

**IDENTITIES, MENTAL HEALTH AND THE
WORKPLACE:
A CRITICAL EXPLORATION**

By

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ABSTRACT

The incidence of mental illness is both a widespread and growing; and yet studies show that employers are reluctant to hire people with mental health conditions (MHCs). Despite often having an excellent set of qualifications and skills, backed up with a sound employment record, the stigma surrounding mental illness means that people with MHCs struggle to gain and maintain employment. This study explores the experiences of people with MHCs in work. The research focuses on how these individuals manage their condition while maintaining a legitimate identity at work in the context of widespread stigma over mental illness.

Taking a critical poststructuralist approach to identity, and drawing on semi-structured interviews with people with MHCs, the research highlights a complex set of factors facilitating the construction of a pejorative mental illness subject position that prevails in contemporary society and in the workplace. The study also illustrates how individuals act upon this subject position and the effects this has on their working lives. Finally, the study considers the agential practices of self-management that are illustrative of the process of resistance and the negotiation of a legitimised identity. The study considers the effectiveness of these struggles over seeing, being and doing for the long term prospects of mental health at work.

The study offers contributions to knowledge in three areas: to critical identities literature by including the experiences of mental health in the study of marginalised identities at work; to the literature on invisible and stigmatised identities, by providing a better understanding on the processes of identification; and to theorising on resistance and resistant identities as practices of self-care (Foucault, 1986). In doing so, the research not only critically analyses the concerns of a marginalised group at work but also offers broader implications to understanding mental health of all workers, and for society at large.

Key words: mental health and illness, identity, stigma, self-care, organisational discourse



DECLARATION

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With dedication to all those who struggle with mental health conditions and for their families.

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Chapter 1: Introduction

Stephen Fry has revealed he had to be brought back to the UK to be “looked after” last year after attempting suicide while filming abroad. In an interview for Richard Herring's Leicester Square Theatre Podcast, Fry said: “I took a huge number of pills and a huge [amount] of vodka.” The actor revealed his producer found him in an “unconscious state”.

Fry, who has bipolar disorder, has discussed his struggle with mental health issues in the past. During the recording with Herring, in front of a live audience at the central London theatre, Fry said it was the first time he had said in public that he is “not always happy”. “I am the victim of my own moods, more than most people are perhaps, in as much as I have a condition which requires me to take medication so that I don't get either too hyper or too depressed to the point of suicide.”

Fry told the audience that, in light of his role as president of the mental health charity, Mind, he wanted to be open about his feelings. “The whole point in my role, as I see it, is not to be shy and (to be) forthcoming about the morbidity and genuine nature of the likelihood of death amongst people with certain mood disorders.” He said there is “no reason” for someone wanting to take their own life. “There is no ‘why’. It's not the right question. There's no reason. If there were a reason for it, you could reason someone out of it, and you could tell them why they shouldn't take their own life,” he said (BBC News Entertainment and Arts June 6, 2013)

Being a writer and a comedian may not be the most ordinary job one can think of but Fry's struggle with his mental health condition (MHC¹) mirrors the experiences of many others who have a MHC. People struggle with MHCs and this is not only a struggle for their own health and wellbeing because it also has a spill-over effect in their ability to thrive in everyday life.

¹ For succinctness, someone being diagnosed as having a mental health condition will be referred to here as having a MHC. Please see appendix 2 for detailed information regarding the MHCs which this study considered.

The focus of this thesis is on the work aspects of these lives. The study aims to reveal and explore the meanings surrounding mental illness within work organisations and how this affects and is affected by notions of identity and material circumstances (i.e. living conditions, gaining an income and securing employment). Fry states that there is ‘no reason’ for someone wanting to take their own life. There is no ‘Why?’. Although there are different MHCs, which manifest themselves in different ways and different levels of severity, the invisible nature of mental illness and the way in which it manifests itself in ‘unreasoned’ ways may indeed be one of the causes for the societal stigma, misunderstanding, secrecy, pain and struggle associated with mental illness. Indeed it is often extremely difficult to explain what it means to have a mental illness; to disclose a MHC to others; to ask for help and to come forward. As such, many individuals with MHCs suffer in silence and do not gain the support and recognition which is often necessary for them to participate fully in work organisations.

This work aims to examine the complex meanings surrounding the notion of mental health and mental illness and the way in which these are manifest in the lives of individuals with MHCs. The research was conducted during a period of economic downturn where the global financial crisis, austerity measures and recessionary effects on employment, present a highly competitive labour market and one that is potentially more problematic for individuals with MHCs. The notion of the ‘ideal worker’, that is, someone who can be selflessly devoted to the needs of the organisation and to engage with unfettered performance and commitment to work (Rose, 1988; Acker, 1990; 1992), suggests that people with MHCs are potentially distanced further from this norm because of their stigmatised identity and of the material and discursive challenges of their condition.

This introductory chapter sets the scene for the thesis. The chapter begins by exploring the evolving discourse of mental illness, leading to the contemporary understandings of MHCs in work organisations. Following this, the aims of and

approach to the study will be introduced. The final part of the introduction will outline the structure of the thesis.

1.1. The discourse of mental illness

The Foucauldian notions of discourse and the subject is a widely adopted theoretical approach within the social sciences broadly, and organisation studies specifically. Discourses can be understood as bundles of linguistic and material practices that ‘systematically form the object of which they speak’ (Foucault 1972, p.49). Discourses ‘do not identify objects, they constitute them and in the practice of doing so conceal their own invention’ (ibid.). Through this process ‘human beings are made subjects’ (Foucault 1982, p.208) within a discourse. As such individual space for action is reduced within the constraints of normalising discursive regulation and the expectation from individuals that each will live up to the subject position embedded in discourse (e.g. Pêcheux, 1982; Knights and Willmott, 1989; Dean, 1999).

Discursive regulation is created and reinforced through the micro-politics embedded within everyday interaction and through this process we are encouraged to behave in a certain way, which is a desired and expected form of thinking, being and behaving. Other ‘non-desired’ forms of being or behaving are excluded. In this process individuals gain meanings from a number of subject positions which then define their sense of subjective identity² (Foucault, 1982). These meanings are gained by internalising normalising discursive practices into our social and

² Whilst identity is a popular term which has been broadly used in organisational literature, it is important to make it clear that, in Foucauldian literature, the notion of identity as it is referred to in this study is more commonly known in critical literature as subjectivity (e.g. Bergström and Knights, 2006). Although this study adopts a critical position, it uses the term identity as opposed to subjectivity. This is in order to make this thesis as accessible as possible to a wide range of readers since identity is a concept more readily understood in everyday language (see chapter 2 for a detailed explanation on how this concept is being used in this thesis).

individual self-understanding, which then define us (e.g. Foucault, 1982; Rose, 2010).

One instance by which discursive regulation is particularly significant is in the context of mental illness. Whilst taking different complexions throughout history, the meanings embedded within the discourse of mental illness have been consistently understood oppressively and pejoratively. 'Being mentally ill' was regarded as a 'vice' during the 13th century, 'a different class of humanity' in the 17th, and a non-curable disorder (Foucault, 1971) of the 'will', or a 'moral' problem in the 18th century (Mayo, 1838 cited in Blackman 2001, p.116-117).

One of the most significant landmarks in the evolution of the notion of mental illness was during the enlightenment era which saw the establishment of the sciences. The main ideas of reason and the Cartesian view that science is explored through the observable body (Scheper-Hughes and Lock, 1987) stood against what was regarded then as 'lunacy'. This is probably because the symptoms of mental illness manifest in unusual, invisible and non-physical ways.

As a population who did not follow the main ideas of 'reason', and did not conform to the subsequent expectation that they would be part of the labour force, those considered insane were segregated out by the State. Together with other marginalised groups (e.g. those considered to be poor, criminals, or ill) they were placed into asylums and away from their communities and the rest of the working population. These individuals who did not work were classified into what evolved into the class of unemployment (Donnelly, 1983). Thus, 'the mentally ill' became linked to a reduced social role, exclusion and unemployment (Foucault, 1971; Doerner, 1981; Peterson, 1982; Porter, 1987; Rose, 1989).

With time and further exploration of populations within asylums, specialised divisions were created followed by medical exploration and those who were diagnosed as mentally ill were admitted into special 'mentally ill' asylums. The growth in the asylums during the 19th century provides evidence of the formal regulation of inmates, and the increasing numbers of admissions (Scull, 1979; Rogers and Pilgrim, 1996). At the same time, medical physicians who were predominantly qualified in treating physical illness and the provision of medical advice started to become specialised in what came to be known as psychiatry (Bracken and Thomas, 2005; Szasz, 2008). The scientific exploration carried out in the asylums of illnesses found therein, thus established the ground for what came to be known as the psychiatric profession; and the increased recognition in the notion of 'mental illness' started to spread within the wider population (Foucault, 1971; Bracken and Thomas, 2005).

The construction of the discourse of mental illness is thus understood in a multifaceted way. It illuminates how discourse creates spaces (asylums, hospitals), objects and practices (various technologies for treatment; sectioning) and a number of subject positions (the mentally ill, the psychiatrist, the mental illness nurse, the asylum warden, legal experts).

As the medical diagnosis of an individual as mentally ill resulted in immediate social isolation and repression through forced admission into an asylum, the discourse of mental illness can be seen as standing at the interface between the medical and the political spheres. The pejorative subject position resulting from it, namely here the 'mentally ill' subject position, is understood as socially constructed through repression in both the medical and the socio-political spheres. Within the medical sphere, the inappropriate conditions found in the asylums, the poor treatment and reduced number of discharges (Rogers and Pilgrim, 1996) as well as the legitimacy of the authority of mental health professionals to make a diagnosis and to lead the course of the patients' treatment, served to repress the

agency of the patient to be in control over their lives and their own recovery (Foucault, 1982).

Within the social sphere, the secrecy and segregation of the 'mentally ill' in the asylums and the dominance of psychiatry as a science and a profession over mental health-knowledge, is also associated with restricted distribution of information about mental illness to the public. And this public ignorance, in turn, promotes stigma and fear (Scheff, 1966; Bracken and Thomas, 2005). This construction of mental illness as deviant and the practices of social exclusion of sufferers are an integral part of the mental illness discourse (Foucault, 1971; Gordon, 1986; Porter, 1987); practices relating to such a pejorative subject position prevail to this day (Bryne, 1999; Blackman, 2001).

Although remaining as a stigmatised subject position to this day, the latest set of meanings within the mental health discourse sees the ascendancy of the anti-psychiatry movement. This movement is not new, having existed nearly as long as the notion of psychiatry. Its aim is to criticise the social oppression and psychiatric treatments in the asylums, operating as a social movement around the world (e.g. the anti-asylum society, Mad Pride). Together with critical writers (e.g. Szasz, 1961; Laing, 1967; Foucault, 1971), the anti-psychiatry movement fights against the repression inherent in mental health language and treatment as well as the stigmatisation, labelling, segregation and forced hospitalisation (e.g. Goffman, 1961; Szasz, 1961; Laing, 1967; Guattari, 1995; Geller and Harris, 1994).

Alongside these campaigning organisations and critical writers, other initiatives have served to change the mental health agenda, especially in relation to greater recognition of human rights, a general move to consumerism in health services, global institutional changes within the health systems, the individualisation of health-care and care in the community. These factors, coupled with the critiques raised by the anti-psychiatry movement, have led to greater recognition of

patients' voices. A variety of mental health services were introduced into national health systems (in the UK, US as well as other countries), some of which are led by the patients themselves and have led to a growth in the recognition of the need for dignity and control by the patient over their treatment.

All these, together with the impact of anti-discrimination legislations (e.g. in the UK, Disability Discrimination Act, 2005; Equality Act, 2010), disability movements, mental health promotion and anti-stigma campaigns (led by charities and the health services), contributed to the changes within the meanings of mental illness over the years. However, whilst the notion of mental illness has changed since it was established (Bracken and Thomas, 2005), this discourse still carries with it pejorative and oppressive meanings to this day both in wider society (Turner, 1981) and, more specifically, in work organisations (Gelb and Corrigan, 2008).

1.2. Employment and mental illness

Within the tight labour markets prevalent during times of recession, as was the case when this thesis was being undertaken, employers can be more demanding and more selective of workers. Given this tight labour market, there are greater pressures to enhance career prospects and this then urges everyone to work harder and 'better'. In the light of these constraining employment situations the struggle of those with enduring and stigmatised illnesses may not come as a complete surprise. Indeed, recent employment reviews draw on the struggle of people with MHCs both socially and at work (Üstün, 1999; Ungar, 2011). In the UK, the Marmot Review (2010) for example, highlights the struggle of individuals with MHCs in the workplace and draws attention to the way in which they can be cyclically trapped in poor working conditions and reduced employment opportunities.

Strikingly, studies continuously refer to the discrimination and stigma attached to mental health and illness at work, highlighting how these not only affect the lives of those with continuous and enduring MHCs (e.g. Akabas, Gates and Galvin, 1992; Ritsher and Phelan, 2004) but also entire working populations. For instance, a recent UK based report illuminates how, whilst a large part of the working population suffers from stress at work, employees are still reluctant to disclose this stress to their employers (Mind, 2013a). Likewise whilst the statistic draws on figures whereby one in four people suffer from a period of mental illness in their lives, only a few will report this to their employer (Paton, 2007).

The growing figures of mental illness worldwide (WHO, 2003; 2007) and the millions of working days which are lost every year to mental health absence overall (e.g. Greenhalgh, 1994; Braunstein, 2000; The Sainsbury Centre for Mental Health, 2007) thus stands in contrast to the reluctance to disclose mental health matters at work (Mind, 2011; 2013a). This issue is particularly heightened for the population for whom these issues are starker. The person with a MHC has a double paradox: that of being encouraged through the techniques of mental health care to self-disclose as a part of therapeutic healing, while at the same time feeling compelled to hide their condition from work colleagues for fear of becoming recognised as a 'mental' person: being identified with a stigmatised and marginalised identity that can have significant material consequences for their employment prospects and their daily experiences at work.

However, whilst disclosure of a MHC may lead to stigma, discrimination and could also jeopardise the career prospects of the individual, the costs of concealment are also high. Concealment can often result in restricted relationships with work colleagues, limited career prospects, constant worry over hiding the MHC, and may also lead to delayed treatments (Gelb and Corrigan, 2008). The paradoxes of managing a stigmatised condition in the workplace thus suggest a number of conflicting motives which may affect people with MHCs at work and their attempts to secure material conditions and to manage their health. These motives can also

have an effect on the way in which these individuals construct and negotiate a sense of self at work through a number of competing discursive arenas.

Whilst the stigma of 'mental illness' can have detrimental effects on the lives of individuals with MHCs at work, the paucity of studies which examine the experiences of these individuals in achieving meaningful, fulfilling and decently remunerated work (i.e. having access to decent employment, which has career prospects, in which one's talents are recognised), suggest that this important subject requires further investigation. Additionally, this paucity of studies underscores the need for in-depth, nuanced analysis that considers the different experiences of individuals with MHCs, mediated by the nature of employment and the particular MHC.

By exploring the different ways in which individuals respond to, and identify with, the discourse of mental illness, a greater appreciation of the forms of struggle and the nature of agency can be gained.

1.3. Studying identities at work

This thesis is predominantly concerned with the way in which individuals with MHCs negotiate their identities at work and with the discourses upon which they draw during that process. Equally, the thesis examines how the meanings of mental health and illness at work are constructed through the experiences of individuals with MHCs. As individuals gain meaning from a discourse as a way of doing and being, they come to identify with dominant discourses which make available subject positions and self-understandings. This thesis utilises the notion of identity which arises from this interaction as a site for the production of knowledge.

This investigation would also allow for gaining an insight into the multiplicities of meanings that individuals with MHCs draw on in their attempts to make sense of their identity and self-understanding. This process will also reveal the different discourses and subject positions which are salient in the lives of these individuals. Additionally, however, whilst individuals construct their identity through the resources and constraints of discourse, their overarching identities are never fully determined by discourse, but rather individuals bring their own interpretations and discursive resources into their identity construction. For this reason the studies of identities as sites for knowledge production are important because, whilst this allows for an exploration of the struggles and the experiences of individuals with MHCs, it also allows for the exploration of practices of agency, resistance and the embracement of fresh knowledge.

Thus, studying identities will allow the exploration of the motivations of different individuals in responding to the discourse of mental health and the ability to compare and contrast how individuals with MHCs live up to constraining discursive regulation as well as their struggles, agency and resistance to them. The setting of identity as a site for discursive regulation of social processes and the individual's construction of self, affords the potential for the exploration of contemporary discourses, practices of agency and resistance as well as new/fresh meanings within the construction of mental illness and the way in which individuals understand themselves and live their lives.

This approach would also allow for studying how and why individuals respond in different ways to the discourse of mental health and enables us to compare and contrast the complex and diverse contexts facing those with MHCs in their attempts to gain and maintain employment. This type of exploration could then illuminate how people with MHCs make sense of their own experiences and struggles.

As a former Employment Specialist in the not-for-profits sector I became aware of the complex struggles faced by individuals with a MHC in their attempts to gain and maintain employment. They must, for example, deal with the dilemma around the disclosure of the MHC in the workplace, the management of their condition, the unpredictable nature of their symptoms, the social stigma, discrimination, and misunderstandings relating to the nature of the illness. All of these were constant dilemmas in the lives of those whom I have assisted in gaining and maintaining work. However, what struck me most profoundly was the pronounced suffering they endured and the lack of awareness or public recognition of what these individuals had to manage. This study thus endeavours to illuminate the experiences of individuals with MHCs in the workplace. It aims to gain an insight into their lives and the struggles they face and, as such, this study also has a political essence to it. It wishes to explore how and in what ways, in their attempts to secure employment, these individuals also work to construct a sustaining and legitimate identity and a positive sense of self through their employment.

This research offers a number of contributions to theorising and researching mental health at work and the way in which people with stigmatised identities construct a personal sense of meaning through work. Whilst the literature on identities is broad and has been studied from a number of theoretical approaches, this study takes a poststructuralist understanding of the concept, that sees identity as fluid and context bound, constructed through a number of subject positions and located in relation to discourse (e.g. Holmer-Nadesan, 1996; Thomas and Linstead, 2002). Consequently, this research considers the inter-relationship between the literature on critical identity studies and the discourse of mental health and illness, involving a study of identity construction that also asks the questions: What is meant by being an employee with a MHC? How do people with MHCs negotiate their identity in the workplace? Hence, how do they act upon and contest a 'mentally ill' subject position, and with what effects?

Equally, the research aims to identify how individuals relate to the predominant employment and societal discourses and how do they respond to prevailing discourses on employment and the notion of the committed high performing worker. Hence the study questions how people with MHCs themselves relate to hegemonic discourses. Consequently, the study seeks to interrogate how individuals with MHCs position themselves in relation to deep-seated discourses that have become so well established that they function as the ‘taken for granted truth’ and as the ‘natural’ state of affairs.

By examining the discourses and subject positions that the study participants highlight, the research aims to gain an insight into experiences of having a (debilitating) health condition. As a consequence of its approach, this study not only wishes to examine how individuals with MHCs construct, contest and negotiate their identities in different contexts but also how discourses are (re)constructed and contested and the impact which they have on the lives of individuals in contemporary employment. Following the critical examination of the literature and of the lack of studies that sufficiently address the employment experiences of people with MHCs, this study explores three inter-related questions.

First, the study aims to explore the different forms by which people with MHCs construct identity. It wishes to tease out more of the subtleties in understanding the experiences of people with MHC at work. Hence what does it mean to have a MHC at the contemporary workplace? How is the notion of mental illness constructed in the empirical material? Through this exploration, the study wishes to illuminate some of the processes embedded within the critical notion of identity construction and discourse and the different subject positions that comprise individuals’ identities. Hence: What is the relationship between an individual’s notion of self and the discursive resources available to them in constructing their identity? To what extent does their MHC influence this construction?

The second interrelated question that this thesis examines is: What are the paradoxes and struggles experienced during the attempts to secure employment and a legitimised identity at work? And what is the impact of these on their identity and attempts to enhance career prospects and how do these intersect with their self-care and health management? How do individuals negotiate the dilemmas around the declaration of a MHC, as part of their self-care, versus the potential price of declaring a stigmatised identity? As such the study asks what are the different forms of struggle experienced by these individuals in their attempts to secure employment and a legitimised sense of self at work?

Thirdly, the thesis examines the exercise of agency and resistance in the process of identity construction and discursive regulation. It aims to understand better the acts of agency and resistance as they take place through the process of negotiating identity in relation to the mental health discourse and subject positions. It aims to examine how these individuals take on, resist or challenge the discourse of mental illness in the work setting. The study of these matters of agency and resistance is particularly important in this context because it provides insight into the way in which individuals might unsettle the meanings around the mental illness discourse and subject position and thus providing knowledge to aid the improvement of the lives of people with MHCs at work.

