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**Career development of individuals with mental health conditions: a social capital perspective**

**Abstract**

Purpose: This paper examines the career development of individuals with mental health conditions using a social capital lens.

Design: We draw on 257 qualitative surveys and 15 semi-structured in-depth interviews with individuals with mental health conditions.

Findings: The findings suggest that several factors influence the (lack of) career development of individuals with mental health conditions. More precisely, four inter-related factors were identified: their lack of visibility, their struggle to build relationships and bond, their difficulty to socialize and finally their difficulty to build trust.

Research implications: Previous research has shown that individuals with mental health conditions struggle to develop and sustain their careers but that this needs more attention from researchers. In addition, while social capital has been associated with many positive outcomes for individuals in terms of their careers, little is known about the role of social capital for individuals with mental health conditions as they navigate their careers.

Originality: This study sheds light on the social capital factors that influence the career development of individuals with mental health conditions at work.

**Keywords:** mental illness, career development, social capital, visibility, socialisation, trust, relationships.

Workshop 2: The work-life for people with disabilities and prejudice

**Introduction**

Mental illness, defined as diagnosable psychological disorders that are “characterized by dysregulation of mood, thought, and/or behavior” (Center for Disease Control and Prevention, 2016) has been put forward as an important workplace issue (Follmer & Jones, 2018). Despite an increase in the number of individuals who face mental health conditions (Weissman et al., 2017), little is known about how those individuals navigate the workplace and develop their careers (Elraz, 2018). It is important to know more about mental health conditions at work, both from an organization’s perspective and from the standpoint of individuals with mental health conditions themselves. For organizations, a better understanding of the issues individuals with mental illness face at work is important as mental illness is expensive, both in a direct way through health care expenses as well as in a more indirect way through absences, more mistakes and lower productivity for example (Greenberg et al., 2015). Moreover, those costs are likely to increase in the future (Collins et al., 2011). In addition, it has been argued that employing individuals with mental health conditions lead to an improved organizational culture, enhances one’s reputation and leads to higher levels of loyalty and commitment amongst employees and customers (Peterson et al., 2017). For individuals with mental health conditions themselves, more insights in the factors that play a role in the way their careers unfold might help them to increase their chances that they obtain and maintain employment. This is important as having work has been found to structure their lives and helps them to deal with their condition as well as they can (Boot et al., 2016; Sutton et al., 2012). Moreover, it gives them a sense of belonging and purpose (Jackson et al., 2009), helps them to be financially independent (Niekerk, 2009) and has even been associated with recovery from serious mental illness (Dunn et al., 2008).

This study examines the career development of individuals with mental health conditions at work. Previous research has shown that such individuals struggle to develop and sustain their careers but that this needs more attention from researchers (Peterson et al., 2017). More precisely, while social capital has been associated with many positive outcomes for individuals in terms of their careers (Kwon & Adler, 2014), little is known about the role of social capital for individuals with mental health conditions as they navigate their careers. Social capital, defined as the product of investment strategies, individual or collective, consciously or unconsciously aimed at establishing or reproducing social relationships that are directly usable in the short or long term (Bourdieu, 2011; 84-85), has been proven to be a useful theoretical framework in studying career advancement (Bozionelos, 2015; Edelman et al., 2004; Truss & Gill, 2009). As a consequence, we considered this a potentially useful lens through which to theorize an understanding of career development of individuals with mental health conditions, leading to the following research question: *How can the career development of individuals with mental health conditions be understood using a social capital perspective?*

**Literature Review**

*Context*

The term mental illness encompasses more than 200 classified mental health disorders outlined in the fifth edition of the American Psychiatric Association’s (APA’s) Diagnostic and Statistical Manual of Mental Disorders (DSM–V) (APA, 2013).

Individuals with mental health conditions are a vulnerable population. The unemployment rate of this population is higher than average (Harris et al., 2014), under-employment is a serious issue (Levinson et al., 2010) and they struggle to integrate at work (Elraz, 2018).

