investigation of the intersection of provincial, federal, and organizational policies would provide insights into how these policies could be better integrated to facilitate the worker experiencing episodic mental health issues, as well as those workers on short-term and long-term sick leave. Future research could also evaluate the efficacy of liability training for managers, and could help determine the best way to support managers in order to provide appropriate front-line support for workers experiencing mental health issues. Work disability prevention initiatives need to embrace a more sociological perspective, and include a multi-stakeholder perspective to add to the understanding of the experience of the worker with mental health issues.

6.5 Conclusion

Overall, by shedding light on the ruling relations of sick time utilization for workers living with mental health issues, this study offers an original contribution to literature. Using institutional ethnography, this research begins in the everyday actualities of workers experiencing mental health issues, and explores the disjuncture between their lived experience and the workplace
processes that coordinate sick time utilization. By explicating the social relations and institutional processes that coordinate sick time utilization, I show how the experience of the worker is shaped and organized both locally within corporate policies and procedures, and translocally through healthcare policy and government legislation.

These insights offer new understandings into how complex biomedical and physically based attendance management programs use language and categories that are not reflective of the everyday experience of the worker with mental health issues. This inadvertently causes workers to utilize vacation time instead of sick time when unwell, and makes them question the legitimacy of their illness and associated self-management behaviours. This study also provides new perspectives on the management process of mental health issues in the workplace, and highlights the complex challenges that managers face in navigating employee privacy issues and legal concerns. It also contributes to the literature by highlighting how tensions are created through textually coordinated work activities between the corporate and healthcare sector. These insights are important in establishing where and how to enact change from the standpoint of the worker, and they have implications for the direction of future research in workplace mental health.
References