1.4. Thesis route map

In the following two chapters, the literature that informs this thesis will be discussed, starting in chapter 2 with an exploration of the research on identities and organisations. This chapter covers the literature on identity as understood from a number of theoretical points whilst placing particular emphasis on the way in which identity is critically understood in organisational and management studies. The chapter begins by introducing the notion of identity whilst

distinguishing between the essentialist (e.g. Bakhtin, 1981; Giddens, 1991) and the constructionist approaches (Goffman, 1961; Mead, 1982).

The chapter then continues by evaluating a number of perspectives on identity in organisations and leads to a more detailed examination of Foucauldian and poststructuralist-informed literature on identity within organisations—a perspective that this study adopts. The chapter examines in more detail this understanding of identity as fluid, and constructed in context and in relation to a number of subject positions drawn from a discourse (Foucault, 1977a; Alvesson and Willmott, 2002), and continues by evaluating other identity related concepts, thus covering a number of topics including those of agency, resistance (Clegg, 1989; Kondo, 1990; Knights and Vurdubakis, 1994; Thomas and Davies, 2005a) and the ‘ethics of the care for the self’ (Foucault, 1985). The chapter concludes by highlighting the gaps in the literature on identity in the context of mental illness and hence sets out the need for the current research.

The following chapter, chapter 3, then sets out the literature on the discourse of mental health and illness and its application in the workplace. The chapter begins by introducing the discourse of mental illness. It describes the way in which the discourse of mental illness results in a pejorative subject position. The discussion then continues by enlarging the discussion, presented at the start of this thesis, on the development of the discourse of mental illness and explores the implications of what can be seen as two dominant meanings and elements associated with the mental illness discourse named in this thesis, namely ‘the mental health patient’ and ‘the stigmatised subject position’ (e.g. Goffman, 1968; Foucault, 1982). The remains of the chapter explain how the notion of mental health and illness is understood in contemporary organisations today. The discussion focuses on the issues of stigma and discrimination surrounding both mental illness and mental health concerns at work. The way in which mental health stigma impacts on disclosure decisions at work and the effect on the lives of individuals with MHCs is also considered.

Following the evaluation of the literature on organisations and the discourse of mental health and illness, the final section of chapter 3 sets out the conceptual framework of the thesis, highlighting how identity, the mentally ill discourse and the subject position which it carries for the individual with a MHC, are understood and used during this research. Inspired by a Foucauldian approach to discourse and subjectivity, the conceptual framework considers identity as an ongoing composite of a number of subject positions and thus as a relatively fluid but context bound concept that is crafted (Kondo, 1990). Exploring how individuals with MHCs construct an identity through the meanings they attribute to a number of subject positions resulting from discourse will also throw light on the meanings embedded within the discourse and subject positions of mental illness at work. Therefore, the study utilises the conceptual setting for identity and discourse to examine how individuals with MHCs negotiate their identity at work and, consequently, how the discourse and subject position of mental illness is understood in its interrelationship with contemporary employment discourses.

Chapter 4 outlines the methodology and research design adopted in this thesis, taking into account the rationale for the ontological, epistemological and methodological underpinnings of the research and their relationship to the method chosen. In addition, the chapter explains the processes of empirical analysis as well as the ethical considerations and reflexive position underpinning this examination. In particular the chapter provides a detailed account on the meanings embedded with a Foucauldian driven ontology and epistemology and the consequent discursive informed methodology that this study adopts. The chapter also provides an account of the method used and the way in which the data was collected and analysed.

Chapters 5, 6 and 7 are the three chapters that report the main empirical findings of the thesis. Chapter 5 highlights the stigmatised and pejorative meanings ascribed to mental illness. The chapter illustrates how mental illness is associated

with negative attributions, fear, and ignorance. The empirical material illustrates how mental illness is constructed as more than an illness *per se*. It illustrates how the pejorative meaning of mental illness is constructed as a social identity label. The chapter then moves on to deal with the way in which these pejorative meanings are perpetuated in the workplace by associating mental illness with pretence, subterfuge, confusion and misunderstanding.

Chapter 6 turns our attention to the individual dilemmas surrounding the declaration of mental illness at work and in other settings. The chapter discusses a range of challenges over the decision to disclose or conceal a MHC in the work context. In doing so, the chapter discusses the impact of stigma and discrimination on career prospects, management of the MHC and feelings of subterfuge and secrecy. The chapter considers the factors contributing to decisions to conceal a condition and to undertake complex forms of subterfuge. These factors are considered in the light of the implications on health management, career development and an overall sense of being. The tensions, conflicts, and costs related to displaying a MHC, and the struggle to maintain wellness and be open at work whilst living up to normalising discourses, is discussed.

The final empirical chapter, examines the idea of 'self-management' and the way in which it illustrates a shift in the passive medical subject position of the 'mental health patient' and the move into 'mental health self-management' as a way of maintaining work and enhancing career prospects. The second part of the chapter illustrates how the attempts to open up the discussion on mental health at work are displayed in the empirical material both through the individual and the organisational levels. The chapter concludes by highlighting how the facility to reshape the pejorative meanings attached to mental illness leads to the emergence of positive images and attitudes toward mental health and illness in the workplace.

The discussion chapter is centred on the following main issues: In addressing the first two research questions the chapter will seek answers to the questions: To what extent is the discourse and subject position of mental illness understood through the identity construction of study-participants? How do people from a wide range of sectors and hierarchical mix attribute meanings to mental illness at work? How do people with invisible and stigmatised illness negotiate an identity in the workplace in a way that allows them to live up to predominant employment discourses? How do these individuals maintain a semblance of an 'ideal performing worker' and what are the costs that this process entails? Having considered the findings in light of these questions, the discussion chapter then moves on to address the third and final research question by looking at issues of agency and resistance. The discussion considers how resistance can be understood as an attempt to rewrite employment discourses, and to recraft meanings within the context of mental health and illness in the workplace. It also considers the way in which the notion of agency can be understood as practice of self-care for people with MHCs.

The final chapter, chapter 9, draws the main conclusions of the thesis and outlines the central contributions that this research makes to the literature on critical identity studies and to the literature on mental health and illness at work. The practical contributions of the research are also considered by highlighting the relevance of the study for managers and for policy makers. The remainder of the chapter deals with the limitations of the study whilst examining questions related to the research design and to the theoretical positioning of the study. The predominant concerns related to the reflexive positioning of the author in crafting the study are also addressed. The chapter concludes by looking at the potential scope that this study may have towards improving and developing future practice whilst delineating the possibilities for further research.

The next chapter provides theoretical background information and explores the key concepts which will be used throughout the thesis namely; identity, discourse, subject position, agency and resistance.

Chapter 2: Identity and organisation

2.1. Introduction

This study explores the identity experiences of individuals with Mental Health Conditions (MHCs) in work organisations. It utilises insights from poststructuralist thinking, taking a critical discursive approach to identity, influenced by Foucauldian analysis of discourse and the subject (Foucault, 1982; Bergström and Knights, 2006) to gain an understanding of the way in which people with MHCs in employment formulate an understanding of their self. This study follows the poststructuralist tradition of identity research, exploring the construction of the self as a political site for discursive power regulation and resistance. It utilises Foucauldian influenced literature on identity in organisations, drawing on insights into the multiple processes of identity construction and the tension between discursive regulation and acts of agency and resistance within organisational contexts.

The chapter will be structured as follows: The first part will present an overview of the concept of identity, followed by a discussion from several perspectives considering the study of identity in social and organisational studies (2.1.1). A poststructuralist perspective, specifically one that utilises the discourse approach of Foucault, is introduced, setting out the interconnected ideas on power, discourse and the subject (2.2). This will be followed by a discussion on critical identity studies (2.2.1) in the organisation literature. The role of agency in the construction of identity will be discussed next (2.2.2). This will be followed by a discussion on resistance and the ways in which this has been looked at in identity studies (2.3), leading on to a discussion on Foucault's notion of the ethics of the care for the self (2.3.1), two illustrative pieces within critical management studies (CMS) (.2.3.1.1) and a short critique (.2.3.1.2)

2.1.1. The notion of identity

‘Who am I?’ or ‘How do I define myself?’ and consequently ‘How should I act in different situations?’ are the main questions which stand at the heart of the notion of identity. Often referred to as the self, notion of self or self-understanding³—identity—is a well-researched topic within the social and organisational sciences (Cerulo, 1997; Alvesson and Willmott, 2002; Knights and Vurdubakis, 1994; Alvesson, Ashcraft and Thomas, 2008; Thomas, 2009). It can be understood as the intersection between an understanding of the self, the social (Ybema et al., 2009) and other environmental factors such as a person’s job role, and personal situation. This important interface between the self and the social may have been one of the reasons why identity is a popular topic, allowing for a simultaneous exploration of individual lives and wider socio-political processes and circumstances (Hardy, Lawrence and Phillips, 1998).

Identity is not a straightforward concept and has a number of different meanings, reflecting different theoretical orientations. There are fundamental differences in the ways in which the concept of identity has been studied and, whilst it covers a wide range of issues such as the self in social interaction (Turner, 1984), consciousness, thoughts, feelings and values (Hassard, Holliday and Willmott, 2000), other sets of meanings are also embedded within the notion of identity. Two broad ways of conceptualising identity can be noted: essentialist and constructionist. Essentialist approaches work with the idea that identity is a given and permanent essence (Ashforth, 1998; Ashforth and Mael, 1989; Gioia, Schulz and Corley, 2000; Haslam, 2004). The approach includes psycho-social theories which study how individuals relate to themselves (Freud, 1999) and to their

³ Whilst different writers use different terms, this thesis refer to identity in the main as this is the most accessible and most frequently used in common parlance. However, when referring specifically to the individual’s conception of their self (notwithstanding the aspect of identity that is attributed on someone by others), I will refer to the self, notion of self/self-understanding.

environment (Lacan, 1968) as well as existential approaches which examine the way in which the individual's self-understanding provides them with a sense of meaning and purpose (Frankl, 1959).

Recently, however, the influence of poststructuralist philosophies, feminisms and other theories of identity politics introduced a constructionist position, focusing on the role of identity in the analysis of society, economy (Bauman, 2006; Sennett, 2006; Giddens, 1991), and work (Cerulo, 1997; Alvesson and Willmott, 2002; Alvesson et al., 2008; Thomas, 2009). Included within the constructionist approach are issues related to social role (Goffman, 1961; Mead, 1982), as well as gender, ethnicity, class, nationality, organisational and professional memberships (Child and Rodrigues, 1996; Grimshaw et al., 2001) as well as citizenship, employment, or family membership (Webb, 2006).

For some analysts, the constructionist approach to identity relates to the move towards a postmodern era which consequently produces a more unstable set of identity anchors (Bauman, 2006). Whereas Marxist analyses of the class society draws on a pre-determined, fixed and stable identity (Willmott, 1994), modern life has been characterised by a weakened sense of identity (Sennett, 1998; Lair, Sullivan and Cheney, 2005). The unstable social structure, ongoing change, achievements-orientated culture and the pervasive worries and anxieties (Bauman, 2004), may have reflected back on the nature of identities, viewing them as achievable and unstable as opposed to stable, permanent or pre-determined (Albert, Ashforth and Dutton, 2000). Thus, identities today can be understood as partial and not absolute, crafted through practice, and negotiated in context (Bauman, 2004).

This study adopts a constructionist perspective on identity. It explores how individuals with MHCs construct their identity and negotiate a notion of self across a number of contexts and in relation to work, thus utilising available theorising on

identity within organisations. Furthermore, the thesis utilises insights from poststructuralist and Foucauldian literature which then adds a discourse/power approach to the understanding of identities. In other words, whilst utilising the overall constructionist approach for studying identities, the specific stance taken adopts a discursive and critical approach that assume that identities are constructed in discourses and through the dynamics of power relations (this will be explored in more details in the section 2.2). Identity studies have been particularly influential in the study of organisations and, together with the associated concepts of identification and dis-identification, identity control and identity resistance, has informed a whole gamut of studies; some of which are discussed below.

Identity in organisational studies has been extensively examined from a variety of perspectives: the organisational lens (Albert and Whetten, 1985; Dutton, Dukerich and Harquail, 1994; Czarniawska-Joerges, 1994; 1997; Elsbach, 1999; Gioia et al., 2000; Fiol, 2002); in relation to professions and knowledge workers (Pratt and Rafaeli, 1997; Meriläinen et al., 2004; Thomas and Davies, 2005a); concerning organisational effectiveness (Ashforth and Mael, 1989; Haslam and Reicher, 2006); within the social perspective of work (Hogg and Terry, 2001; Alvesson and Kärreman, 2001); group and social identities (Dahler-Larsen, 1997; Scott, Corman and Cheney, 1998; Kuhn and Nelson, 2002; Haslam, 2004; Ashcraft and Alvesson, 2007); managerial control (Knights and Willmott, 1999; Alvesson and Willmott, 2002; Thomas and Linstead, 2002) as well as the personal and individual lens (Pratt and Foreman, 2000; Sveningsson and Alvesson, 2003). Identity studies also draw from a range of theoretical frameworks, varying from descriptive/positivistic and interpretive accounts (Ashforth and Mael, 1989; Giddens, 1991; Ibarra, 1999; Albert et al., 2000; Kreiner, Hollensbe and Sheep, 2006) to critical identity studies (Knights and Willmott, 1989; Kondo, 1990; Kunda, 1992; Ibarra, 1999; Thomas and Linstead, 2002; Adib and Guerrier, 2003; Ashcraft and Flores, 2003; Collinson, 2003; Klein, 2000; Watson, 2008). The discussion below will throw more light on identity research from each of these theoretical frames.

2.1.1.1. Positivist approaches to identity

Identity studies in organisations taking a positivistic perspective tend to utilise psycho-social theories as well as social psychology. The main theoretical frameworks in this context are Social Identity Theory (SIT) and self categorization theory (SCT) by Tajfel and Turner (1986). Organizational studies that have adopted this approach take the assumption that ‘individuals engage in forms of cognitive distortion in the identification process’ (Kenny, Whittle and Willmott, 2011, p. 16). Overall, studies which utilise this approach are interested in exploring the role of identity for a wide range of organisational issues such as the processes by which individuals come to identify with a particular group within the organization (O’Connor and Annison, 2002); group cohesion (Ashforth and Mael, 1989); social support (Haslam and Reicher, 2006); performance; organizational behaviour; managerial targets (Haslam, 2004); commitment (Sass and Canary, 1991); decision making, loyalty and motivation (Ashforth and Meal, 1989; Elsbach, 1999) and organisational effectiveness (Haslam, 2004).

Those who have drawn on psycho-social approaches have outlined benefits for resolving managerial issues or methods to improve employee performance. Accordingly, such an orientation has attracted a number of points of criticism from scholars taking alternative approaches. Given its clinical origins, the psychological approach has been criticised for its neglect of social settings (Kenny et al., 2011). Furthermore, viewed through an epistemological lens, this approach treats identity as coherent and sustained across situations, thereby limiting the possibility to examining processes of contradiction, social construction or changes taking place across situations (Aschcraft and Alvesson, 2007; Alvesson et al., 2008).

More broadly, the psycho-social approach can also be accused of reducing identities and social processes to a cognitive practice. This in turn, does not allow for understanding how identities are located within broader discourses, or for understanding multiplicities of meanings (Wetherell and Potter, 1992). This perspective is also criticised for its inability to accommodate historical processes

(Parker, 1997), cultural differences (Butler, 1993), social construction and change (Ascraft and Alvesson, 2007) as well collective and political struggle.

Overall, the core focus of the critique of the positivist psycho-social approach to studying identities is its assumption that identities are constant and stable, thus rendering them unable to compare and contrast across different situations and identification processes.

2.1.1.2. Interpretive approaches to identity

Whilst the main focus of descriptive/ positivist studies is to examine issues related to organisational identification and effectiveness, the main focus of interpretivist studies is on the experiences of the individual, their reflections in relation to their lives and work and trying to identify how individuals react to the multiplicity of meanings in organisational life. This approach is based on the interactive nature of identity and its construction through context and the relation with the 'other'. These ideas are based on phenomenological theorizing on identity, one significant aspect of is the theorizing on 'symbolic interaction' (Cooley, 1902; Mead, 1934). The notion of 'symbolic interaction' takes the assumption that individual action is based on the meaning resulting from social interaction and the processes of interpretation (Blumer, 1969).

Furthermore, Mead's theorizing on the self as comprised of the dynamic between the 'me' and the 'I' (Mead, 1934) is significant here. Whereas the 'me' relates to the way by which we internalize the meanings gained through the interaction with our environment and significant others, the 'I' addresses the responses and reactions of the individual to their environment. This approach draws attention to the way in which identity is constructed through interaction with the 'other' and through responses to our environment. Thus we come to understand ourselves through what we have learned in our environment, how we react to our environment and the meanings we attribute to our experiences (Mead, 1934).

When applied within the workplace, this perspective aims to understand the contradictions and continuities of the individual experience at work. It stresses the interactional conditions and consequences of 'identity production' and takes the stance that individual's notion of self is relational and dependent upon their interaction with the other (Sluss and Asforth, 2007). Identity studies that have adopted this approach examine how individuals engage in ongoing processes of identity construction to derive a positive and coherent sense of self. This approach focuses on the way in which individuals narrate their identity through a range of communications, cultural meanings, experiences and aspirations (Knights and Willmott, 1989; Sveningsson and Alvesson, 2003) and in a way that helps them gain coherency in their construction of self (e.g. Collinson, 2003).

Given the assumption that identity is constructed through a relational and social interactive process, and between the individual and the work setting, the approach draws the attention towards the *processual* nature of identity and suggests that identity is always evolving in relation to 'the other' (Alvesson et al., 2008). As such, certain settings, discourses, or social interaction may trigger a tension or may challenge existing ideas of the individual about themselves in a way that would then impact on their identity construction (Klein, 2000; Alvesson and Willmott, 2002).

The focus on the continuous and interactional nature of identity is reflected through the notion of 'identity work' (Alvesson et al., 2008), a popular term utilised in analysing this process (Alvesson and Willmott, 2002; Watson, 2008). Studies taking this approach have examined how employees are encouraged to know themselves through identifying with the organisation such that they and the organisation's identity become as one (Kunda, 1992); and how employees' 'identity work' becomes more active across a number of settings (Watson, 2008) causing tensions between self-understandings and organisational ideals (Klein, 2000; Alvesson and Willmott, 2002). Given the assumption that identity is constructed in

interaction, identity work may also be triggered in situations such as stress and uncertainty (Alvesson et al., 2008); in radical circumstances (Ibarra, 1999) or crisis (Beech, 2008; Watson 2008). In that sense, studies on work and organizations have extensively used the interpretive approach for studying a range of identity issues, from bullying at work (Kaufman and Johnson 2004; Lutgen-Sandvik, 2008) uncertainty (Collinson, 2003); resignation (Ebaugh, 1998); undertaking new professional roles or making career choices (Ibarra and Barbulescu, 2010); socialization (Ibarra 1999); leadership (DeRue and Ashford, 2010); entrepreneurship (Fauchart and Gruber, 2011) and culture and identity at work (Swidler, 1986; Weick, 1995; Czarniawska-Joerges, 1997).

Although it offers a significant contribution to the understanding of identity in organisations (Alvesson et al., 2008), the interpretive perspective tends to focus on localised contexts and personal social relations which may in turn limit the possibility to address wider cultural, socio-political and institutional concerns within which local practices take place (Ibarra, 1999; Kreiner et al., 2006). Thus whilst the approach may provide insights into how individuals construct their identity through a continuous process, in social relations, and within certain context, and whilst this perspective addresses the criticism directed towards the descriptive positivistic approaches, it is limited in its ability to accommodate the dynamic relationship between understandings of self and wider socio-political, cultural and historical situated practices.

Whilst some of these issues may have been partially examined in studies which have adopted the interpretive approach, they are more clearly reflected within the stream of organisational studies which have adopted a critical perspective (Alvesson et al., 2008). These studies examine how cultural, political and historical practices are reflected through the process of identity construction and through the dynamic relationship of employers' expectations on employees' construction of self (Deetz, 1995; Holmer-Nadesan, 1996; Meriläinen et al., 2004; Thomas and Davies, 2005a). Influenced by poststructuralist theorising and Foucault's work on

discourse and subjectivity, these studies take a perspective which regards identity as comprised through power dynamics, being fluid, context bound and compounded by a number of subject positions.