Moreover, Baldwin and Marcus (2007) revealed that the employment rates and wages of individuals with mental illness were significantly lower than those of individuals without such disorders, with the wage differentials being greatest for those with the most severe mental illnesses. As a consequence, many individuals with mental illness benefit from government income support (Heffernan & Pinkilton, 2011) or work in supported employment (Burton et al., 2015). Their mental disorders affect their workplace functioning in that they are more often absent at work (Levinson et al., 2010; Swales, 2012).

*The careers of individuals with mental health conditions*

Individuals with mental health conditions do not only face exclusion and stigmatization (Swales, 2012) but also encounter some difficulties in obtaining and maintaining employment. For example, the fluctuating manifestations of their symptoms might negatively affect their functioning at work and they may need to justify gaps in their employment history (Harris et al., 2014). In addition, it has been argued that their negative self-perceptions and poor communication skills negatively affect their job opportunities (Baker & Procter, 2014). This is important as their difficulties to get and keep job have a detrimental effect on their well-being and financial situation (Baker & Procter, 2014). Indeed, research has consistently shown how beneficial work can be for individuals with mental health conditions as it provides them a sense of belongingness and meaning, as well as occupational and health rehabilitation (Leufstadius et al., 2009).

*Theoretical framework: Social Capital*

Social capital, is of strategic importance to individuals as it is found to lead to many positive outcomes (Kwon & Adler, 2014; Lee 2009). For example, greater social capital has been

linked to higher compensation and more career success (Bozionelos, 2015; Richardson & Kelliher, 2015), knowledge transfers and innovation (Maurer et al., 2011) as well as performance (Moran 2005).

One can distinguish between cognitive, structural and relational social capital (Nahapiet & Ghoshal, 1998). We focus here on relational social capital. Relational embeddedness is defined as the ‘personal relationships people have developed with each other through a history of interactions’ (Nahapiet & Ghoshal, 1998: 244) and focuses on the quality of the relationship between individuals. Key aspects of relational embeddedness include interpersonal trust and trustworthiness, overlapping identities, and feelings of closeness or interpersonal solidarity. Although most previous research has focused on structural embeddedness, it has been argued that the effectiveness of one’s social capital rests on more than just the structural conﬁguration of one’s network and researchers are increasingly acknowledging the importance of relational embeddedness (Elfenbein & Zenger, 2014; Hollenbeck & Jamieson, 2015; Moran, 2005). Positioning social capital as a relational phenomenon, this study aims to get more insights on the influence of one’s social capital on the career development of individuals with mental health conditions. More specifically, we consider how one’s social capital in the form of one’s relationships, bonding and visibility affects the career development of individuals with mental health conditions.

**Methods**

Our study had two phases: phase 1 consisted of 257 qualitative surveys and phase 2 involved 15 in-depth interviews. The survey allowed us to identify themes and this was followed-up by semi-structured interviews to further shed light on the career development of individuals with mental health conditions at work.

*Recruitment and sample*

Participants were recruited using a variety of channels. A mix of networks and professional associations related to mental health/illness as well as social media and forums were used to invite individuals who self-identified as someone with a mental illness to participate to fill out an online survey using Qualtrics. It is important to highlight that one selection criterion was that one needed to be clinically diagnosed with a mental illness, individuals who self-diagnosed were therefore excluded. This was mentioned upfront in the introductory comments of the survey. Moreover, only individuals who chronic long-term disorders were included as it was expected that individuals with one-off incidents would cope differently with their mental health conditions at work. Anonymity was assured and no incentive to participate was provided. For the survey study in phase 1, the sample consisted of 8% of males against 92% of females. It should be acknowledged that this does not reflect society as the World Health Organization estimates that overall rates of psychiatric disorders are almost identical for men and women. Average age was 34.8 years, ranging from 16 to 64 years of age. Participants lived in different areas in the world. 55% was European, 29% North-American, Oceanian, 3% African and 2% Asian. They worked in a variety of sectors including healthcare, retail, hospitality, administration, customer services and education. 91% reported being diagnosed with more than one mental disorder. It is difficult to determine whether this reflects comorbidity rates in the wider population as estimates vary widely depending on the disorders studied. A wide range of disorders were mentioned when being asked about this through an open question. We later coded the disorders in line with the classification used by the DSM-5. As participants often reported several disorders, the percentages do not equal 100%. This information can be found in Table 1.