2.2. Foucault, discourse and identity

The Foucauldian approach to discourse and the subject is a widely influential theoretical framework across the social sciences broadly and organisation studies in particular. Discourse can be understood as linguistic and material practices that ‘systematically form the object of which they speak’ (Foucault, 1972, p.49). Discourses ‘do not identify objects, they constitute them and in the practice of doing so conceal their own invention’ (ibid.).

According to Foucault (1980; 1982), it was during the enlightenment, which saw the establishment of sciences as the ‘norm’ for understanding that systematic State regulation of populations became widespread. Together with the development of knowledge, new disciplines and new categories (e.g. health and illness) the subsequent taken for granted ‘truth’ became more commonly and universally determined and widespread. This process of knowledge production and its circulation through the power dynamic of language and other material practices is then referred to in Foucauldian terms as discourse.

Discourses evolve within societies, whereby every culture has its own regimes of ‘truth’ (Foucault 1980, p.131) which are particular kinds of concepts and structures that divide experiences into what is considered to be the taken for granted/the norm or the ‘correct way’ as opposed to false/abnormal and ‘incorrect’ ways of being. This practice of categorisation or classification, or the division into what is acceptable and what is not, by which knowledge is being produced, then suggests that meanings are constructed through a relationship of

power and domination. So the State and other legitimised bodies are then engaged in this dividing process and in the creation of the norm which then encourages the rest of the public to think and behave accordingly. This then suggests that discourse and discursive regulation operate at the interface between the social and the individual and that power is productive in a sense that in its operation it produces knowledge, subjects and objects as well as resistance and new meanings (Foucault 1980, 1982).

In that sense, power and power relations are embedded within discourse in a subtle way. Power is circulated through discourse in a dynamic relation that produces meanings. As such, power is not an independent unit but is rather created and reinforced through discourse (Foucault, 1980) and in this process it also produces knowledge (Mills, 2003; Hook, 2007). Thus discourse and power are intertwined in a way that discourse is the tool by which power is created and through which it is circulated but equally discourse is born from power. Thus it is power that places the individual as both its 'vehicle and the effect' of its practice (Foucault 1980, p.98).

Discursive power produces and reproduces discursive categories that tell us what is true and false and this therefore is the way in which we then understand ourselves, the world, our behaviour, desires and so on. Thus, power is everywhere and moves around within a discursive flow (Foucault, 1977). It is fluid and hidden, not owned by anyone, but is rather based on the dynamics between entities (people, organisations and states). Therefore, power goes beyond economic considerations or the practices of exercising power *per se*. The meaning of power thus also transcends the notion that it is repressive, preventive, and bad or negative (Foucault, 1980). It is not understood as a physical entity which controls others but rather is understood as a daily practice which is created, reinforced, exercised and resisted through discourses and individual action. As such, discursive regulation governs individuals as a force that acts upon and through individuals' understandings of themselves on a minute basis (Foucault, 1982) and through this

process they gain an understanding of themselves and act upon themselves (Foucault, 1978; 1980; Rose, 1989; 1996).

Thus, at the individual level, discourses shape the way in which people feel, think, act, behave and understand themselves. Individuals draw meanings from discourses in a way that both enable them to gain a positive identity resource but equally in a way that constrains their actions (Deetz, 1992). In this process of meaning production through and from discourse, individuals engage with that duality of both experiencing and practicing power (Foucault, 1980) in a way that reinforces meanings but also in a way that creates resistance and evolves new meanings (Hardy and Thomas, 2013).

Discursive regulation is created and reinforced through the micro-politics embedded within everyday interaction whereby individuals are expected to behave in a desirable and expected way and according to the subject position within discourse. In this process of discursive regulation 'human beings are made subjects' (Foucault 1982, p.208) in a sense that they are encouraged to think and act according to discursive norms and practices which make them subjects, positioned in discourse. Individuals are thus expected to be, think and behave in a certain way and in accordance to the subject position located within discourse. In this process they gain an understanding of self from a number of subject positions which comprises their identity (Foucault, 1982).

For instance, as was illustrated in chapter 1, the discourse of mental illness embeds within it the assumption that the 'mentally ill person' is dysfunctional and incapable. An individual who is diagnosed with mental illness incorporates within their understanding of self the 'mentally ill' subject position. Whilst that individual can relate to that subject position in a number of ways (i.e. they can accept it and feel like an incapable person; they can deny or reject it or they can resist and rewrite it), one aspect of their self-understanding would evolve around

the notion of 'being mentally ill'. Likewise an employee is expected to behave according to employment discourses and the desired norms of behaviour of being an employee. Thus the meanings which are embedded within discourse are normalising discursive practices which are then internalised into our social and individual identities and self-understanding (e.g. Foucault, 1982; Rose, 2010).

Consequently, as discourses can be understood as both resources and constraints within the process of identity construction, individuals construct their identities according to a number of subject positions and the meanings they attribute to them (Foucault, 1977; Musson and Duberley, 2007; Thomas, 2009) each of which contributes a part—and not forming the totality—of identity (Holmer-Nadesan, 1996). Discursive regulation therefore has a direct relationship to the way in which individuals understand and name 'who they are' (e.g. worker or parent) and 'who they are not' (e.g. criminal or pervert). And this process of identity construction takes place through the way in which individuals are evaluated by others and how they evaluate themselves. Thus the understanding of humans as subjects conceptualises individuals as products of historic contexts, situations, relations, discourses and institutions (Foucault, 1977; 1980; 1982).

Overall, within this Foucauldian theoretical framework, the understanding of identity illuminates its context bound nature and so identity is located within discourse and through discursive regulation. Therefore, both discourses and the subject positions resulting from them are not fixed entities but rather something that is dependent upon time and place as well as historical and social context (Foucault, 1977). As such identity can be understood as being fluid and dependent upon discourses and contexts. This conceptual framework of identity, as regulated within the power dynamics of discourse, represents a long tradition within critical identity studies, some of which are discussed below.

2.2.1. Identity and critical management studies

Identity studies in organisations have highlighted how employees construct their identities at work and in organisational contexts. Within the context of critical identity studies, research has focused on the context of organisational control and discursive regulation. Whilst identity regulation in organisational studies has been looked at in terms of 'direct control', i.e. organisational hierarchy (Martin and Siehl, 1983; Schullery, 1987; Alvesson, 1995; Ezzamel and Willmott, 1998); completing specific tasks under tight supervision (Friedman, 1990); or formal procedures such as appraisal (Townley, 1993); performance or pay systems (Kunda, 1992); it has been argued that indirect control of discursive regulation (e.g. Alvesson, 1995; O'Doherty and Willmott, 2001) which is discussed below, could enforce greater organisational control than methods of direct control (Willmott, 1992; Barker, 1999).

A number of studies investigated how organisational discourse impacted upon employees through indirect practices such as that of identity regulation at work (Czarniawska-Joerges, 1994; Christensen, 1995; Thomas and Linstead, 2002; Musson and Duberley, 2007). Studies have examined how managerial discourses regulate employees' identities by embracing particular personal goals, desires (Knights and Willmott, 1989; Deetz, 1995), and a sense of identification that fits in with organisational goals (Smircich and Morgan, 1982; Cheney, 1991; Willmott, 1993; Alvesson, 1996).

Influenced by the Foucauldian approach to power and the subject (Foucault, 1982), a number of these studies have highlighted how identity regulation within organisational discourse produces a subject position of the 'ideal worker' that fits with desirable behaviour, obedience to cultural norms and sets of values (Acker, 1990; 1992; Sewell and Wilkinson, 1992; Willmott, 1993; Townley, 1993; 1994; Grey, 1994; du Gay, 1996; Casey, 1999). The discourse and subject position of the 'ideal worker' has a long history in organisational studies and represents the way in which government and work organisations define the preferred way of working

which then has normalising effects (Rose, 1988). The discourse draws on the way in which both employees (Acker, 1990) and those who are seeking employment (e.g. Cremin, 2010) are expected to position themselves in relation to, and to aspire to this ideal worker (Rose, 1988; Acker, 1992).

This ideal worker is associated with characteristics such as being fit, productive and healthy (Bedeian, 2007) as well as having a high work performance, unquestioning commitment to the organisation (Acker, 1990, 1992). Thus the ideal worker is able to demonstrate complete commitment to the organisation: (Connell, 1987; Tienari, Quack and Theobald, 2002), having the skills and attitude to maintain a competitive advantage (Cremin, 2010), demonstrating careerism (Kerfoot and Knights, 1993, 1998), self-assertion, 'cool rationality' (Meriläinen et al., 2004), ambition, passion (Ehrenreich, 2009), responsibility and initiative (Fogde, 2009; 2011).

Maintaining a performative semblance is thus a significant aspect of the 'ideal worker' subject position. The expectation of unfettered performance/commitment to work also demonstrates a lack of 'vocabulary to acknowledge or describe weakness and failure' (Kerfoot and Knights, 1993 p.674). Thus, any non-work concerns such as health or family (Meriläinen et al., 2004) remain excluded from that ideal semblance (Acker, 1998) and from the continuous expectation to relentlessly be and do more (Costea, Amiridis and Crump, 2012). Overall, the ideal worker subject position is strongly associated with 'being a productive worker': someone who is capable of engaging with unfettered productivity, unencumbered by personal issues such as other interests, health, wellbeing and family (Meriläinen et al., 2004). Whilst all these expectations, which are embedded within the 'idealised worker' discourse and subject position may be highly demanding, they remain unchallenged in many contemporary work organisations which embrace this discourse and working culture (Foster and Wass, 2013).

These studies have also highlighted the tension inherent in the dynamics between the attempts to live up to an ‘idealised worker’ subject position, and the constraints that are then created around the management of other subject positions—in other words, the employee’s preferred interests (Sveningsson and Alvesson, 2003; Thomas and Davies, 2005a). These tensions, which are further discussed below, have been addressed in terms of the dynamic between organisational discursive regulation and the levels of freedom/agency/control/space for action that individuals have to regulate their own identities within managerial/employment discourses.

2.2.2. Identity and agency

Foucauldian and poststructuralist literature on employment and social studies have continually referred to the long-running debate on the role of agency within the construction of identity (Alvesson and Willmott, 2002). The poststructuralist stance to identity studies go beyond the ‘traditional dualism between structure and agency’ (Holmer-Nadesan 1996, p.49; see also Alvesson and Willmott, 2002), which represents the ongoing debate and the continuous tension between individual agency and organisational structure⁴ (Mintzberg, 1983; Reed, 2005; Ybema et al., 2009). Foucauldian, notably Foucauldian feminist analysis of identity have considered issues of agency and the extent of control individuals have over their own selves (McNay, 2000). Weedon (1987), for example, refers to agency as arising through the ‘space between the position of a subject offered by a discourse and individual interest’ (ibid., p.112-113). Despite this, it is fair to say that issues of agency within Foucauldian studies of identity in organisations are still rather undeveloped (Bergström and Knights, 2006).

⁴ The debate over structure and agency draws on Marxists ideas which hold that individual identity is fundamentally shaped by the structure of society and is a reflection of a subject’s place in the social structure of the economy and their position in the class hierarchy (Marx, 1976). This Marxist interpretation holds that an individual’s agency is pre-determined by the social structure of class.

Identity literature in organisations has examined how employees' identities at work are more or less active within the constraints of organisational discursive control and thus, whilst not directly addressing issues of agency, agency is inferred through these studies. This highlights how individuals negotiate their identities at work by actively positioning themselves in a discourse whilst equally being constrained within the meanings of that discourse and the subject positions produced. Although not directly addressed in these studies, it can be inferred that agency may be the space within the normalising discursive regulation in which individuals may construct their identity by actively positioning themselves relative to the meanings produced in organisational discursive regulation and the subject positions resulted (Kondo, 1990; Thomas and Davies, 2011).

These studies also suggest that the compound nature of identities (Collinson, 2003) within the power dynamics of discourse represents the agential tension between the passive subject (less agency) and the active subject (more agency). On the one hand, some Foucauldian driven studies present the impression of a 'passive self', being controlled and determined by organisational discourse, and on the other hand, other studies have criticised this deterministic 'reading' of organisational discourse by arguing that Foucauldian theorising of the self also calls for an 'active self', where individuals can resist the imposition of certain identities prescribed through the managerial discourse (Thomas and Davies, 2005a; Thomas, 2009).

Overall these studies may suggest that there is scope for individual action within organisational discourse that can vary from being extremely restricted to having more scope for action and resistance. These studies have criticised the deterministic analysis of organisational control over the minimal scope for individual action (Hollway, 1984; Rosen, 1985; Knights and Willmott, 1989; Deetz, 1992, 1994; Jacques, 1996; Barker, 1999).

Thus at the same time that the literature illuminate the organisational attempts to create the 'appropriate individual' (Alvesson and Willmott 2002, p.629) through forms of managerial discourse which has also been referred to as a form of 'manufacturing subjectivity' (Knights and Willmott, 1989)—stressing how 'managers are the "recipients" and "bearers" of powerful regulative efforts' (Alvesson and Willmott 2002, p.636), the tension that this form of regulation places on employees (Newton, 1998) also results in resistance (Alvesson and Willmott, 2002). Therefore the view that hegemonic discourses (Alvesson and Kärreman, 2000a) regulate employees into an 'iron cage of subjectivity' (Kärreman and Alvesson, 2004) may have failed to appreciate both the scope for individual agency in shaping identities and the ability, even the recognition, that employees, too, can resist.

A popular standpoint in critical identity studies accommodates this view and thus does not examine employees as 'passive consumers of managerially-designed and designated identities' (Alvesson and Willmott 2002, p.621). Thus identity can be understood as resulting from the interface between organisational control and the individual's scope for action within it (Bergström and Knights, 2006). These studies suggest that normalising managerial discourses do not define employees' identities (Alvesson and Willmott, 2002), but rather employees have the scope to actively interpret these discourses (Clegg, 1989) and to resist (Thomas and Davies, 2005a).

Although managers may have access to organisational resources of discursive regulation, discourses also depend upon employees' reading of them so that 'employees are not passive receptacles or carriers of discourses but, instead, more or less actively and critically interpret and enact them' (Alvesson and Willmott 2002, p.628). Whilst, however, critical identity studies suggest that individuals can actively resist the subject position imposed on them through individual discourse, this resistance is the result of a struggle. The tension between the restrained identity within organisational discourse and individuals' understanding of their own

subject position (Kunda, 1992) cannot therefore be gained ‘without inertia, pain, resistance and unintended consequences’ (Alvesson and Willmott 2002, p.637).

Thus, identity can serve both the elements of organisational control as well as employees’ resistance (Kondo, 1990; Thomas, Mills and Helms-Mills, 2004; Thomas and Davies, 2005a). Identity studies which draw on employees’ resistance to organisational control (Ezzamel and Willmott, 1998) and the struggle they experience to construct their identity within the dynamic between their own identity and organisational discourse (Thomas and Davies, 2005a; 2005b; 2011) will be examined in the discussion below.

2.3. Resisting subject positions

Taking a Foucauldian approach to study identities in organisations embeds within it the notion of resistance: resisting the identities imposed on individuals through the regulation of organisational discourse (Weedon, 1987; Kondo, 1990; Deetz, 1992; Gottfried, 1994; Alvesson and Willmott, 1996; Holmer-Nadesan, 1996; Thomas and Davies, 2005a; Thomas, 2009). The attention to power dynamics in organisational studies puts emphasis on the way in which resistance is embedded within the daily practices of work (Edwards, Collinson, and Della Rocca, 1995; Ezzamel and Willmott, 1998; Knights and McCabe, 2000; Fleming and Spicer, 2003) and the way in which an evolving power dynamic is forming a site for political contestation (Kondo, 1990; Meyerson and Scully, 1995; Katila and Meriläinen, 2002; Thomas and Davies, 2005b). Whilst it has been suggested that agency can be understood as the *scope* for action within the constraints of discourse (Weedon, 1987), resistance can be seen as an action of contestation to the identities imposed upon individuals. As such, whilst agency is viewed as providing scope for action, resistance may be understood in terms of utilising the agency space and acting upon it in a way that brings into being new meanings (Thomas and Linstead, 2002).

Resistance can be a result of the tension between two competing subject positions (Thomas and Davies, 2005a) or as resulted from a tension between the way in which individuals are expected to behave and to be, according to the subject position embedded in discourse, as opposed to what they believe. As such, resistance can reveal, at least partially, the way their own values should be represented (Clegg, 1989). Critical identity studies illustrate how resistance weakens organisational discourse. These studies highlight how resistance to the subject position, which resulted from organisational discourse, serves to both bring into being new meanings (Kondo, 1990; Thomas et al., 2004) and to weaken the predominant organisational discourse (Thomas and Davies, 2005a; Thomas, 2009).

Foucauldian driven literature on organisational and social studies highlight the way in which resistance to discourse is a practice that allows for multiple ways of being, and hence greater space for difference. As such resistance is important for studying identities because it can introduce alternative ways of being at work. This is particularly significant for the study of identities because it illuminates the process by which meaning is produced through forming and reforming individual understanding of the self in relation to the main organisational and societal discourses (Holmer-Nadesan, 1996; Thomas and Linstead, 2002; Sveningsson and Alvesson, 2003).

A number of concepts which address issues of identity resistance can be identified in the literature, one of which is identity struggle. Identity struggle can be looked at in terms of the tension between individual personal values and organisational discourse or job expectations (Sveningsson and Alvesson, 2003). Studies highlighting the struggle to construct a sense of self have looked at the way in which the inconsistencies, difficulties and uncertainties of work in contemporary organisations lead to tensions and fractures within individuals' construction of self (Casey, 1995; Jackall, 1988; Knights and Murray, 1994; Watson, 1994). Identity struggle thus arises when there is a clash between self-definition and work situation (Sveningsson and Alvesson, 2003).

Sveningsson and Alvesson (2003) illustrate the identity struggle experienced by a senior manager in a research IT firm. The manager's perceived struggle between her personal identity and her work identity was triggered by conflicting organisational demands which required her to perform as a successful leader without devoting much time to leadership. The contradiction between her personal values and beliefs and expectations from her work organisation led her to find meaning not in her identity as a manager, but in her identity outside work in tending her farm. Finally, identity struggle has also been studied in relation to major life crises (Pals, 2006) and the way in which these impact upon the overall capability of an individual to undertake the work they used to do before these crises arose (Maitlis, 2009).

Also associated with the analysis of identity resistance is the concept of dis-identification. Dis-identification has been looked at both in terms of critical (Ibarra, 1999; Thomas and Linstead, 2002) and non-critical literature (Dutton et al., 1994; Elsbach, 1999; Carroll and Levy, 2008) and can be understood as a process that takes place when individuals oppose the identity position offered to them in the dominant organisational discourse. Non-critical literature such as social identity theory highlighted the way in which dis-identification occurs when the process of positioning an individual's own identity in relation to the identity forced on them by the organisation is resolved by the individual not defining themselves by the same characteristics as their organisation (Dutton et al., 1994). Critical identity literature which has examined the context of dis-identification has drawn attention to how dis-identification is 'a form of dislocation arising from the deployment of the tools and symbols of the dominant by the marginalised' (McNay 2000, p.103; Hennessy, 1992) and how the coexistence of both identification and dis-identification ensues (Kondo, 1990; Thomas and Davies, 2005a; Thomas and Davies, 2011).

For example, as part of a large identity study of employees in the public sector, Thomas and Davies (2011) explored the processes of dis-identification experienced by those working in the social services. Organisational change within the public social services included new bureaucratic regimes, fewer staff and higher case loads. Describing how new working practices undermine the quality of service, employees dis-identified with bureaucratic-managerial demands, highlighting how these result in tension around their professional ethic as deliverers of public care. Though participants struggled with new job expectations, employees created new meanings through practices of dis-identification. The professional understanding and work ethics of social workers who have participated in their study illustrated the importance of providing care and revealed how this enabled them to embrace new meanings which they applied to the bureaucratic-managerial demands with which they had dis-identified. This process illustrated how the participants were able to maintain what they believed remained at the heart of their role.

In a study on university cleaners in a large US university, Holmer-Nadesan (1996), examined how managerial discourses of class and gender and their associated meanings created identity tensions for employees. Instead of confronting the masculinist managerial discourse and understanding their identity as 'lower-class female workers', the female service workers introduced meanings of nurturing and care into their identity construction and into the meaning they gained from their job. Female employees drew on the meaning of their role as providing care for students, a position that appeared as more 'natural' (Marshall, 1991) and thus more meaningful to them than dealing with 'lower class' tasks of cleaning (Holmer-Nadesan, 1996).