Insert Table 1 around here

For the interview study in phase 2, the sample consisted of 11 females (73%), against 4 males (27%). The interviewees were sampled the same way as the participants in phase 1, but were not taken from the survey sample. Average age was 40.9 years, ranging from 26 to 60 years. 60% was European, 33% North-American and 7% Oceanian. 73% reported being diagnosed with more than one mental disorder. The demographic characteristics are provided in Table 2.

Insert Table 2 around here

*Instruments and approach*

The study was conducted after ethical approval was obtained and participants had signed an informed consent form.

In phase 1, 257 surveys were conducted. The survey consisted of 24, mainly open-ended essay questions. The survey consisted of four blocks of questions based on the existing literature on mental illness in a work context: general information about the participant; questions about their functioning at work; questions about workplace adaptations; and finally questions about their identity and stigma. The survey was administered both in Dutch and in English. Back-and-forth translation ensured consistency between the English and Dutch versions. The survey responses revealed themes related to their career development, such as their difficulty to bond with others, build relationships and socialize. As we noticed that these themes were all related to the concept of social capital, we build an interview guide to a better understanding of how individuals with mental health conditions at work develop their career, using a social capital lens. The interviews thus build on the themes identified in phase 1.

In phase 2, 15 semi-structured interviews were conducted. The interviews were conducted face-to-face when possible and by telephone or Skype for those conducted over a long distance. Most interviews lasted for between one and one-and-a-half hours and were held in English, Dutch or French, depending on the preference of the interviewees. All interviews were fully transcribed and translated into English. An interview guide was used, but in line with our choice for semi-structured interviews, we also let the interviewees elaborate on themes we had not anticipated and were not included in the interview guide. Building on the survey in phase 1, during the interviews questions asked were about their career development and the role of social capital in this process.

*Analysis*

In phase 1, the surveys consisting of mainly open questions were analysed using content analysis (Stemler, 2001) with the help of NVivo software. This analytical approach was chosen in order identify themes. Difficulties to bond and build relationships, a lack of self-confidence and related lack of visibility as well as difficulties to build trust emerged as the main themes. They were used to build the interview guide for phase two.

In phase 2 we conducted and analyzed the in-depth interviews. Following Strauss and Corbin (1990), we first undertook complete readings of each case. We used thematic analysis to code the data (King, 2004) with reference to the overarching concept of social capital. We developed some of the themes a priori based on our reading of the literature, such as ‘building relationships’ (Seibert et al., 2001). Others were added as the analysis evolved such as ‘building trust’. The analysis involved an iterative process of coding to develop a codebook, which was modified in line with each new case. Figure 1 below shows how the analysis evolved from the first-order themes to the broader categories and dimensions in the third and final step. This way of presenting the data structure has been developed by Gioia and colleagues (2013). During the first step of the analysis, all the responses were read to get a feel for the data. Then, the coding process was started using the themes identified in phase 1. The codebook was constantly modified by adding new codes, creating sub-codes or merging some codes, as the existing codes were tested against each new case. The survey data were included at this stage. The first-order codes can be found at the left in Figure 1. In the second step of the analysis and after coding the data, we focused on the connections between the codes and the identification of higher-order conceptual codes. We moved away from the rather descriptive formulation of first-order codes, where the words of the participants themselves were used, to a higher level of abstraction where meaningful themes were created based on the first-order themes (Strauss & Corbin, 1990). In addition, connections between the different themes and concepts that were conceptually meaningful were explored in order to provide an evocative model of the factors the affect the career development of individuals with mental health conditions. The second-order themes can be found in the center of Figure 1.

In the third and final step of the analysis, we brought the different themes together, indicating how the difficulties of individuals with mental health conditions can be understood as a consequence of a lack of relevant social capital. Those final aggregated theoretical dimensions can be found on the right of Figure 1.

Insert Figure 1 about here

**Findings**

The findings suggest that several factors influence the (lack of) career development of individuals with mental health conditions. More precisely, four inter-related factors were identified: their lack of visibility, their struggle to build relationships and bond, their difficulty to socialize and finally their difficulty to build trust.

*Lack of visibility*

A first theme that emerged from the findings was being visible. The participants highlighted their struggle to be visible to important individuals in their organizations and linked this to their perceived lack of confidence. Many participants mentioned they thought they were *“not good enough”*, which hindered them to take initiative, be pro-active or take the lead. As a consequence, they were often fairly invisible to important decision-makers in their organizations. As one participant with mood and psychotic disorders mentioned:

*I constantly don’t think I’m good enough. I’m not very good at having work relationships, especially with my boss*.

Similarly, their low levels of self-confidence impacted their functioning in the sense that they were unsure about their skills and capabilities, which hindered them from developing a strong professional image as a participant with personality disorder explained:

*My functioning at work can and has been effected, my under-confidence means I look for confirmation from others. Which in turn can look like you can't do your job.*

*Difficulties in building relationships and bonding*

A second theme that emerged was their difficulty in building relationships. The participants reported that their mental disorders formed a barrier to building good professional relationships at work. Work relationships generally refer to patterns of exchanges between two interacting members or partners, whether individuals, groups, or organizations, typically directed at the accomplishment of some common objectives or goals (Ferris et al., 2009). Work relationships, especially positive interpersonal relationships (Ragins & Dutton, 2007), play an important role in organizations. Past research has focused on the overall quality of interpersonal interactions; the degree of trust, respect, loyalty, and felt mutuality that characterizes good work relationships (Ferris et al., 2009; Stephens et al., 2012). They explained that their conditions sometimes hindered communication or that being with others was difficult due to social anxiety for example, as the following quotes illustrate:

*I struggle a lot with relationships and struggle with social anxiety.*

*Anxiety makes it extremely hard to communicate with other people.*

For some participants simply being around other people was difficult and all they wanted was*“to isolate myself from colleagues”* as a woman with mood and trauma- or stress-related disorders explained, especially when their symptoms would play up. The following participant with mood and anxiety disorders reported:

*During flare ups work is very difficult, particularly interacting with co-workers. Coping at work leaves me exhausted and unable to function out of work.*

As the participants seemed to socialize less outside work because they were tired after work as the above quote illustrates, it was more difficult for them to establish friendships or bond with co-workers. A childcare worker with a personality disorder explained how she struggled building positive relationships with colleagues:

*I always end up having issues with co-workers. I generally make friends and then I think they are against me and I can't go near them without hatred. I'm very black and white which makes things difficult long term*.

*Difficulties to socialize with others*

Apart from building relationships at work, socialization was another key theme that emerged. Socialization here focuses on the relationship building aspect of relationships (Ferris et al., 2005). They reported that both socialization at work and after work was difficult. Their difficulty with the social aspect of work hampered relationships with colleagues as they were often tired at the end of the day and could not engage in socializing outside work. As one participant explained:

*I loved working in the bookshop, but being with people all the time was exhausting, so I was either working or sleeping, pretty much*.