However, at the same time, these identity meanings created a tension between taking on, rejecting, resisting and dis-identifying, with the managerial discourse. Although the sense of nurturing and providing care for students created a positive sense of self, these meanings were relative to the managerial discourse and therefore revitalised it. While attempting to reject the meanings of low-class work

embedded within the managerial discourse, driven by the need to be recognised and appreciated by the management, the service workers turned back to the same normalising managerial discourse they had rejected (Holmer-Nadesan, 1996). These experiences of identifying and dis-identifying, taking on and rejecting or resisting managerial discourses, therefore highlight some of the challenges and contradictions inherent in constructing identities through and within organisational discursive regulation (Kondo, 1990).

Finally, identity resistance has also been researched in relation to forms of detachment, through humour, irony or cynicism (Ezzamel, Willmott and Worthington, 2004; Fleming and Sewell, 2002; Kosmala and Herrbach, 2006). Satire and humour have been theorised as methods for dis-identification which can enable employees to distance themselves from organisational domains (Collinson, 1988) and to keep their autonomy and personal beliefs (Žižek, 1999). However, at the same time that dis-identification has been looked at in terms of resistance and the evolution of new meanings (Kosmala and Herrbach, 2006), expressing humour as a form of dis-identification has been criticised for its limited effects, being seen as a form of fantasised autonomy (Thomas, 2009). Thus rather than enhancing a greater sense of freedom or individual control when at work, the benefits of dis-identification through humour and cynicism may be seen as providing a false sense of agency (Žižek, 1999). Therefore, it could be argued that such dis-identification actually demonstrates the individual's limited agency or scope for action within organisational discourse, illustrating how their individual identity is bound by the very discourse being resisted (Thomas, 2009).

Thus, resistance can take place in different forms: struggle, identification and dis-identification, and cynicism all contribute to the emergence of new meanings and can be understood as crafting one's sense of identity through the challenges and the struggles of daily experiences at work (Kondo, 1990; Holmer-Nadesan, 1996; Thomas and Linstead, 2002; Thomas and Davies, 2005a; Sveningsson and Alvesson, 2003). Thus we can see how critical identity studies and Foucauldian literature on

identity and interrelated concepts can serve to examine how identities are captured as fluid and context bound, compounded by a number of subject positions and located within the tension between discursive regulation, agency and resistance.

Another important concept within the theorising of agency and resistance has been examined within Foucault's later work on the ethics of the care for the self (Foucault, 1986). The Foucauldian literature on the ethics of the care for the self further adds to an understanding of resistance and agency in that it illustrates how, by utilising a set of practices, individuals make space in discourse. Whilst not being sufficiently addressed in organisational studies (Starkey and Hatchuel, 2002), Foucault's notion of the ethics of the care for the self is substantial in the context of this study and will also be returned to in chapter 8 (section 8.4.2). Located within the intersection between discursive regulation and self-care, the techniques or ethics of the care for the self (Foucault, 1986) are self-regulatory practices taken on by individuals in relation the way in which they conduct themselves within the constraints of social norms, materiality and discourse (Foucault, 1978; 1988b). These self-regulation technologies of resistance are further discussed below.

2.3.1. The ethics of care of the self

Foucault's later work in the area of resistance and agency (McNay, 1994) has been referred to in different ways (i.e. 'technologies of the care for the self'; the 'ethics of the self'; the 'care for the self'; self-care). This work evaluates how a set of self-care practices, which took place in different societies throughout history, can create greater space for individual action within the constraints of discourse (Foucault, 1991). Contrary to suggestions that Foucault's later work represents a fundamental disjuncture from his previous theorising (Žižek, 1999), this thesis emphasises a continuation between Foucault's earlier phases of work

(Foucault, 1971; 1982) and his later work (Foucault, 1991). In doing so, a broader understanding can be made, of how disciplinary mechanisms and the self disciplining nature of the ethical self complement one another (Harrer, 2005). This then suggests that self disciplining one's self utilising the ethics of the care for the self is a practice which is embedded in relation to discourse and situated context (Foucault 2003, p.34) and thus within a dynamic of power relations. So whereas in his earlier work, Foucault is concerned with those sets of practices, which construct the individual, in his later work he engages with the way by which subjects construct their own being. As Harrer (2005, p. 78) argues: '*[t]he genesis of the subject essentially includes these two sides: subjection and self-constitution.*'

In this line of thought, the techniques of self-care are '*situated in the interstices of power relations, at the level of individuals' daily practices*' (McNay 1994, p.7). They represent the way in which we can create space within normalising discourses, which would then enable us to practice certain levels of agency, freedom, liberty and autonomy (Foucault, 1985). Foucault describes these practices as: '*those intentional and voluntary actions by which men not only set themselves rules of conduct but also seek to transform themselves, to change themselves in their singular being*' (Foucault 1985, p.10).

While being context bound, these practices do not reflect upon a specific culture (Foucault, 1991). Rather, they can be understood as regulatory whereby individuals establish 'a certain relationship of domination of mastery' over themselves (Foucault 1988a, p.35). During this process individuals make themselves 'object[s] of self discipline, personal aesthetics and self-learning' (Starkey and Hatchuel 2002, p.652). In the due course of this process of domination and of mastering one's conduct individuals come to know themselves better in a way that helps them gain self-knowledge which is essential for their self-care (Rose, 1996). Foucault highlights how this process is acquired through an 'historical investigation into the events that have led us to constitute ourselves

and to recognise ourselves as subjects of what we are doing, thinking, saying' (Foucault 1997d, p. xxxv).

As such the ethics of the care for the self can be understood as a continuous process whereby individuals relate to themselves and capture their sense of being through a certain set of practices which are both personal and technical but are also equally related to an external system of roles, norms or authorities (Rose 1996, p.139). For Foucault, therefore, it is this interconnection between *'the freedom of the subject and its relationship to others which constitutes the very stuff of ethics'* (Foucault 1997b, p.300). In other words, the technologies of the care for the self are composed from both self-knowledge *'but also knowledge of a number of rules of acceptable conduct, or of principles that are both truths and prescriptions'* (Foucault 1997b, p.285).

In his theorising of the self, Foucault illustrates how the ethics of self-care bears an historic essence which can be tracked all the way to antiquity. Naming them as *'the practice[s] of freedom'* (Foucault 1997b, p.284), Foucault describes how these ethics were meant to enable a sense of autonomy and authenticity within the way in which people lived their lives and relate to themselves. According to Foucault, these practices are meant to be practical tools which aim to help individuals live their lives with fewer constraints from the norm or from social expectations which require them to behave, think and be in a certain way (Nealon, 2008). The ethic of the care for the self can thus be understood as practiced through *'bodies and souls, thoughts, conduct and ways of being'* in order *'to attain a certain state of happiness, purity, wisdom, perfection or immortality'* (Foucault 1997a, p.225).

By practicing these self-techniques the individual creates a certain level of space and autonomy in relation to the norm. As such the notion of the ethics of the care for the self can be understood as a practice that allows individuals the scope for action within discourse, the 'norm' and the space to resist. In his analysis of the

practices of the care for the self, Foucault articulates how this sense of 'norm' has changed throughout history:

The way in which certain forms of spiritual practice which could be found in Greek, Roman and early Christian ethics had become incorporated into priestly power, and later into the practices of the educational, medical and psychological type (Foucault 1986, p.11).

The changes in the sense of what is the norm are directly linked to the meanings of the care for the self during the different eras. Foucault therefore differentiates the notion of care of the self, which took place during antiquity and Greco-Rome, to the ethics of the self which are indicative of the move to the social norms and structures during Christianity and the Enlightenment from which individuals built practical rules to examine their own behaviour (Foucault, 1985).

The ancient Greco-Roman cultures focused on the care of the self through what Foucault referred to as ethics-oriented morality: the relationship individuals have with their own self through different actions, thoughts, and feelings as they endeavoured 'to form themselves as ethical subjects' (Foucault 1985, p.26, text modified). Care for the self was then based on internal work of self-cultivation and self-improvement. In Hellenic-Roman and Christianity, however, the internal work of self-improvement was considered to be self-love (Foucault, 1997b) and the focus of self-regulation since that period has taken place through code-oriented morality. Code-oriented morality referred to self-regulation through reaction to social rules and behavioural codes, what Foucault referred to as '*the way in which the individual establishes his relation to the rules and recognises himself as obliged to put it into practice*' (Foucault 1985, p.27). Similarly, care for the self in the enlightenment period was understood through individual reliance on external authorities for self-regulation (Randall and Monro, 2010). Following the enlightenment, contemporary societies then moved on to the reliance upon social norms, law and science, rights and wrongs and 'normalising regimes of truth' (McNay 1994, p.141).

So therefore we can see the differences between normalising practices as progressed through history and how these may then be linked back to the ethics of the care for the self. Foucault highlights the way in which, whilst the Ancient Greek ethic evolved from certain central moral essences, they had the liberty to establish an individual relation to themselves, to enable a sense of autonomy and independent aesthetic of being in the world that 'maximises pleasure, beauty and power obtainable from life' (McNay 1994, p.142). This is the sense of autonomy in relation to the norm that Foucault discusses in his analysis of the care for the self in contemporary societies. In order to reach this sense of autonomy and to establish a set of modern ethics of the self within contemporary practices of discourse, Foucault, encourages the individual to be involved in a constant practice of self-criticism and self-awareness (McNay, 1994).

This form of critical self awareness was attained through reflexivity, which is maintained as a basic principle in the ethics of self-care. However, this key component emerged in different forms throughout history (Foucault, 1997a). One example, which relates to the practice of self-examination, is the shift in the nature of examining one's thoughts. Whilst during antiquity and Greco-Rome one examined one's thoughts in relation to reality through the 'review of what was done, of what should have been done, and the comparison of the two' (Foucault 1997a, p.238), during Hellenic-Rome this had shifted into the examination of one's thoughts in relation to rules. Later, during the period dominated by Christianity the focus became the examination of hidden or secretive thoughts (Foucault, 1997a).

The study of the care for the self also indicates how other reflexive practices took place in different formats throughout history. For example, whilst the main focus during antiquity was self-control and an active, not passive, perspective on life, this focus then shifted during Greco-Roman times into a type of self-examination that relied as little as possible on external forms and appeared through individual

practices of self-regulation (Foucault, 1985) within the four main life dimensions of body/dietetics, marriage/economics, eroticism and truth/wisdom (McNay, 1994).

An important aspect of these practices during antiquity and Greco-Roman times included the care for the body and soul through ‘permanent medical care’, whereby one acted upon oneself as one’s own doctor and therefore had to gain certain self-knowledge in order to do so. Self-examination during that time took place in relation to two main principles, namely: ‘take care of yourself’ and ‘know yourself’. Foucault refers to the way in which gaining self-knowledge was understood as a purifying process: *‘Access to truth cannot be conceived of without purity of the soul. Purity of the soul is a consequence of self-knowledge’* (Foucault 1997a, p.243).

Self-knowledge is thus considered a purifying practice and an authentic one and can be gained by active conscience or a set of activities which, amongst others, could be related to ‘faith, books [and] dogma’ (ibid.) as well as intellectual work such as meditating, reading, writing letters to friends, making notes and relating them to one’s own life, confidently engaging in conversations, exercising and doing practical tasks, examining and memorising duties and principles and reflecting on one’s emotions and the time that has gone by (Foucault, 1986).

Self-knowledge is thus as reflexive practice which aims to help us to get closer to the ‘truth, heart, and soul’ (Foucault 1997a, p.243) and is a fundamental practice within the individual self-construction of themselves as ethical subjects. Foucault notes: *‘The task of testing oneself makes the question of truth—the truth concerning what one is, what one does and what one is capable of doing—central to the formation of the ethical subject’* (Foucault 1986, p.168). Thus the ‘ethical subject’ is captured as someone who is actively engages in reflexive and ‘purifying practices’, one of which is *self-disclosure*.

Foucault highlights the way in which self-disclosure, or 'truth telling', has been a fundamental principle and an ethical practice of the care for the self throughout history (Foucault, 1997a). Truth telling was manifested in Greco-Roman practices through 'recognition of facts' (namely: *exomologesis*). This form of self-disclosure was placed across what was then considered the four dimensions of life (i.e. the body, marriage/economics; eroticism and truth/wisdom) and manifested itself through the declaration of 'who one is' (not necessarily the declaration of faults) to the others in the community (McNay, 1994).

During the classic period and in Christianity, this practice of self-disclosure was considered as a form of self-declaration of facts. Hence, 'to recognise publicly the truth of one's faith' (Foucault 1997a, p.243, text modified). At this period this also meant that 'everything that could not be expressed is a sin' (ibid., p.248, text modified). This practice then developed into a 'confession of faults'. Either it be to oneself, a priest, religious institutions, a penal tribunal or the community (ibid.). The practice of self-disclosure then remained a popular act until today. Practices such as 'continued verbalisation of thoughts' and the confession as a 'mark of truth' (ibid., p.248-249) remain a significant practice in many contemporary life spheres:

The confession has spread its effects far and wide. It plays a part in justice, medicine, education, family relationships and love relationships, in the most ordinary affairs of everyday life, and in the most solemn rites one confesses one's crimes, one's sins, one's thoughts and desires, one's illnesses and troubles (Foucault 1978, p.59)

So we can see how this sense of verbal self-disclosure of facts, feelings, thoughts, and actions as a purifying act, is deeply embedded within daily modern life and is expressed in a range of forms, including '*therapist and patient, social worker and client and in the relation of the "educated" subject to itself*' (Rose 1996, p.132).

Building on his historic analysis of these ‘purifying’ practices of the care for the self and the fundamental principle of reflexivity and self-criticism, Foucault is encouraging us to engage with the ethics of the care for the self in the present by being constantly involved in practices of self-transformation (Foucault, 1985; Brewis, 2004). This encouragement to be self-aware and to reach this sense of autonomy in modern life through constant self-transformation, also addresses the ‘danger’ of self-normalising our own self ethics of care. Indeed in contemporary societies we are being encouraged to live independently in all aspects of life such as our health, bodies, education, consumption and employment (Rieff, 1987; Rose, 1996; 1989) and to self-regulate ourselves as our own liberated subjects. And thus we become our own subjects within our own normalising principles, regulating our conduct even more effectively than any external forms of regulation (Frank, 1998).

Foucault addresses this ‘danger’ of becoming subjects within our own normalising principles, thus limiting our own sense of individualism and authenticity, and so encourages us to take on a form of ‘ethic of discomfort’ (Foucault, 2003): to self-detach from ourselves by relating to ourselves in a challenging and not straightforward way and so bringing a sense of critical self-awareness into the practice of self-care (Foucault, 1997a).

Thus, in order to practice the ethics of self-care in the present, one needs to ‘attempt to transform oneself into the ethical subject of one’s behaviour’ (Foucault 1985, p.27) through forms of practices that are brought down to an individual level and are related to the way in which each individual wants to live their life. Ongoing self-transformation is thus a continual process of creating and improving, independent sets of values (instead of sticking to external norms) that reflect upon what appears as ‘the natural and inevitable in one’s own identity’ (McNay 1994, p.145).

The 'transformation of one's self by one's own knowledge' (Foucault, 1997c, p.131) thus allows for practicing the 'arts of existence' (Foucault 1985, p.10). The practice of self-transformation is a creative and self-critical investigation that is meant to incessantly challenge our own limits to examine the diverse prospects of what we can become (McNay, 1994). This sense of innovation and creativity embedded within the practice of reinventing ourselves reflects upon a personal examination of what is significant for the individual in a particular moment. This then suggests that there are differences between individuals' self-care: 'just as there are different forms of care, there are different forms of self' (Foucault 1997a, p.228).

The multiplicity in the ways by which individuals relate to themselves emphasises how the practices of self-care are not meant to be unified and, consequently, do not reflect on a particular line of rationality but are instead an ongoing creative process. The creative process of inventing and re-inventing ourselves in multifaceted ways through the practices of self-care thus express agency to manoeuvre within discursive regulation as well as to resist the imposition of one unified norm. Foucault stresses, whilst building on Kant, how the 'critical ontology of ourselves' in the present (Foucault 1984a, p.50) allows every person to live their lives as 'a work of art' (Foucault 1984b, p.351). Self-care as the practice of resistance thus illustrates how being, just like art, is not an inevitable or a given but is rather 'a process of self-creation and therefore... open to change and re-creation' (McNay 1994, p.148).

Although *'the full significance of Foucault's ethics of care has not yet been thoroughly researched in the field of management and organisation studies'* (Randall and Munro 2010, p.3, see also Starkey and Hatchuel, 2002), a few organisational scholars have used the theoretical framework of 'care for the self' to analyse contemporary identity issues. A discussion of two of these studies—Brewis (2004) and Randall and Munro, (2010), is presented below.

2.3.1.1. Care for the self and organisational studies

Whilst there are a number of studies which address Foucauldian theorising on the ethics of the care for the self into organisational contexts (Chan and Garrick, 2002; Crane, Knights and Starkey, 2008; Ibarra-Colado et al., 2006; Iedema and Rhodes, 2010; McMurray, Pullen and Rhodes, 2011), the analysis of ethics of the care for the self in organisations is still relatively understudied (Starkey and Hatchuel, 2002).

However, of particular relevance to this thesis is Brewis' (2004) self-reflexive account of her own self-care. Building on Foucault's notion of the care of the self, Brewis (2004) presents an analytic account of her own reflexive practices of self-care when dealing with mental health-related experiences. In the course of analysing her technologies of self-care, Brewis (2004) draws upon her own self-understanding in relation to the way she used to live her life and the impact this had on her mental health and identity construction. Adopting a reflexive stance, Brewis draws on her own identity image and describes herself as a determined and 'strong-willed' (ibid., p.30), *'achievement-oriented individual, a risk-averse workaholic who bases her self-worth on others' judgements and career progress, puts work first and has difficulty relaxing'* (ibid., p.31).

Following a mental health-related experience and endeavouring to maintain good mental health by trying 'to be, think and do in different ways' (Brewis 2004, p.32), Brewis critically analyses her own identity and takes on a number of new self-care practices. These included joining an anxiety management group, taking time off work and being more self-aware of her own thinking processes. Specifically, Brewis comments on how she engaged in a practice of self-transformation by 'cultivating new ways of thinking, being and doing' (ibid., p.36).

Whilst these new self-critical technologies for gaining new self-knowledge and for self-caring carried with them many benefits, Brewis (2004) also reflects on the limitations of these new practices of self-care as ‘alternative ways... which carry with them downsides of their own’ (ibid., p.37). Although appreciating their limitations, Brewis also recognises the way in which these new practices, create space for ‘freedom to make alterations’ (ibid., p.38). Thus, her account reflects upon the basic notion of the ethics of the care for the self in modernity—hence the ongoing practice of self-criticism, discomfort and self-transformation (Foucault, 1986; 1997a).

Whilst Brewis (2004) recognises the discomforted nature of self-caring in different ways and the restrictive outcomes that this process entails, her account highlights the way in which the practice of self-care creates the space to resist the way one relates to oneself in one’s own being. Similarly, by making alterations to the way in which one is living within one’s self, her account also illustrates how these practices can create space for resistance within the way in which one normalises one’s own self-regulation. And this is, according to Foucault’s theorising of self-care, is the main application of the ethics of the care for the self in the present (Foucault, 1986).

Brewis’s (2004) study illustrates how the application of the practices of self-care (Foucault, 1986) in the present are manifested within her identity construction as a form of resistance to her own ‘normalising’ methods for self-regulation. In a similar manner, the ethics of self-care can be looked at as practices which can address resistance to normalising discourse.

The study of Randall and Munro (2010) examines this latter point and illustrates how self-care practices create space for resistance within normalising professional and health discourses. Drawing from interviews with mental health practitioners in the voluntary and statutory sectors in Scotland, the authors illustrate the

scepticism of mental health professionals towards the acceptable normalising techniques of treating mental health patients. Instead of popular and normalising techniques for dealing with mental health concerns appearing through forms such as medical diagnosis, disclosure work and medication, the practitioners suggested alternative forms of providing care through a number of principles which give voice to patients' own experience and own competence to self-care and to lead the course of their own treatment.

These same mental health practitioners expressed their dissatisfaction with the way professional knowledge of mental health care is used and the unequal power relationship between medical professionals, who regulate a patient's illness, and patients who are passive subjects in the management of their own illness (Jones and Porter, 1994; Atkinson, 1995; Roffe and Roffe, 1995; Lupton, 2003). Instead of using this medical and professional knowledge to determine the course of a patient's treatment, the practitioners again suggested alternative methods based on forms of self-care, self-knowledge and the ability of patients to lead the course of their own treatment.

Using pragmatic and exploratory approaches to caring, the practitioners, together with their patients, developed coping strategies that enabled the patients to engage in leading the course of their own treatment and actively self-caring and being in charge of the process of their recovery. By illuminating the importance of a treatment process led by the patient (and not by medical professionals, as normalising medical discourses suggest), and the importance of patient self-knowledge and self-understanding as a valid source of knowledge, equal to scientific knowledge, the practitioners embraced a sense of respect and equality in the relationship between the therapist and the patient. By embracing such practices of self-care as vital forms of treatment (Foucault, 1985; 1986), the practitioners express their resistance to the normalising professional discourses whereby patients are regulated as subjects with restricted agency to lead the course of their own treatment (Randall and Munro, 2010).

Randall and Munro's (2010) analysis then reveals how, by drawing on the practices of self-care as a valid form of treatment and by rejecting the notions of normalising professional discourses, the practitioners themselves found a new sense of meaning in the construction of their professional identity. The discussion of Randall and Munro (2010) therefore illustrates the practical implications of the notion of the 'ethics of the care for the self' for contemporary organisational life both for treatment and care, as well as for the construction of identities at work.

This thesis develops a critical examination of the ethics of the care for the self in the context of mental health and organisational life. At the same time, however, unlike the study of Randall and Munro (2010), this thesis explores how practices of self-care are experienced from the perspective of the individual as opposed to that of the health professional and, when compared with Brewis's (2004) account, the thesis focuses on the workplace setting to explore how mental health experiences are manifested in the accounts of a large population of working individuals with varied enduring health conditions and in different employment contexts⁵. Whilst the Foucauldian theorising of the care for the self is a significant framework for addressing important concerns of agency and resistance within the study of identities, it is vital to address some of the main criticisms which have been attributed to this approach.

2.3.1.2. The ethics of 'care for the self': Limitations

Foucault's later work on the ethics of the care for the self raises a number of points of criticism which may also have an impact on the application of his work in other social and political settings. One point of criticism deals with Foucault's discussion on the ethics of the care for the self as a 'work of art', a practice which

⁵ Full details of the aims and approach taken in this thesis are addressed in the following chapter section 3.4.

was historically applicable only for privileged groups. As such, whilst Foucault's earlier work on discourse and the subject has wide political and social implications, his later work on self-ethics is limited in that sense maybe because of its aesthetic aspect (McNay 1994, p.12). The examination of the ethics of the care for the self as a practice was considered as something which was rather too aesthetic for people struggling in their daily lives. Historically this practice was something that was restricted to privileged males for whom the ethics of self-care could have been a reality (Foucault, 1986), also suggesting that these practices were not possible for individuals from lower social groups, nor for women or, historically, slaves.

Furthermore, whilst these practices were historically initially restricted to a privileged group, Foucault does not sufficiently address how, nonetheless, they could have been practiced by anyone at any time or place. For instance, Foucault argues that slaves had no opportunity to practice the ethics of self-care as they were not free (Foucault, 1997b). As such, although Foucault explains how these practices were limited to a privileged social group he does not sufficiently address how certain fundamental practices could have been applied for the benefit of all. For example, reflexive thinking as a practice of self-knowledge is a fundamental principle of the ethics of self-care which could be freely practiced by anyone capable of thinking and remembering (Skinner, 2007).

At the same time, although not sufficiently addressing the perhaps restricted ability of non-privileged groups to practice self-care in previous centuries, in his application of this theorising to modern societies Foucault does call for everyone to self-care in their own way, and thus recognises the multiple ways of self-caring for different individuals and in different settings (Foucault, 1997a). This point is particularly important in the context of this thesis because it addresses the assumption that anyone is capable of self-caring and can thus practice agency and resistance. Thus even those who may be disadvantaged are, in certain settings,

capable of self-caring in a sense that would bring new liberating practices into constraining situations and thus new meanings into the construction of identities.

The second point of criticism refers to Foucault's refusal to promote a specific way of being as a better way. This point was of particular concern to identity politics scholars coming from feminism, postcolonialism and queer theory, sensing that the theorising of the care for the self could have better addressed and promoted the issues of those who are marginalised and disadvantaged. This is because the refusal to address a specific way of being as better may also equally promote practices of domination. Thus, whilst his work on the ethics of the care for the self provides a contribution to theorising resistance, Foucault's silence in terms of specifying an ideal way of being which is better has led to accusations of there being a deliberate 'refusal to legislate for other autonomous movements' (McNay 1994, p.10) and thus his theorising on the care for the self also led to claims of his being ethnocentric and gender blind (ibid.).

However, as also discussed elsewhere in this work (chapter 4, section 4.2), the nature of the theorising of the ethics of self-care is based on the fundamental principle of difference in a sense that embraces multiple ways of being, self-caring, self-knowing and reflexivity (Foucault, 1997a). As such, the promotion of an idealised or unified way of being/resisting clashes with the fundamental principle of self-caring. This thesis takes on board this point, wishing to explore if and in what ways multiplicity of practices of self-caring appear within the lives of individuals who are marginalised in the workplace and how they produce new meanings in discourse and through the process of identity construction.

Lastly, the theorising of the ethics of the care for the self was criticised for the privilege given to one's own self-care over the care for, and the relationship with, the other. The restricted discussion about caring for others and the main focus of the theory of the care for the self being based on the idea that care for the self is

privileged in that it takes priority over relationships with others (McNay 1994, p.152). This implies that others' interests are inferior and devoid of self-interest. Thus the notion is questioned because of the egocentric nature and the superiority of self-interest which is embedded within these practices (ibid.). This thesis addresses this criticism by attempting to examine how certain practices of self-care can have wider and broader applications in term of caring for others, or even prioritising the care for others as a practice of self-care. During the course of this thesis, and particularly in the discussion chapter (section 8.4.2), the issue of care for others as a practice of self-care will be looked at and is addressed as a contribution of the thesis to the theorising of self-care as a practice of agency and resistance (Foucault, 1986).

2.4. Concluding remarks

The main concern of this chapter has been to outline the analysis of identities in organisations. The constructionist perspective on identity, which takes identity to be unstable and constructed, rather than pre-determined, and as compounded by a number of subject positions, was promoted as an effective approach of conceptualising identity for the purpose of this study. More specifically, the critical stance to the study of identity in organisations was presented, specifically the identity/discourse tension in its relation to power and resistance (e.g. Thomas and Linstead, 2002). The discussion of critical identity studies revealed the process by which employees' identities are regulated within normalising managerial discourses. Agency—the level of control that employees have over their own selves and actions within the regulation of normalising discourses was presented. This illustrated how identities in organisations have been studied as more or less constrained within managerial discursive regulation and how the scope for individual action resulted within this process.

The chapter delineated the meanings embedded within the notion of resistance when resistance is defined as a form of contestation to the subject position imposed upon individuals within the regulation of discourse. The Foucauldian notion of the ethics of the care for the self (Foucault 1985, 1998a) as a practice which enables one to gain more space for action and to resist was discussed in detail, allowing for an evaluation of this theorising and its application in organisational studies. Utilising the theoretical framework discussed during the course of this chapter, the next chapter now moves on to discuss the mental illness discourse and subject positions, allowing for an evaluation of the meanings embedded within and their application in organisational literature.

Chapter 3: Mental health and illness—discourses and subject positions

The aims of this chapter are to explore the evolving discourse of mental illness and how the components and parameters of this discourse are presently understood. This analysis will draw on the concepts introduced in Chapter 2 to evaluate the literature on the discourse of mental health and illness and its associated subject positions. This chapter will be structured as follows: An introduction to the discourse of mental illness (3.1) followed by a discussion on two predominant meanings and subject positions which arise from the discourse: the ‘mental health patient’ (3.1.1); and the ‘stigmatised subject position’ (3.1.2), with an emphasis on Goffman’s (1968) notion of stigma and related concepts (3.1.2.2).

The chapter will then continue by drawing on contemporary changes within this discourse (3.2) and subsequent subject positions (3.2.1, 3.2.2). The last part of the chapter will discuss mental health and work (3.3), dealing with matters concerning the stigma, discrimination and struggle experienced by people with MHCs at work (3.3.1); and the organisational perspective on mental illness (3.2). Lastly the discussion deals with the scope for this study, its theoretical framework and aims (3.4).

3.1. Introduction to the discourse of mental illness

Whilst taking on a number of hues through history, mental illness has been consistently constructed in a negative form. Mental illness was considered a vice in the 13th century, as something suffered by ‘a different class of humanity’ in the 17th century and as a non-curable problem (Foucault, 1971) of ‘morality’ and ‘disorder of the will’ (Mayo 1838, cited in Blackman 2001, p.116-117), during the Enlightenment. The literature testifies to the ways in which the discourse of

mental illness is derogative. The Enlightenment and the development of science during the 18th and 19th centuries became a landmark in the exploration and the regulation of mental illness. During that time, mental illness was considered as contradicting the dominant ideas of rationality and reason because it represented a set of unreasonable, unusual, or abnormal thoughts. The examination and the exploration of the so-called notion of ‘lunacy’ or ‘insanity’ during the process of the segregation of inmates in the asylums greatly contributed to the development of the discourse of mental illness and of the ‘mentally ill’⁶ subject position.

The literature on the establishment of the asylums indicates how the discourse of mental illness (Bracken and Thomas, 2005) evolved within the intersection between the medical and the socio-political. This came at a time when the regulation of disadvantaged populations by the state took place, in part, by their being segregated from the rest of the population by their being put into various kinds of restrictive custody. Among those were the ‘poor’ (individuals in need and those out of work) and criminals (Rogers and Pilgrim, 1996) as well as individuals who did not follow the dominant enlightenment ideas of reason, rationality and logic (Porter, 1987). Only later did medical exploration into their respective conditions take place and only subsequent to that were those who were categorised as mentally ill moved into separate asylums. It was then that medical professionals, who at first treated only physical illnesses and provided moral advice, became more specialised in this new discipline of psychiatry (Bracken and Thomas, 2005; Szasz, 2008).

In the UK, a number of Acts (Madhouse Act and the County Asylum Act, 1828; 1844 Report of the Metropolitan Commissioner in Lunacy; Lunacy Act, 1845; The Lunacy Legislation reports in the beginning of the 19th century) provide evidence of the

⁶ The notion of the ‘mentally ill’ and subsequent meanings is presented in quotation marks to emphasise its constructed and contested subject position. However, in order to allow for ease of reading and to avoid a clumsy style, the quotations marks are omitted throughout the thesis but will reappear at the start of a chapters 5-9 as a reminder to the reader that this notion is presented as a socially constructed term and is no means a way of inferring an essentialised medical condition.

formal regulation of inmates in the asylums in the 19th century (Rogers and Pilgrim, 1996). These reports are testament to the rapid growth in the number of asylums and to the increasing numbers of admissions to asylums during this period (Scull, 1979). The reports criticise the asylums' inappropriate conditions and treatments, the reduced numbers of discharges and their failure to provide cure and therapy (Rogers and Pilgrim, 1996).

This repression of the mentally ill within the asylum system points to the links between medical notions of mental illness and state's preoccupation with the regulation of populations. It is suggested that the meanings embedded within the notion of mental illness lie at the intersection between these medical, and socio-political meanings. In that sense, the growth in the number of asylums during the 18th century promoted medical exploration and the establishment of psychiatric knowledge through the scientific exploration of behaviour and symptoms (Rogers and Pilgrim, 1996). Increasingly, psychiatrists, instead of general doctors, assumed control over the asylums. This increasing trend towards scientific exploration within the asylums facilitated the establishment of the psychiatric profession (Foucault, 1971) in Britain in 1846, and the notion of 'mental illness' became increasingly recognised as a particular phenomenon (Foucault, 1971; Bracken and Thomas, 2005). This in turn led to the development of what is referred to here as the 'mental health patient' subject position (discussion in section 3.1.1 below).

However, at the same time as it fulfils the medical role of providing a cure for illness, psychiatry also fulfils a political role through its 'legitimising the exclusion of those who do not have a role in modern society' (Bracken and Thomas 2005, p.88, text modified) and is therefore a way for the state to regulate populations (Foucault, 1971; 1977; Doerner, 1981; Porter, 1987). Thus, separate from its medically related subject position, deviancy and social exclusions are constructed as another integral subject position within the discourse (Foucault, 1971; Gordon, 1986) and will be named in this thesis the 'stigmatised subject position' (discussion

3.1.2. below). These two subject positions are further discussed in the two sections below.

3.1.1. Psychiatry and the 'mental health patient' subject position

Psychiatry was introduced as a natural science to explain mental illness as a pathological illness (Thomas, 1997) identifiable and recognised as a medical illness (Kety, 1974; Engel, 1977; Klerman, 1977; Ludwig and Othmer, 1997). Psychiatry, within the spectrum of biological sciences, follows the traditional medical model of medicine which medical professionals adopt and which has embedded within it a set course of procedures for making a diagnosis and recognising illnesses. The medical model follows the tradition of diagnosing symptoms and syndromes and its main assumption is based on finding the causes of illness and prescribing treatment (Laing, 1971). Another subsequent assumption by which the medical model operates is that the medical professionals have the authority and the legitimacy, resulting from their ascribed roles, to determine the course of a patient's treatment.

As such, the power relations embedded within the medical model, and hence in psychiatry, are characterised by the domination of the control which the health professional exercises throughout a patient's treatment and which results from the legitimacy and consequent authority of their role, empowering them to give medical diagnoses. Consequently, the control the patient has over the course of their treatment is limited. This asymmetric patient-doctor power relation and the passive subject position of the patient are therefore reinforced through 'legitimised medical knowledge' (Foucault, 1982). As such someone who is being diagnosed or labelled as a 'mental health patient' used to have restricted and passive agency within the traditional medical model and is expected to conform to the diagnosis prescribed by the doctors (Foucault, 1971; 1982; Rose, 1989; Thomas, 2007).

Furthermore, a long tradition of medical ethics is embedded within the medical model and the doctor-patient relationship which exemplifies the unequal power relationship between medical patients and doctors and the restricted control which medical patients have over the course of their treatment. One example for this is the notion of paternalism which suggests that medical professionals use their medical knowledge and experience to decide what is best for the patient. Similarly, the notion of beneficence (Gillon 1985, p.75-6)—‘doing good for others’—represents a patient’s restricted agency in the sense that the notion of ‘doing good’ can have more than one meaning and may stand against a patient’s own will. Such an ethical conception does not accept the assumption that patients are able to understand the complexities of their illness or treatment. Nor does it allow that they should have such autonomy restored to them as might lead to their being empowered to control the treatment of their own illness (Gillon, 1985).

Therefore, the standard method of making a psychiatric diagnosis and determining the course of treatment as defined by the international system of classifying mental disorders, leaves a restricted space for the value of subjective experiences (Mishara, 1994) and cognitive procedures such as thinking, feelings and behaviours (Bracken and Thomas, 2005) or the recognition of the patient’s subjective experiences and knowledge of their own condition.

Furthermore, the Cartesian division between the invisible mind and the soul as the spiritual, and the visible body as a separate entity is the longstanding foundation of both science and medicine. In practical terms, this division leads both disciplines to focus only on what is observable (Scheper-Huges and Lock, 1987) and, as such, the reduced recognition of non-physical symptoms is noticeable throughout science and medicine. This dualism in turn spawns a certain dominant approach to be found within psychiatry itself (Churchland, 1986; Smythies, 1992; Thomas, 1997). The existence of this unobserved, unquantifiable aspect of mental illness partly explains how someone considered a mental health patient might be

more marginalised than someone diagnosed with a physical or visible illness, the dimensions of which fall within the paradigms of the medical model.

Whilst the evolution of the combined notions of the medical model, psychiatry and the medical patient produces a conception of the mental health patient as someone who is passive, incapable of leading the course of their treatment and marginalised even when compared with a 'physically-ill patient', the discourse of mental illness also embeds within it prevailing meanings which have wider social and political implications in the lives of those who are being medically diagnosed as mentally ill. These societal meanings, pejorative in nature, are discussed below and are illustrated through what is being referred to in this thesis as the stigmatised subject position.

3.1.2. Deviancy and social exclusion: the stigmatised subject position

Apart from providing medical advice, the discourse of mental illness has a socio-political aspect to it whereby, as a profession, psychiatry is understood as a means through which authorities and communities are enabled to control and regulate excluded groups. This in turn implies that the understanding of madness as an illness in modern societies is socially constructed. It also implies that the classification of the normal and the non-normal/insane (Foucault, 1971; 1980; 1982) has embedded within it a form of social exclusion (Gordon, 1986).

This pejorative classification arises because the diagnosis of mental illness under the medical model requires the linguistic processes of naming, categorising and classifying someone as 'insane', ('mad' or mentally ill). This very process degrades those so classified, asserting that they cannot be considered as 'normal' or 'un-ill' (Foucault, 1971). As such, the discourse of mental illness illustrates how psychiatry and the medical model are incorporated within the social structure (Durkheim,

1964[1895]) in a way which ensures that a diagnosis of illness legitimises the social exclusion surrounding it. This procedure has long been used to enforce and legitimise the management of deviancy (Scull, 1979) in previous centuries and to establish particular meanings around psychiatry and mental illness which prevail to this day (Porter, 1987; Doerner, 1981; Bracken and Thomas, 2005).

Foucault illustrates how this process takes place when he evaluates the segregating of individuals in the asylums and names it 'The Great Confinement' (Foucault 1971). According to Foucault, the economic considerations of the state were the initial reason for shifting populations into the asylums as a form of labour market regulation (Foucault, 1971; Doerner, 1981). When cured or rehabilitated, individuals were expected to return into the labour market (Rogers and Pilgrim, 1996). This division between those who could and wanted to work and those who could not (Rose, 1985) constituted the class of the unemployable in previous centuries (Donnelly, 1983), and illuminates how the categorisation of the mentally ill was linked to a reduced social role and unemployment (Rose, 1989).

Thus the notion of being 'mad' was associated with being unproductive, 'discreditable' (Szasz, 1961; Goffman, 1961; 1968; Hunt, 1966; Chamberlin, 1977) and socially ineffective (Peterson, 1982; Porter, 1987; Foucault, 1971). Scholars critical of the status quo therefore argued that psychiatry is a means of 'isolating', 'treating', 'correcting,' or 'punishing' individuals (Schur, 1971). Consequently, society perceives the mentally ill as lacking a social or economic role and, therefore, as weakening the social system (Parson, 1951).

The social construction of mental illness as a pejorative and stigmatised identity is also linked to a lack of public education and ignorance as well as to a sense of secrecy. The segregation and the isolation within the asylums system, and the domination of medical professionals over the discourse relating to mental illness, has also been seen as restricting the distribution of mental health knowledge to

the public as well as to other professionals, leaving them ignorant of the nature of mental health conditions. This process of obscuring uncomfortable realities also promotes fear, which in turn reinforces social exclusion (Bracken and Thomas, 2005). This sense that we should fear those diagnosed with mental illness illuminates further how, in addition to their reduced social and economic role, the mentally ill is also being viewed as hopeless, dangerous (Cohen and Struening, 1962; Taylor and Dear, 1981; Brockington et al., 1993; Link et al., 1999; Pescosolido et al., 1999); violent (Scheff, 1966); unpredictable (Lloyd, 2010) and a potential threat to the community (Peterson, 1982; Porter, 1987).

This constitution of mental illness and the mentally ill remains a pejorative and discriminative discourse and subject position until this day. This discrimination can take place on interpersonal levels (Lloyd, 2010) and also on wider institutional levels by excluding people with MHCs from participation in legal, economic, social and other institutional activities (Link and Phelan, 2001) such as gaining employment (Corrigan, Kerr and Knudsen, 2005) and living independently (Wahl, 1999).

Although the emotive term 'madness' is not officially used today, mental illness is still associated with continued experiences of stigma and prejudice (Rivers, 2005). Still, today it seems that the effects of stigma on a person receiving a psychiatric diagnosis can act as a mark of shame (Byrne, 1999; Blackman, 2001). This exclusion is also manifested through marginalisation and various forms of discrimination (Clinard and Meier, 1992; Dovidio, Major and Crocker, 2000), social inequality (Williams, 1999; Marmot Review, 2010) and other inequalities in rights and responsibilities such as reduced citizenship and marginalisation (Bracken and Thomas, 2005), isolation (Huxley and Thornicroft, 2003) and poverty (McCrone and Thornicroft, 1997). The ongoing stigma of people with MHCs in organisations (Goffman, 1961; 1968; Hunt, 1966; Campling, 1981) and in employment supports the view that mental illness is still regarded as a shameful condition (Rose, 1985;

Blackman, 2001) which restricts social mobility (Bracken and Thomas, 2005) and causes despair, dislocation and oppression (Williams, 1999) for these individuals.