As a consequence, social isolation was common and many individuals would withdraw from social situations during work hours. As the following participant highlighted:

*I withdraw from the social aspect of work (parties, work drinks, even lunch breaks) and self-isolate (time to breath or unwind.)*

*Difficulties to establish trust*

The participants mentioned that the unpredictable nature of their mental health condition led to absences and fluctuations in performance and moods which colleagues often found confusing. This hindered building trust:

*Needing to take time off work has become a real issue and interferes with my relationship with my employers, my colleagues and my clients. Which I understand if I am reliable for 2 months then drop the ball for a week or two, then go over and above for the next two months. People find it difficult to continue to remain confidence in which service they are going to receive.*

Similarly, the lack of legitimacy of mental illness compared to physical illness formed another barrier for building trust. The participants reported how their condition made them feel less trustworthy as a participant with anxiety and mood disorders mentioned:

*Anything that isn’t physical isn’t real.*

**Discussion**

Located within a social constructivist paradigm, we aimed to provide employees with mental health conditions the opportunity to reflect and report on their career development and the factors that influence their career. Using a social capital lens, this study seeks to theorize the career development of individuals with mental health conditions at work. As we have reported, participants reported that their career development is impacted by four key influences: their visibility to decision makers in their organization that they related to their lack of confidence; the quality of relationships with other organizational members; their ability to socialize with others during and after work; and the capacity to build trusting relationships that the linked to the fluctuating symptoms of their conditions as well as the lack of legitimacy surrounding mental illness. These findings are depicted in Figure 2, below.

Insert Figure 2 here

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Table 1: Percentages of reported disorders based on DSM-V classification in survey study.

|  |  |
| --- | --- |
| **Disorder** | **Percentage** |
| Personality Disorders | 59% |
| Anxiety Disorders | 54% |
| Mood Disorders | 53% |
| Trauma- and Stressor-Related Disorders | 26% |
| Obsessive-Compulsive Disorders | 15% |
| Eating Disorders | 7% |
| Autism-spectrum disorders | 3% |
| Psychotic Disorders | 3% |
| Neurodevelopmental Disorders | 2% |

Table 2: Demographic characteristics of interview study.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Interviewee | Gender | Age | Nationality | Disorder(s) | Function |
| 1 | Male | 26 | Dutch | Autism-Spectrum | Sports coach |
| 2 | Female | 31 | American | Anxiety/Mood | Music teacher |
| 3 | Male | 58 | American | Mood | Administrative worker |
| 4 | Female | 36 | Dutch | Obsessive-Compulsive/Anxiety | Cleaner |
| 5 | Female | 38 | Australian | Anxiety | Primary school teacher |
| 6 | Female | 46 | American | Trauma- and Stress-related/Mood | Bookshop |
| 7 | Female | 29 | British | Personality/Anxiety | Engineer |
| 8 | Male | 44 | British | Autism | Programmer |
| 9 | Female | 32 | American | Eating/Mood/Anxiety | Business Analyst |
| 10 | Female | 38 | American | Personality/Mood | Psychologist |
| 11 | Female | 41 | American | Mood | Doctor |
| 12 | Male | 56 | Dutch | Psychotic/Mood/Anxiety | Deliverer |
| 13 | Female | 60 | Dutch | Anxiety | Care provider |
| 14 | Female | 37 | French | Anxiety/Obessive-Compulsive/Mood | Personal assistant |
| 15 | Female | 42 | French | Anxiety/Mood | Designer |

Figure 2: Perceptions of factors influencing the career development of individuals with mental health conditions.

Visibility to decision makers in their organization

Capacity to build trust at work

Ability to build relationships with other organizational members

Career development of individuals with mental health conditions

Social capital

Ability to socialize with others during and after work

Figure 1: Data analysis structure

-Lack of confidence barrier to take initiative, be pro-active or take the lead.

-Feeling that one is not good enough.

Feelings of uncertainty and inadequacy.

-Asking for help and confirmation, leading to difficulty to establish a strong professional image.

Lack of visibility

Lack of social capital

Difficulties to build trust

Difficulties to socialize with others

Difficulties in building relationships and bonding

-Unpredictable nature of symptoms is confusing for co-workers, hindering building trust.

-Lack of legitimacy surrounding mental health conditions undermines trust.

-Being around people perceived to be difficult. Perceived need to be alone.

-Difficulty to socialise outside work.

-Withdrawing from social aspects of work.

-Difficulties with communication.

-Mental health condition makes bonding difficult.