This legacy of stigmatisation impacts upon the identity construction of someone who is diagnosed with mental illness. Constructing a positive sense of self for people with MHCs is therefore highly problematic given this association with social rejection, a restricted social network, isolation, unemployment and low income (Perlick et al., 2001; Corrigan et al., 2005).

Consequently, people with MHCs can be prone to 'self-stigma' (Goffman, 1968), an internal feeling of suppression, inferiority, guilt, shame, a sense of uselessness and dependence (Reeve, 2002; 2006), reduced self-esteem and self-efficacy (Link, 1987; Markowitz, 1998), a wish for secrecy (Goffman, 1968), as well as a reduced sense of self, impaired coping mechanisms, confidence and ontological uncertainty (Thomas, 2007). As stigma is an integral part of the construction of the pejorative mentally ill subject position, a detailed discussion on the concept of stigma and of living with a stigmatised identity as studied through the work of Goffman (1961; 1968) is outlined below.

3.1.2.1. Stigma and mental health

Historically, the word stigma *'used to signify any bodily sign that indicated something bad about the moral character of a particular person'* (Papadopoulos 2009, p.11). The Greek word 'stigma' literally means the marks resulting from pricking slaves to determine an owner-inferior relationship (Falk, 2001). Similarly to its original lingual meaning, a mark of inferiority, Goffman (1968) defines stigma as a pejorative social perception of 'blemishes' within 'individual character' (ibid., p.14) resulting from records of mental disorder, addictions and unemployment, as

well as inferiority of race, nation or religion and 'blemishes' in the form of abnormalities of the body.

In his theorising of stigma, Goffman (1968) describes how the stigmatised hold an undesired differential from what was anticipated by society or by the 'normals' (ibid., p.15) and are thus being treated in an inferior way which can reduce their life chances. Thus, as a result of the stigma, the identity of the stigmatised becomes labelled and marked. Goffman (1968) illustrates how stigma is something that remains permanent as a mark of shame, even after the stigmatised have been rehabilitated.

This sense of inferiority intensifies the constraints experienced by the stigmatised person, who may become engaged in a continuous endeavour to correct their identities through a range of strategies designed to allay the disabling image foisted on them by others and, when possible, to conceal their stigma. The perceived visibility of the stigma can thus be crucial in the lives of the stigmatised and may have a direct impact upon their decision as to whether or not to disclose a stigmatised 'differentness'. Goffman (1968) described the disclosure process of an invisible stigma as a crucial dilemma: *'to display or not to display; to tell or not to tell; to let on or not to let on; to lie or not to lie; and in each case, to whom, how, when, and where.'* (ibid., p.57).

Goffman (1968) named the process of hiding the stigmatised condition as 'the management of undisclosed discrediting information about [the] self' (ibid., p.58) and named it, 'passing'. The meaning of passing is the move from the stigmatised world to the world of 'normals' and as such bears within it many benefits. Goffman (1968) explains passing as being 'a whole man... an adult with dignity and self-respect' (ibid., p.149). Equally however, the costs of passing are high; they entail ongoing concealment, even from close friends or other family members, secrecy and potential blackmailing (by the ones who are aware of the stigma) and, 'a very

high level of anxiety, in living a life that can be collapsed at any moment' (Goffman 1968, p.108-109).

Goffman (1968) also explains how passing for normal is not always possible. This may be due to evidence in personal biographies and to unexplained employment gaps which indicate a history of illness. These may become a tricky hurdle to negotiate so that the individual can 'pass' in many areas of life (Mills 1962 cited in Goffman 1968, p.79). Nonetheless, even when passing for normal is possible, Goffman (1968) illuminates how the 'passer' remains to a certain extent different from the 'normals' (ibid., p.149). This theoretical framework has broad applications across the social sciences and in organisational studies.

A number of organizational studies highlight the dilemma surrounding the act of disclosing a stigmatised condition at work (Clair, Beatty and MacLean, 2005). These studies illuminate some of the strains involved in living up to an identity at work when a significant part of it is stigmatised. They illustrate how this process can lead to a sense of fraud (Herek, 1996) and a struggle over not receiving the required support at work (Tse, 2004; Ellemers and Barreto, 2006).

Overall, examination of the struggle faced by individuals with MHCs in the workplace (dealt with further in section 3.3 of this chapter), which have been studied within the theoretical framework of Goffman's stigma theory for identity, has contributed to the understanding of the way in which individuals with stigmatised and invisible identities manage their stigma over a number of contexts, and also to an increased realisation of the costs that this process entails.

This study draws on Goffman's theorising regarding stigma; however, it also recognises the limitations of this approach. Although the approach illuminates both social and individual processes on identity, the lack of emphasis on power

dynamics suggests that the Goffmanian approach is restricted in terms of identifying practices of resistance and change that this study aims to explore.

In other words, whilst providing a theoretical framework for understanding how individuals act upon a stigmatised subject position, the Goffmanian approach is limited in terms of understanding broader contexts and power dynamics. This then limits the ability to accommodate for agential acts of resistance and change and the possibility for individuals to reposition themselves in relation to a stigmatised identity. In turn, access to understanding greater social processes and the introduction of new meanings into a stigmatised subject position is restricted. Yet, the study utilises the significant benefit of the Goffmanian approach for understanding how individuals with stigmatised and invisible identities behave at work and what are the main hurdles experienced by them in relation to the dilemma over disclosing their condition.

The discussion has, so far, highlighted how the discourse on mental illness was historically constructed through stigmatisation and marginalisation. The discussion illustrated the process of the social construction of the mentally ill discourse and subject positions and the pejorative meanings embedded within them. Whilst remaining a prevailing discourse until this day, the discussion below will illustrate how the main two subject positions which are embedded within the discourse: namely the mental health patient, and the stigmatised subject position have been challenged, changed, recrafted and resisted.

3.2. Resistance and change: changing subject positions

At the same time that the discourse of mental illness has embedded within it pejorative meanings which remain relevant to this day, a number of significant changes within both the medical and the socio-political aspects of the discourse

require attention. Referring to the mentally ill discourse and the stigmatised subject positions, the protest activity of critical writers and the anti and post psychiatry movement (e.g. Hearing Voices, Mad Women, British Mental Health Service Movement, Self-Harm Network, UK Critical Psychiatry Network) to challenge the pejorative meanings attributed to mental illness reflects changes within both the medical and the social domains.

The central argument of the anti and post-psychiatry movement is located at the interface of medical definitions of mental illness and political struggle (Lewis, 2006). It challenges social oppression as well as the medical model and traditional forms of treating MHCs. Critical writers, social activists and the anti-psychiatry movements have criticised the pejorative meanings attributed to mental illness as well as the categorisation of individuals as mad, insane, abnormal or mentally ill.

They further criticise the oppression of mental illness, the repressive nature of treatment, as well as labelling and stigmatisation (Goffman, 1961; Szasz, 1961; 1998; Scheff, 1966; Cooper, 1967; Laing, 1967; Foucault, 1971; Basaglia, 1979; Scull, 1979; Castel, 1992; Guattari, 1995; 2000). For instance, the work of Szasz (1971, 1976) illustrates the argument of the anti-psychiatry movement through resisting the forced hospitalisation of people diagnosed with mental illness and the way in which this reinforces the repressive and pejorative societal view and the oppression of these individuals, restricting their freedom (Szasz, 1976).

The anti-psychiatry movement is not new; it has existed nearly as long as psychiatry itself. Already established by the end of the 18th century, the anti-psychiatry movement challenged the use of psychiatric 'power' for political repression. Evidence of one of the very first activities of this movement draws attention to the Anti-Insane Asylum Society which was established in the US at the end of the 18th century. This movement protested against forced medical hospitalisation, the treatment meted out in the asylums and the consequent

stigmatisation and labelling of patients (Geller and Harris, 1994). In the process, it established the grounds for more protest. This was taken up by advocates whose main aim was to challenge the control embedded within the psychiatric discourse and the way in which it restricts the agency of individuals who are regulated within it (e.g. Miller, 1986).

The protest of the Mad Pride movement was founded during the seventies in the US. Mad Pride acted together with other anti-psychiatry advocates (e.g. The Insane Liberation Front in Portland Oregon, The Mental Patients' Liberation Front in Boston), to resist the oppressive social construction of mental illness and the suppression, discrimination and disrespectful forms of treatments. Overall, the anti-psychiatry movement has fought against the exclusion of mental health patients from treatment planning and also act as advocates for hospitalised mental health patients. It has also developed alternative forms for coping with mental illness (Lewis, 2006).

Anti-psychiatry movements worldwide (e.g. Hearing Voices, Mad Women, British Mental Health Service Movement) have promoted social and cultural change, as well as full citizenship and respect for people with MHCs (Chamberlin, 1977; Perlin 2000, p.21), social recognition and the abolishment of discrimination and oppression both in treatment and, politically, as an oppressed category (Bracken and Thomas, 2005). They have succeeded in their significant campaigns to change mental health laws, increase awareness for human rights and improve mental health education (Lewis, 2006). Some of the achievements of the post-psychiatry and anti-psychiatry movement (Foucault, 1971; 2003; Thomas and Bracken, 2001; 2004; Lewis, 2006) in changing meanings within the discourse of mental illness have included the call to shift the unequal power relations between medical patients and mental health professionals. The movement has spearheaded resistance to traditional forms of mental health treatments and led the call for an increase in the range of mental health services and for increased consumer participation in treatment planning and facility regulation (Gillon, 1985; Zinman, Harp and Budd, 1987; Bracken and Thomas, 2005; Lewis, 2006).

The attempts to change and to recraft the oppressive discourse of mental illness, as embedded within the intersection between the medical and the political struggle of people with MHCs, are also manifested through policy and the work of mental health charities. For example Mind, one of the largest mental health charities in England and Wales, aims to provide advice for people with mental health issues and it works as an advocate in a wide range of areas, including campaigning against the stigma and discrimination suffered by people with MHCs and demanding social justice in the form of welfare and NHS reforms. It also works to promote the wellbeing of patients and the development of future strategy in the treatment and prevention of mental illness (Mind, 2013b). Together with other charities and mental health organisations (e.g. Rethink, Hafal, Mental Health Foundation), Mind operates in a way that promotes mental health education and awareness to all mental health concerns, whether commonplace or severe. It also works to resist social injustice and discrimination and to highlight where there is insufficient mental health treatment or access to services (Mind, 2013b).

Other health organisations and governmental bodies have also been engaged with these matters and their action continues to have implications at both global and local settings. For instance, the Marmot Review (2010), which was commissioned by the World Health Organisation (WHO), highlights the inequalities resulting from the exclusion of people with MHCs and indicates the way in which these impediments should be tackled both socially and medically. A number of its recommendations were incorporated in the strategic plans of some of the local authorities in the UK and of other commissions which attempted to create change within the meanings of mental illness both socially and in terms of the mental health treatments available.

One example is the Health Improvement Plan for Rushmoor (2010-2013) which incorporates both social and health-related strategies at the local and the community levels by planning to reduce social exclusion, address stigma, promote

good mental health and increase access to mental health services. Overall we can see how the attempts to change the meanings within the discourse of mental illness have been addressed for over a century through the activity of anti-psychiatry movements as well as other advocates and charities. It is also apparent in the policies adopted and in how local communities have attempted to tackle both social oppression and exclusion and unsatisfactory mental health treatments. These attempts to overturn the meanings within both aspects of the mentally ill discourse (medical and socio-political) have also been addressed more purposefully by specifically focusing on the medical domain and the social domain. The discussion below discusses further the changes and shifts in meanings within the two main subject positions of the discourse (namely the 'mental health patient' and the 'stigmatised subject position'). It commences with a discussion on the medical subject position (section 3.2.1) and continues with a discussion on the social domain being applied within the mentally ill discourse (section 3.2.2).

3.2.1. Challenging the mental health patient subject position

The resistance to the pejorative meaning embedded within the discourse of mental illness within the medical domain is manifested predominantly through the introduction of alternative forms of treatments, a consumerist approach to health services and in various types of mental health promotion. These are indicative of the change and the recrafting of the meanings embedded within the power relations between mental health patients and professionals. The contesting ideas of the anti-psychiatry movement together with the general growth in the consumption of services represent a substantial change in meaning within the medical aspect of the mentally ill discourse and subject position which are visible in a number of health systems one of which is the UK's NHS.

The general growth in the consumption of public services in the UK was manifested within the mental health system and was accompanied by the increased public

regulation of professional medical treatments and services, representation of patients' interests, involving patients in the development of planning of services, individual care, and the research and development of mental health services. The importance of patients' own interests was also a key concern for a number of National Institutes for Mental Health (HMSO, 2000; NIMHE, 2000) and was fed back into government policies (Bracken and Thomas, 2005).

The gradual incorporation of varied mental health services into the NHS included a vast investment and the gradual introduction of new national standards for mental health services in the early 1990s. These services included: providing care in the community and establishing social psychiatry units (Thomas, 1997), increasing the availability of alternative services managed by mental health patients (Rogers and Pilgrim, 1996), increasing service access, improving services for people with severe mental illness, providing care that optimises the engagement of clients with the services, reducing risk, preventing crises as well as mental health promotion (Bracken and Thomas, 2005).

The gradual prevention of illness and promotion of good mental health has also been evident through mental health policy and illustrates the changes in the meanings, dialects (Thomas, 1995) and practices (Rogers and Pilgrim, 1996). Promoting the maintenance of good mental health also has social and economic implications (Tudor, 1991) and represents the linguistic shift in mental health promotion, hence the move away from 'illness' into 'health' and wellness. This issue is also manifested through health conditions management programmes and the shift away from treating illness into the management of a health condition.

The move into health conditions management also incorporates the move into patient involvement in treatment planning, facility regulation, the representation of patients' interests and optimising their engagement in their care management. The NHS Experts Patients Programs (EPP) draws on the growing recognition in

patients' subjective experience of their illness and their own expertise in managing it (NHS, 2012a). These ideas are representative of the move towards patients exercising autonomy and ownership (Thomas, 1997) and of the treatment of their own illness (Gillon, 1985). The campaign promotes equality in the relationship between the patient and the health professional and the recognition that patients are the experts in the knowledge of their illness.

Apart from it being a cost-effective and sustainable way of maintaining good health, the self-management programme is an alternative mental health service and a recognised public health measure for self-care. Originally piloted in the NHS in 2002, the EPP is a community service where courses follow health and social care policy by focusing on encouraging individuals to take control over their own health and wellbeing and to improve the quality of their lives whilst providing more cost-effective care (NHS, 2012a).

Rooted within the programme is the recognition that people with long term health conditions are already self-caring on a daily basis and making decisions which affect their health. The EPP is therefore tailored around that recognition and aims to support them in the daily decisions they make about the management of their health. Based on an equal-partnership model, the programme is delivered not only by health professionals but by individuals with experience of living with a health condition, and aims to offer the return of responsibility, supporting change and build confidence (NHS, 2012a).

The shift within the meanings of the medical lens is therefore a reflection of the historic move from forced treatments or hospitalisation in segregated asylums to community-based treatment (Miller, 1986), to a more considered consumption of mental health services and the recognition of the patients' 'voice'. These changes also illustrate the shift in policymaking and in the public services provided. It illustrates the significant move away from operating within the traditional medical

model involving the patient's passive role, and towards choice in the consumption of services and greater agency (Bracken and Thomas, 2005).

This move also represents a shift in the power relations between patients and professionals. Rather than being restricted within a subject position that is forced on them by medical professionals, mental-health-services-consumerism today involves the autonomy and the freedom of choice for users to consume a variety of mental health services in the community (Thomas, 1997). It brings the involvement of patients in leading their own treatment and in regulating mental health services overall. Consequently, it reflects upon patient/health professional equality as well as a dialogue and partnership (Cawley, 1993). The move away from the domination of medical knowledge and towards the recognition of patients' subjective experiences and the ability to lead the course of their own treatment also reflects upon greater equality between medical knowledge and patients' knowledge of their own illness (Thomas, 1997).

So far we have seen how the medical discursive perspective and consequent mental health patient subject position within the discourse of mental illness has been recrafted together with greater changes in health policy and practice and consequent health services and the gradual recognition of the patient's voice. All these changes within the medical perspective also express the attempts made to overcome social and health inequalities and associated exclusion (Black et al., 1982; Marmot Review, 2010). As such, the changes within the medical perspective have implications upon the social side of the discourse and consequently stigmatised mentally ill subject position, which are discussed separately below.

3.2.2. Challenging the stigmatised subject position

Resistance and contestation to the social oppression and exclusion which has accompanied the discourse of mental illness is visible from the activity of a number of social movements and is also seen in governmental policies, legislations and reports. Whilst the general sense of such contestation was illustrated in earlier discussions addressing some of the activity of the anti and post-psychiatry movement, the following discussion will address these issues of resistance to stigma and oppression in more detail, drawing particular emphasis on the contributions of the social model, the disability movement, anti and post-psychiatry movement and policymaking in this area. The discussion illustrates how these forms of resistance to stigma and the exclusion embedded within the mentally ill discourse and subject position are indicative of the attempts to change and recraft these pejorative meanings.

A great contribution to the change in meaning within the mentally ill discourse and associated subject position is the work of critical and anti-psychiatry movements which are, by and large, manifested in the argument embedded within the British social model. The British social model was established as expression of resistance to the traditional medical model and to the exclusion and social barriers that arose from it. Originally developed along with the American Civil Rights model (Davis, 2006), the social model differentiates between impairment and disability by claiming that disability is a socially constructed category (Oliver, 2004). The meanings incorporated within the model illustrate resistance to the social barriers and the labelling of illness and this resistance is underpinned by the claim that health conditions or impairments do not need to have a direct link to social exclusion (Dredger, 1989; Campbell and Oliver, 1996; Charlton, 1998).

The social model argues that, as it is the society that labels individuals as well or ill, it is society that is responsible for the exclusion of these individuals because of the social barriers they face. Arguing that the medical model was relying upon medical categories of normality, the identification of symptoms and a subsequent

diagnosis based upon them, the social model draws on elements of social responsibility, regarding individuals with impairments or health conditions (Oliver, 2004). Taking the standpoint that the identities of individuals with impairments or health conditions are oppressed, the social model counters the exclusion of these individuals and suggests that society can accommodate this individual difference.

According to the model, physical and mental impairment should not be constructed as an oppressed and excluded because society can still accommodate the differences between individuals (Oliver, 2004). Within the context of MHCs the implication of the social model is that the exclusion attached for MHCs then creates further barriers to recovery. The social model advocates the separation of the impairment itself from its associated effects, excluding social barriers. While viewing the impairment as a physical or mental condition, the disability is understood as a result of the societal conceptualisation of the impairment as a negative experience (ibid.).

As for the social model, critical psychiatry draws on the argument that mental illness is socially constructed to the extent that much of the social infrastructure around the illness constitutes the symptoms and, ultimately, the illness itself (e.g. Szasz, 1961). Social theories on mental illness argue that apart from recognising mental illness as a neurological disease, social elements such as the relationships that people with MHCs are having with their social world should also be considered as socially constructing the illness in itself (e.g. Goffman, 1961).

For instance, the work of Goffman (1961) draws on the social understanding of the way in which mental illness is understood through socially constructed elements. In his book 'Asylums', Goffman (1961) draws on the social behaviour of people with MHCs living in a closed institution. Unlike the medical explanation of mental illness, Goffman (1961) concludes that many of the behaviours expressed by inmates were caused by institutional life and not by the nature of the patients'

mental illness. Likewise, Barton (1959) highlights that mental health patients in closed institutions experienced 'institutional neuroses' resulting from a long institutional stay.

Brown and Wing (1962) also have regard for the impact of the social environment (long term residency in mental institutions) on mental health patients' behaviour and symptoms. These studies stress the way in which contextual settings such as hospitalisation and the social environment re-ignite the social construction of the illness and the subsequent stigmatisation attached. Similarly, the work of critical psychiatry writers emphasises the perspective which condemns the prevailing social construction of mental illness and argues that it is a form used by the State to subjugate sections of the population (Szasz, 1961; Goffman, 1968; Foucault, 1971; Scull, 1979). This argument follows the rationale of the social model which holds that the oppressed category of mental illness was constructed and regulated by the state and, thus, that it is the state which needs to remove those oppressing barriers. An extreme argument within this vein is illustrated in the work of Szasz (1971; 1976) who argues that psychiatry and the state should be separated, that mental illness is a myth (Szasz, 1976) and that the term - mental illness - should be used only as a metaphor (Szasz, 1998).

Whilst studies express the recognition of social factors in the construction of mental illness and the entire category of disability, the understanding of the social model in the context of mental illness is limited (Oliver, 2004). As mental illness (as well as a number of other illnesses), does not clearly address the differentiation between the pre-existing impairment (e.g. Goffman, 1961) and the socially constructed disability, the use of the social model may be understood as restrictive (Davis, 2006; Shakespeare, 2006). Nonetheless, the social model contributed largely to the development of the social category and reform-oriented movement of people with disability (Davis, 2006) which resists the positioning as inferior, and the widespread oppression of people with physical or mental disabilities and illness.

Unlike medical categories—which differentiate between medical conditions, impairments and mental illness—the social category, and movement, of people with disabilities merges all types of illnesses, disabilities and health conditions and draws on diversity within the wide range of health conditions and impairments (Davis, 2006). Emerging in the 1970s and the 1980s, the new cultural and political disability movement attempted to achieve basic rights for these individuals and to counter the social oppression and the discrimination applied to them (Oliver, 2004).

Some critical writers and activists, however, advocate moving beyond resistance to the social oppression embedded within the category of illness and disability because it symbolises the protest against oppression when adopting the standpoint of an oppressed category (Davis, 2006). Instead of maintaining an oppressed standpoint, they call for an embracement of pluralism and acceptance of different ways and modes of being. This argument is based on the recognition that the meanings of illness and disablement are unstable, leading to the call for the blurring of the lines between what is considered disability and what is considered ‘normality’. Therefore, instead of looking at the binary relations of oppression and power, they call for the removal of the categories of normality and deviancy altogether (Gilroy, 2000; Davis, 2006).

The resistance manifested within the social model, anti and post-psychiatry movement and the disability movement, is also reflected through government policy and reports, and anti-stigma campaigns. Whilst illustrating a more liberal and less radical view, anti-stigma campaigns, governmental reports and policies indicate the continuation of attempts to shift the negative meanings, stigma and social exclusion associated with MHCs. For instance, the ‘Confident Communities, Brighter Futures’ Report by the UK Department of Health (2010), draws on strategies to generate employment opportunities and decrease the stigma assigned to mental health sufferers by reducing the causes for social exclusion through

improving life factors such as education, housing, employment and reducing exposure to violence (Department of Health, 2010; Marmot et al., 2010).

Likewise, the Marmot Review (2010) highlights the social and employment inequalities for people with disabilities and mental illness in many life aspects such as education and skills, neighbouring ability and the capacity to integrate into communities as well as employment. The report highlights the importance of employment for these individuals, encouraging employers to make or adapt jobs and working conditions that are suitable for people with a physical or MHC (Marmot et al., 2010). Similarly in the US, governmental action to involve corporate business in social change was attained through the reward of complying with legislation, making adaptations to both the physical and social working environment so as to increase mental health and to prevent negative attitudes towards mental illness (Hall and Hall, 1994).

In the UK, a recent anti-discrimination campaign, Time to Change (2009), points to the attempts of mental health advocates and charities, as well as the activities of role models and the public, to end the discrimination encountered by people with MHCs whilst encouraging employers to support employees experiencing mental health problems and to create a mentally healthy workplace (Time to Change, 2013). Attempts to tackle stigma and discrimination can also be identified in employment legislation. In the UK, the most significant legislation is the Equality Act (2006; 2010). The act harmonized different equality legislation (one of which is the Disability Discrimination Act (1995; 2005)) related to disability, gender and race. The act addresses a range of concerns relating to disability and health discrimination and their application to employment. From the act, health discrimination at work is tackled through establishing that it is unlawful to discriminate or to withdraw a job offer on grounds of mental health or disability and (excluding certain occasions) to ask about an applicant's health situation prior to a job offer (Equality Act, 2010).

Whilst the discussion so far addressed issues related to the social construction of the mentally ill discourse and subject positions and the way in which these issues are being contemporarily addressed, a review of the literature on mental health in the workplace, which is discussed below, provides insights for considering how the meanings around mental health and illness are constructed in social and employment settings and how these then impact upon the working lives for people with MHCs.

3.3. Mental health and work

The World Health Organisation reported an increasing prevalence of mental illness worldwide (Üstün, 1999) whereby 40% of all disabilities in corporate organisations involved mental illness (Ungar, 2011). The impact of psycho social constraints at work on employees' mental health (Trudel et al., 2009) suggests that people who work in organisations with high psychological strain would have higher occurrences of depression (Mausner-Dorsch and Eaton, 2000). Tense or threatening work conditions as well as stress at work (Farrell and Geist-Martin, 2005) also contribute to work-related mental illness (Marshall and Dowdall, 1982; Goldman and Lewis, 2008).

However, studies also draw on the requisite quality of employment for wellbeing and good mental/psychological health (Honey, 2004; Blustein, 2008). The effects of work for good mental health and a strong sense of identity has been examined in comparison to being outside of employment (Batinic et al., 2010), or from job loss (Fouad and Bynner, 2008), and in the context of mental illness. Although there is a paucity of representation of the voices of people with MHCs in the literature on mental health at work (Blanch et al., 1995; Van Niekerk et al., 2008), studies have suggested that in Western countries, people with both severe and mild mental illness are employed in a wide range of sectors. In order to illuminate further on the main issues concerning mental health at work, the discussion below

examines the literature related to mental illness and employment, covering the main anecdotes related to both the individual and the organisational lenses within this context.

3.3.1. Mental health at work: The individual lens

The literature on mental health at work points to the widespread presence and effects of stigma, stereotyping (Akabas et al., 1992; Albrecht, 1992; Baldwin and Johnson, 1998) and discrimination (Feldman, 1988; Charmaz, 1991). Studies illustrate how stigma and work discrimination take place in all aspects of mental health—including common mental health (i.e. stress, anxiety and depression) at work (Paton, 2010) as well as enduring MHCs and mental health related absence (Occupational Health, 2006a). A survey of 738 employees in the UK suggested that an employee admitting to having a mental health problem would result in them being viewed as less employable (ibid.). Quantitative studies suggest that one in five companies in the UK do not consider employing individuals who have a history of claiming incapacity benefits involving mental health problems (CIPD, 2006) and that work organisations only occasionally employ individuals who have, or used to have, a MHC (Manning and White, 1995; Rinaldi and Hill, 2000).

Moreover, it is suggested that more than 20% of employees are concerned about work-related stress (Occupational Health, 2006b), yet people find it difficult to discuss stress at work (Mind, 2011). Studies that focus on people with enduring MHCs, cite how the negative attitudes towards their condition can have a detrimental effect on their performance at work, increase absenteeism, damage their ability to socialise, and result in dangerous and ‘strange’ behaviour (Wilgosh and Skaret, 1987; Feldman, 1988; Diksa and Rogers, 1996; Hand and Tryssenaar, 2006; Tsang et al., 2007) and generally engendering feelings of lack of competence at work (Farina and Felner, 1973; Wahl, 1999).

These common myths and negative stereotypes about people with MHCs at work can be seen in Krupa et al.'s (2009) analysis of documents and interviews about stigma and discrimination. Among the stigmatising concepts drawn from the analysis were assumptions such as: people with mental illness lack the ability to meet the requirements to fulfil the social demands of work; people with mental illness are dangerous; mental illness is not a legitimate illness; working is not healthy for people with mental illness; and providing employment for people with mental illness is an act of charity. The authors also suggested that the impact of the media in initiating stigma against mental illness in society may also be related to the stigma and the discrimination against people with MHCs at work (ibid.).

Widespread stigma and discrimination in the context of mental illness may thus have a significant impact on the ability of people with MHCs to cope with employment (Pinder, 1996; Ritsher and Phelan, 2004; Corrigan, Watson and Barr, 2006; Fung et al., 2007; Vauth et al., 2007). Such assumptions appear to impact on the employment opportunities of people with MHCs (Link et al., 1999) and their struggle with unemployment (Grob, 2005). Indeed, studies and employment reviews (Equal Opportunities Commission, 1997; Anthony et al., 2002; Rosenheck et al., 2006) illustrate the low employment rates of people with MHCs.

The Marmot Review (2010) stresses the high unemployment rates of people with MHCs, and draws on the struggles they experience in employment and the likelihood that they will be in low-paid, poor quality jobs with working conditions that may be harmful to their health, characterised by high risk, low security or employment protection, and with few opportunities for career development, personal and financial growth. As such, many people with MHCs are still trapped in a cycle of unemployment and poor quality jobs, and are marginalised from full work integration (Krupa et al., 2009).

The enforcement of mental illness discrimination through the sensitive information provided on job application medical questionnaires has also been criticised (The Lawyer, 2009), suggesting that the disclosure of MHCs on job applications may be used for covert discrimination by employers (Mind, 2011). The statistics not only suggest that employees are reluctant to talk about stress at work (ibid.) but also how, despite one in four people experiencing mental illness during their life, more than half will not disclose their health condition to their employer (Paton, 2007).

Although people with MHCs are encouraged to disclose their condition to employers (Hatchard, 2008) they are often fearful of the stigma attached to mental illness (Braunstein, 2000; Britt, 2000) and believe that admitting any kind of mental health problem would jeopardise their future career prospects (Occupational Health, 2006a). Limited self-disclosure, however, and fear that a MHC will be revealed, can also be problematic for people with MHCs (Gelb and Corrigan, 2008).

Apart from the implications that non-disclosure has for appropriate treatment of a MHC, ongoing concealment of MHCs can also lead to anxiety (Goffman, 1968), stress, uncertainty regarding recurring mental health episodes, and preoccupation regarding the potential discrimination (Honey, 2003). As such, it may not be surprising that people with MHCs report on guarded relations with work colleagues as well as financial and emotional constraints (Marmot Review, 2010). The costs embedded within the disclosure or the concealment of a stigmatised identity in the workplace also leads to restricted notion of self and self-stigma, a lack of confidence, insecurity, reduced work performance and a sense of not being able to attain full work potential (Leary, 1999; Braunstein, 2000).

However, despite the struggle which many people with MHCs experience in gaining and maintaining paid employment, studies in the area of occupational health and rehabilitation illustrate how work can serve as a strong anchor with profound

source of identity. People with MHCs testify to the benefits of work: gaining a sense of normality, acceptance, belongingness, as well as daily structure, a balanced daily routine and a sense of wellbeing and purpose (Leufstadius, Eklund and Erlandsson, 2009).

A number of studies have highlighted the importance of work in the process of rehabilitation (Simmons, 1965; Van Niekerk, 2009). However, these studies have also drawn attention to the constraints resulting from the nature of the condition. Another factor which may be related to rehabilitation and the ability to regain work in this context also relates to economic circumstances. Warner (1985) draws on longitudinal data from over 100 years and found that more individuals recovered from severe mental illness when levels of employment were high and they had good chances of getting back to work. Whilst the literature provides an insight into the broad picture of how mental health concerns are captured within the workplace, and how that impacts the experiences of working people with MHCs, there is a scarcity of studies examining the identity related issues of mental health and work (Corrigan and Matthews, 2003).

Studies in the area of occupational health, examined cursorily the meaning of work for people with MHCs in relation to identity. Leufstadius, Eklund and Erlandsson (2009) interviewed 12 individuals with persistent MHCs who functioned in various types of work and employment conditions. The interviews focused on the meaning these individuals gained through work. A strong sense of self, pleasure and pride were presented and, apart from earning a living, work provided a sense of being able to contribute socially and within the employment context as well as the experience of belonging and being a part of the organisation. Work was also experienced by these individuals as a contributor to a greater sense of identity, wellbeing, self-esteem, and acceptance as well as a sense of normality on both a societal level and closer networks (ibid.).

Yet, although work provides a positive sense of self for people with MHCs, and whilst the bulk of people with mental health MHCs are eager to work (Mechanic, Bilder and McAlpine, 2002), the discussion above suggests that people with MHCs encounter a number of challenges to gain and maintain employment. Thus, gaining work and establishing a positive sense of self in employment may be problematic for these individuals. Although work is captured as meaningful and beneficial for the occupational and health rehabilitation of people with MHCs, the stigma attached to mental illness may restrict the chances for these individuals to gain, maintain, or thrive in work. However, the negative attributions towards people with MHCs may create problems not only for the individual but also at the organisational level, which is what discussed next.

3.3.2. The organisational costs of mental illness

The negative attributions towards people with MHCs may create problems for organisations as well as for individuals. Studies point to the loss of millions of working days every year due to mental health-related absences (Greenhalgh, 1994; Braunstein, 2000; Economist, 2005; Paton, 2007; The Sainsbury Centre for Mental Health, 2007). From a managerial and occupational health perspective, the unpredictable nature of absenteeism caused by mental illness has been found to interfere with the daily organisational routine and planned activities (Honey, 2003) and with working demands of co-workers who cited unreliability (Tse, 2004) and the need to manage extra workloads (Muir, 1982).

Other studies also draw on other work related concerns with employees having MHCs, such as poor performance (Greenhalgh, 1994; Braunstein, 1999; 2000; Honey, 2003) and the impact this has on the overall organisational productivity (Muir, 1982; Randell, 1998). Whilst mental health concerns at work have many implications at the organisational level, studies present a poor picture regarding the managerial awareness of mental health matters in organisations (Hammond,

2001; Sebastiano, 2008), suggesting that the stigma associated with mental illness is neglected in the workplace (Britt, 2000; Gelb and Corrigan, 2008). This then impacts the management of mental health and illness at work overall and can restrict the implementation of inclusivity and mental health policies (Hatchard, 2008).

Although there is evidence of poor managerial awareness to mental health at work, there are a number of studies that look at issues relating to managerial strategies and employment legislation in this context. These studies report on organisational and managerial strategies which highlight the importance of maintaining good productivity and overall organisational effectiveness when dealing with issues related to mental illness (Muir, 1982) as well as the importance of maintaining consistency between the organisational goals and HR policies in this context (Negri, 2009).

Training for employers and HR managers on how to handle challenging situations related to MHCs (Tse, 2004) and establishing an agreeable form of coping with employee's MHCs at work (Negri, 2009) were regarded as good managerial strategies for coping with mental illness in the workplace (Tse, 2004). More important managerial strategies include open discussion, and anti-stigma campaigning (Gelb and Corrigan, 2008) as well as a deep trustworthy manager-employee relationship (Negri, 2009) and a good relationship with other colleagues and mental health professionals.

The ability to establish shared goals to meet both the needs of employees with MHCs as well as the organisational ones (Hatchard, 2008) were also looked at as critical concern in the context of occupational health and the management of people with MHCs. For example, Tse (2004) examined 31 private businesses in New Zealand and highlighted an overall positive experience on the part of employers employing people with MHCs. The study also highlighted the importance of

managing coping mechanisms for dealing with mental illness at work, drawing on the importance of establishing a contingency pre-emptive plan for times of unwellness which include both health concerns (e.g. seeking external support if needs be) and performance at the organisational level, such as ways of coping with absence and an accumulating workload (Tse, 2004). Additionally, there are a number of policies and pieces of employment legislation that organisations are encouraged to follow. Providing reasonable accommodation, such as job modification (Equal Opportunities Commission, 1997; Disability Discrimination Act, 1995; 2003; 2005, Equality Act, 2010) and following Return to Work programmes, are examples of legislation which highlight the involvement of managerial and occupational health perspective in relation to dealing with mental health matters at work (e.g. Honey, 2003).

Similarly, rehabilitation programmes aim to assist both the organisation and the individual to effectively cope with MHCs at work and for the individual to be able to gain and maintain their employment. These programmes were found to be useful in the recovery from mental illness and the return to the job market (St-Arnaud et al., 2007; Hatchard, 2008) and are effective in taking into consideration aspects such as job choices and the limitations brought about by an illness and the maintenance of achievable employment goals to enable both the management of good mental health and good occupational performance at work, which then benefits the organisation (Honey, 2003).

A scan of the literature on mental health in the workplace illuminates how issues concerning the stigma and prejudices attributed to the discourse of mental illness impact upon the working lives of people with MHCs in a way that builds on the constraints faced by individuals as well as by work organisations. The discussion illustrated the impact that this has upon disclosure, health management and how this then leads to a complex tension around performance, enhancing career prospects and gaining a positive sense of self through work for these individuals.

However, an examination of the literature also shows that, although covering a wide range of issues, studies concerning mental health matters at work, by and large, take a non-critical perspective grounded in a psychosocial approach. The literature also suffers from an overall scarcity of studies which examine the identity construction for these individuals (Corrigan and Matthews, 2003) and this is even more so in the context of critical identity and organisational studies. Identity matters not only because the study of identity can illuminate how things come into being, but also given the benefits of studying identities critically as a way of understanding multiplicities of meanings at the individual and the social/organisational levels. Moreover, there is a lack of studies which have taken an in-depth and longitudinal approach and which are capable of illuminating a broad range of experiences for people with MHCs in a variety of work contexts.

What is lacking are studies taking a critical and in-depth exploration on the identity construction for individuals with MHCs that brings to the fore the inter-relationship between the societal and the individual, power relations and resistance, constraints and agency and it is this that provides the approach to this study.

3.4. This study

In Chapter 2 the literature on identities in organisations was critically explored. The chapter set out the critical discursive approach that this study adopts, highlighting the implications for research from conceptualising identity within a Foucauldian discursive framework (Thomas and Linstead, 2002). More specifically, the chapter provided theoretical focus for this thesis, drawing on Foucault's (1986) 'ethics of the care for the self' to understand the political dynamics of identity construction and contestation. This chapter, Chapter 3, then developed this critical discursive approach in relation to mental illness and mental health at work, highlighting its stigmatised meanings. Drawing on the approach to identities set

out in Chapter 2, this chapter considered the identity conflicts facing people with MHCs in work.

Thus, bringing the theoretical insights from the two chapters together, this study aims to understand and critically explore how people with MHCs constitute their identities in work organisations, and the discourses they draw on in this process. As individuals gain meaning from a discourse as a way of doing and being, and as they come to identify with dominant discourses which makes available to them subject positions and self-understandings. In doing so, the thesis examines how the meanings of mental health and illness at work are constructed, through the experiences of individuals with MHCs.

Moreover, the thesis aims to bring light on how individuals, when confronted by feelings of difference between their own self-understandings and the subject positions within discourse, may challenge those understandings. Whilst individuals construct their identity through the resources and constraints of discourse, their overarching identities are never fully determined. Thus an exploration of the struggles and the experiences of individuals with MHCs also throw light on the practices of agency, resistance and the production of new knowledge.

Therefore, the study aims to examine how individuals with MHCs construct, contest and negotiate their identities in different contexts and also how discourses might be reconstructed and contested, and the impact which they have on the lives of individuals in contemporary employment. Consequently, this research considers the inter-relationship between the literature on critical identity studies and the discourse of mental health and illness, involving a study of identity construction that also questions what is meant by being an employee with a MHC. How do people with MHCs negotiate their identity in the workplace? And how do they engage with the expectation to perform unfettered by any non-work issues?

Hence, how do they act upon and contest a mentally ill subject position and to what effect?

Appreciating better how individuals respond to the discourse of mental health in different contexts, this research also has a micro-political aspect to it in that it illuminates the experiences of an understudied population and seeks understanding of how people with MHCs themselves make sense of their experiences and struggles, hence emphasising the meanings that are important to them.

In sum, the study wishes to explore three inter-related questions. Firstly, it aims to explore the different forms by which people with MHCs construct identity and how is the notion of mental illness being crafted through their experiences? What is the relationship between an individual's notion of self and the discursive resources available to them in constructing their identity? To what extent does their MHC influence this construction?

Secondly this thesis asks: What are the contradictions and struggles experienced during the attempts to secure employment, negotiate a legitimatised identity at work and live up to employers' expectations? And what is the impact of these on their identity and attempts to enhance career prospects and how do these intersect with their self-care and health management? What are the paradoxical twists and turns around declaring a MHC at work?

Thirdly, this thesis examines what are the different forms of resistance and agency practiced by these individuals? It aims to examine how these individuals take on, resist or challenge the discourse of mental illness in the work setting? The study of self-care as a practice of resistance is particularly important because it brings fresh knowledge on how individuals introduce a multiplicity of meanings into discourses and identities through a range of individual practices.

3.5. Concluding remarks

This chapter explored the social construction of the notion of mental illness, providing an account on the way in which it evolved as a prevailed discourse and subject position of the ‘mentally ill person’. The chapter delineated the subject positions within the discourse of mental illness and how although resistance and changes take place within these subject positions, mental illness remained a pejorative and stigmatised notion that affects the working lives of individuals with MHCs today. The scan of the literature on mental health in the workplace revealed how there is paucity of studies looking at the identity construction of people with MHCs in the workplace, thus leading to a gap in the literature that this study wishes to address. Bringing the main highlights from the literature chapters together, the final part of the chapter illuminated the thesis conceptual framework and the gaps in the literature that this study aims to fulfil. Now that the theoretical background and conceptual frame has been established together with the research aims, the following chapter moves on to deal with the research design and the methodological considerations taken during this process.

Chapter 4: Methodology: Researching mental health at work

This chapter sets out the theoretical and methodological approach taken in the study, as well as providing details on the research design and execution. The chapter commences with a detailed consideration of the theoretical and methodological approach taken (4.1, 4.2). Following this, details of the methodological tools taken (4.3) and the ethical considerations (4.4) are presented. The actual research process is then described (4.5), together with details on how the data was analysed (4.6). Finally, the reflexive positioning of the author within the research process and product (4.7) is considered. To start with, however, the chapter commences by examining how the nature of reality and knowledge of it within this study are understood by setting out the ontological and epistemological underpinnings of the study.

4.1. Ontological and epistemological approach

Put simply, ontology can be defined as the nature of, or the positioning by which reality is captured. The ontology adopted in this study follows the ‘linguist turn’ in social and organisational studies whereby reality is constituted through discourse (Alvesson and Deetz, 1996; Martin, 2001). Within this approach, the study adopts the poststructural ontological perspective and one that recognises the fundamental role of power in the constitution of reality. Embedded within this poststructural ontological position is the assumption that reality is not constant, unified or absolute, rather, it is fluid, changing and evolving (Bardon and Josserand, 2011). This ontological position aims to unsettle and to question how things come into being and are taken for granted as reality and truth. It assumes that meaning production is not unified or singular but multilayered and bounded within socio-historical and political contexts (Alvesson, 1996; Oksala, 2010).

Taking a poststructuralist approach thus assumes that what we experience as an independent reality is constituted and comprehended by us through discourse

(Deetz, 2003). The approach draws attention to the multiplicity in meanings, historical contexts and the processes by which the social world is constituted (Bardon and Josserand, 2011). Discourses provide the building blocks by which we access a reality and, as such, this reality is bounded within socio-historical and political contexts (Hook, 2007).

This ontological position follows the poststructuralist tradition of critical identity studies (Alvesson et al., 2008; Thomas, 2009), which was discussed in Chapter 2. It takes the view that individual's understanding of their self is comprised of multiple strands, fragile in nature, changing in different contexts, and fundamentally bound up in discourse and within the dynamic of power relations. Moreover, the core focus of this research, in analysing processes of identity constitution in relation to MHCs at work, takes the view that identity reflects a variety of historical and cultural situations and thus, is a site for a multiplicity of meanings and tensions and a result of power dynamics within discourse (Foucault, 1982).

These ontological assumptions bear consequences for the epistemological approach taken. By its definition, i.e., the way in which knowledge is understood, epistemology is strongly tied to ontology. This is because the way in which knowledge is understood (epistemology) is shaped by the way in which reality is appreciated (ontology). The study takes a subjective epistemology (Joas, 1993; Watson, 2010), where 'reality is understood as being dynamically constructed through human action' (Phillips and Oswick 2012, p.6) and the interpretation and meanings attributed to individual experiences (Bryman and Bell, 2007). Knowledge is thus contextual and situation-specific, where the general object of investigation is the construction of realities and the reflection thereon, by social actors (Thomas and Linstead, 2002). As such the approach takes the stance that what is understood as 'objective knowledge' is produced through discourse (Foucault, 1981; Deetz, 1992). The discussion below addresses in more detail the core concerns of the discursive approach that this study adopts.

4.1.1. Foucauldian Discourse Analysis

The study takes a Foucauldian approach to discourse, where knowledge is created through the circulation of power through discourse. Discourse is thus understood as the medium by which objects and identities come into being. This approach allows for grasping a sense of how modes of thinking of what is considered as knowledge emerge. The Foucauldian discourse approach examines how the micro-politics of power relations inform ways of being, and how certain bodies of knowledge are constituted through rules (Arribas-Ayllon and Walkerdine, 2008) and normalising practices (Hardy and Clegg, 1996).

Taking a Foucauldian discourse approach throws the focus of analysis on how power circulates to produce meanings around mental health and the mental illness subject position. 'Being mentally ill at work' is an expression of the power dynamics in discourse which is manifest in a number of forms, such as declaring or concealing a MHC and the consequential outcomes (for example, in health, career prospects, and sense of a legitimised self), that this process may lead to. This illustrates how the power effects of discourse are spread into the discursive and the material domains, and how the two are intertwined within each other (Hardy, 2011; Hardy and Thomas, 2013). This makes processes of struggle and resistance over meanings and material conditions visible (Taylor, 2001) and in a way that allows for revealing multiplicity when generating and analysing data (Howarth, 2000; Philips and Hardy, 2002).

This consideration of greater social, cultural and historical contexts (Foucault, 1972) thus allows us to go beyond the examination of localised concerns *per se* (Gee, 2005; Alvesson and Kärreman, 2011a; 2011b; Mumby, 2011) to identify how discursive resources are linked in terms of contextual meaning (Alvesson and

Kärreman, 2000b), at the micro and macro levels and the way in which both levels are embedded within one another (Boden, 1994; Marshall, 1994; Oswick and Richards, 2004) through the dynamics of power. This type of examination also illuminates more broadly the context through which discourses emerge and how knowledge produced at the macro level is linked within greater social political and historical settings. It thus allows us to link text and context (Hook, 2001) and to understand how texts emerge and the power relations within their constitution (Foucault, 1972; Philips and Hardy, 2002).

Consequently, knowledge is produced through discourse. It is bound within a certain time, social conditions, culture, language or historical period and the dynamics of power relations. Knowledge is created through processes of inclusion and exclusion (Hook, 2001; Foucault, 1981; Young, 1981) when the meanings produced within this process mark out what is legitimate, or accepted (Foucault, 1980; 1981; McHoul and Grace, 1997). The construction of knowledge, objects and subjects through this process not only defines what is classified as 'knowable' but also defines its limits (Mills 1997, p.33). In turn, this process has an effect at both the individual and the societal level (Hardy and Thomas, 2013).

Utilising the discourse of mental illness as an example (see chapter 3 for details), we can see how meanings associated with mental health and illness have been constructed through processes of classification and the constitution of the science. Through these processes, psychiatry (knowledge), objects (medication, hospitals) and subjects (mental health patient, mental health professionals) are constructed in a particular way which then differentiates them from other bodies of knowledge, objects and subject. As this thesis demonstrates, although the meanings embedded within this discourse have changed, they are still strongly associated with the social construction of the 'mentally ill discourse'.

Utilising a discourse approach is attractive for this study. This epistemology illuminates understanding of the subject and power and, as such, it complements the view on the core concept being examined in this work, namely that of identity. At the epistemological level, identities are bounded within discourse in a 'discursive' positioning which offers: 'a perspective from which to view a version of reality' (Arribas-Ayllon and Walkerdine 2008, p. 102). Thus the number of subject positions offered from a number of discourses provides a number of perspectives from which individuals then construct their own identities.

A Foucauldian discourse approach to identity incorporates the dynamics of power relations within the constitution of the subject and knowledge. Thus identity is captured through the way in which individuals respond to the subject positions within discourse (Foucault, 1982) and relate to them within their own self-understanding. Studying identities allows for gaining an insight into the way in which the dynamics of power and resistance at societal level manifest themselves for the individual (Oksala, 2010).

The application of these theoretical concepts into the frame of this study suggests that in their relation to the mentally ill subject position, individuals construct an understanding of their identity which is a result of discourse and power. Their involvement with this subject position can reflect different responses such as struggle and subjugation as well as resistance and change. Furthermore, apart from engaging with the mentally ill subject position, individuals constituted their identity through the meanings arising from other discourses and subject positions by which they come to know themselves (i.e.: 'an employee', 'a friend' and so on).

It is worth noting that a Foucauldian approach to discourse and identity has attracted considerable amount of criticism (Thompson, 1993; Newton, 1994; 1998; Ackroyd and Thompson, 1995; 1999; Reed, 2000). Although this criticism is partly

due to problematic readings of Foucault's work (Knights, 2002; Carter, 2008; Bardon and Josserand, 2011), it is worth rehearsing some of the key tensions arising from this approach. Overall, the Foucauldian discourse approach has been criticised for insufficiently addressing the role of individual agency and a failure to conceptualise adequately the role of resistance (Ackroyd and Thompson, 1995, 1999). It has also been criticised for neglecting social practices and material settings outside discourse and for localism, nominalism, and reductionism (Reed 2000). Additionally, the discourse approach has been criticised for being ambiguous and unclear (Van Dijk, 1997). Defining what type of discourse analysis is used during the course of a study and following it consistently throughout the research process is also considered challenging (Phillips and Jorgensen, 2002). Each of these points is discussed below.

The most significant criticism of the Foucauldian discourse approach relates to the argument that the Foucauldian project '*downplay[s] the role of agency in the construction, reproduction and transformation of discursive formations*' (Reed 2000, p.525 see also Giddens, 1984; Caldwell, 2007), whilst not giving recognition to the duality of agency and structure (Reed, 2000). However, the theoretical framework and ontological underpinnings of the study addresses how the examination of the notion of agency within the study is not understood as pre-given or as embedded within the social structure, but rather accepts that it is fluid and acted upon as a practice. Agency, resistance and identities are thus not understood as given entities. But rather, individuals are expected to engage in the production of their own agency in order to contest, or resist normalising discursive practices which may limit their scope for action (Bardon and Josserand, 2011).

The Foucauldian approach has also been criticised for being relativistic (e.g. Reed, 2000) and for insufficient recognition of the material conditions outside discourse (Burman, 1991; Parker, 1992; Howarth, 2000). The approach was criticised for focusing on localised textual analysis at the cost of its wider political implications (Burr, 1995), and for degrading the social world and individual experiences into a

form of text or language (Howarth, 2000; Phillips and Jorgensen, 2002). However as illustrated above, at its epistemic level, the Foucauldian discourse approach aims to unpack what is taken as a pre-given 'truth' and objective reality. Instead of claiming that there is no universal truth (hence deeming relativism and localism as foundations of reality), the Foucauldian approach examines how universal truths have come to be known as they are in a way that would examine how they can be challenged. It is thus not a relativist approach which is sceptical about the universal establishment of what is considered as knowledge, but is rather interested in questioning how what is considered as universal 'truth' comes into being (Foucault, 1982). Furthermore, the aim of the study, to examine processes of identity construction and how individuals engage with certain material practices to secure employment and good health, also addresses the criticism that the Foucauldian approach lacks an appreciation of material conditions (e.g. Reed, 2000).

As opposed to textual analysis *per se*, the analysis adopted in this thesis utilises a context bound frame of greater social, cultural and historical processes and this also minimises the degree of relativism which may be attributed to other discourse approaches. Furthermore, the examination of the empirical material is analysed within the consideration of the micro-political level and addresses matters of struggle and contestation. This then illustrates how individual experiences are not 'reduced' into form of text but rather, on the contrary, the medium of language is being utilised to illuminate individual and social experience. Lastly, the discussion so far has clarified the stance this thesis takes to discourse analysis and, as such, it addresses the criticism regarding the ambiguity or inconsistency which is often attributed to the discourse approach (Van Dijk, 1997).

Overall, the discussion above illustrates how the ontological and epistemological approach adopted complements the aims and purpose of this study. The approach provides the foundation for an in-depth exploration of the way in which identities are constructed through the dynamics of the power relations embedded in

discourse and how knowledge is understood within this process. The discussion below now moves on to deal with the methodology adopted in a way that complements the study's aims and its ontological and epistemological underpinnings.

4.2. Methodology

A methodological enquiry in social research can be understood as comprising 'rules that specify how social investigation should be approached' (Ramazanoglu and Holland 2002, p.11). Following the previous discussion on this study's approach to reality (ontology) and to knowledge (epistemology), the discussion on methodology moves on to deal with the techniques and tools for generating knowledge about the social world (Cook and Fonow, 1990; Reinharz, 1992; Pilcher and Coffey, 1996; Hall, 1997). A methodological positioning aims to facilitate the empirical enquiry and is reliant upon particular disciplines and theoretical stances (Guba and Lincoln, 2005) and derived from the ontological and epistemological positioning of the study.

Consistent with the overarching aim of this thesis, a qualitative methodology is deemed the most suitable approach. This is because it allows an evaluation of the different contexts and the complex nature of the social world (Arksey and Knight, 1999). The approach taken in this thesis recognises the subjective experiences of participants as well as the important role of language for connecting knowledge, experience and meaning production.

Whilst quantitative methodology does not provide sufficient access '*to accounts of experiences, nuances of meanings, the nature of social relationships, and their shifts and contradictions*' (Ramazanoglu and Holland 2002, p.155), a qualitative methodology allows and facilitates inquiry into how a phenomenon is understood through the construction of the meanings that people assign to it (Denzin and

Lincoln, 2000). It recognises the mutual role of study participants and researchers in knowledge production. A qualitative methodology also allows for illuminating the individual experience of participants in their reflection on their experiences and construction of self. This also provides the space for study participants to express their thoughts and experiences in a way that produces detailed accounts and rich data.

Overall, a qualitative methodology is thus appropriate for research such as the study under discussion since it permits the examination of the processes by which things come into being or are constructed (Holstein and Gubrium, 1997; 2005). Moreover, a qualitative methodology can facilitate the sharing of experiences by marginalised populations in the process of knowledge production and thus helps in unsettling what is 'taken for granted' (Mies, 1983; Morris, 1993), as a form of social and micro-political action (Mills 1959 cited in Holstein and Gubrium 2005, p.491). Overall, this methodology allows the exploration of how power is exercised and how *'identities, subjects and subjectivities are continuously produced, accepted, resisted, modified and fragmented'* (Holstein and Gubrium 2005, p.498).

In order to follow this form of research enquiry a qualitative methodology utilises a range of research methods, appropriate to the theoretical approach and these are discussed in full length in the next section. However, prior to moving on to the discussion on methods, it is important to address the main points of criticism directed toward a qualitative methodological approach in order to make clearer the methodological choices that this study makes.

Qualitative methodological approaches have been criticised for its lengthy process of data collection and analysis; the substantial influence of the researcher on the study overall; the impact of the sample on the meanings produced and the consequent overall difficulty in making comparisons to or generalising from the

research findings onto larger populations (Burns, 2000). When taken from an objectivist perspective qualitative methodological approaches have also been criticised for their limited validity, limited reliability and the difficulty of replicating studies (contexts, situations, events, conditions, interactions). Whilst recognising this criticism, it is important to note that these points are made from traditional positivist and objective criteria and are thus considered inappropriate for evaluating the strengths and weaknesses of poststructural oriented studies (Saukko, 2005).

The study utilises the suggestion that it is of value to incorporate alternative criteria so as to evaluate poststructural oriented studies by utilising a qualitative methodology and incorporating a reflexive account (see section 4.7) into its qualitative design (e.g. Lather, 1993). Taking a critically reflexive approach (e.g. Alvesson and Sköldbberg, 2009) means that the researcher has the opportunity to provide an account on the process of generating data, analysing it and relating to the studied phenomena overall. Providing a reflexive account is likely to support and enhance the data collection and analysis and gives the study more validity while at the same time making clearer the boundaries of the examination. Utilising the benefits of a reflexive account also addresses the critique that qualitative design tends to be ambiguous (Denzin and Lincoln, 2005) (when compared with structured quantitative approach (Holstein and Gurbrium, 2005)). This is because a reflexive account provides information on the research process and the way in which it was conducted.

This thesis also incorporates the criticism that, due to the ambiguous nature of a qualitative approach, the ability to generalise is restricted (Burns, 2000). As such, rather than aiming to make general claims which could then be replicated in other studies, the study aims to provide an in-depth, qualitative exploration which illuminates a multilayered set of meanings. This point is also reflected through the discourse approach and theorising of identity which aims to explore multiplicities of ways by which individuals construct a notion of self and understand their lives.

Following the discussion on the ontology, epistemology and methodology of this thesis, the discussion below proceeds with an examination of the choice of methods which complements its qualitative design.

4.3. Methods

While a qualitative enquiry can be understood as facilitating the study's design, its methods are the tools by which the study is carried out. Overall, qualitative inquiry tends to be accomplished using methods that utilise the medium of questioning, observing and gathering written materials which are relevant for the topic studied (Dingwall, 1997). Qualitative studies which have adopted a discursive approach tend to make use of forms of documentation, interviews, ethnography and observation. Specifically, face-to-face methods, which provide the opportunity to observe or ask questions, and the use of textual materials (such as policy, legislation and organisational documents), complement well the discourse approach (Alvesson et al., 2008).

For this reason, the study predominantly employs the medium of semi-structured face-to-face interviews as an effective vehicle for exploring how things come into being within the individuals' life experiences (Cicourel, 1964; Kvale, 1996; Fontana and Frey, 2005). The study takes a particular stance for interviews, which accommodates the sensitive topic examined. It employs a narrative style of interviews which examines how life narratives 'speak for themselves' in terms of the way in which they reflect social, cultural and historical conditions in a multilayered way (e.g. Wittner and McCall, 1990; Anderson and Jack, 1991). This approach puts an emphasis on the importance of asking broad questions to encourage the interviewee to draw on the elements of the 'story' which they find important (e.g. Sacks, 1989; Chase, 1995). This style of interviews can be comprised of one or more interviews per individuals which are then used as case studies (Riessman, 1993).

This type of exploration allows the identification of a number of subject positions within each narrative (Bloom and Munro, 1995) whilst examining how, at the same time as individuals are constrained within certain discourses, their stories are not fully determined by them (Chase, 2005). This style of interview draws attention to the way in which salient discourses influence the person's account of their selves and also the extent to which they experience struggle or conflict or congruence with the subject positions and discourses vying for their attention. At the same time, however, this style of interviewing also provides an opportunity to bring to life the individual meanings that people draw on and how they construct a notion of self through their own individual interpretation of discursive meanings. This approach thus serves the study's aims in terms of studying how issues of struggle (Grima, 1991), unsettledness and ongoing identity construction (Josselson, 1996; Stein, 1997) take place over a number of contexts (such as illness (Langellier, 2001) and identities (Foley and Faircloth, 2003)). It is also considered appropriate for exploring how, through intensive examination of explicit life feature, the processes by which things come into being become visible (Riessman, 1993).

Although interviews can be approached from different epistemological perspectives (Cassell, 2005), the narrative style of interviews bears a number of benefits which serves the study's aims and theoretical framework. First, it accommodates the sensitive topic of investigation. It is considered an empathetic approach that takes into consideration the interests of the population studied. Second, the approach makes it possible to collect individual stories as they accrue through the interview situation with minimal disturbances (e.g. Mishler, 1986). Third, the interview setting is deemed ideal for capturing personal narratives because it allows narratives to arise naturally (Bauman, 1986; Briggs, 1986; 2002; Chase, 2005) whilst the semi-structured features of interviewing in relation to certain themes facilitate the making of comparisons and identifying contrasts (May, 2001). Fourth, this serves well the aim of exploring the experiences of an understudied population and for making practical suggestions that would better the lives of those being studied (Fontana and Frey, 2005).

A narrative approach to semi-structured interviews is evident in traditional studies on mental health at work (e.g. Simmons, 1965) and more contemporary studies taking an occupational health approach to studying mental health in the workplace (Kirsh, 2000; Tse and Yeats, 2002; Henry and Lucca, 2004). Likewise, this approach has also been adopted widely in studies on work identities, and is considered useful for generating reflexive accounts of the way interviewees construct their identities (e.g. Thomas and Linstead, 2002; Sveningsson and Alvesson, 2003). These studies emphasised how the interview setting can be understood as a 'trigger' for reflexive thinking over questions of self. Thus, the interview itself is a setting for identity construction in as much as it is a method for gathering information from beyond the interview encounter (Alvesson, 2003).

This focus on the reflexive nature of interviews and the active role of interviewees in the generation of knowledge (Mason, 2002a; 2002b) thus triggers the process of thinking, acting or reflecting upon discourses, subject positions (Thomas and Linstead, 2002) and the boundaries of existing social and historical positioning and power dynamics (Hardy and Clegg, 1997). This, then, also allows for the examination of the deeper meanings of interviewees' experiences and thoughts (Miller and Glassner, 1997), whilst maintaining the apparent advantages of ease and efficiency of asking questions about self-understanding (Alvesson et al., 2008).

The approach recognises the active part of both the researched and the researcher in the process of knowledge production (Kvale, 1996). This enables us to consider how both the interviewer and the interviewee bring their own subjective knowledge through a dialogical interaction in the interview setting (Gubrium and Holstein, 2001) and this thus recognises the role of the researcher in the production of meanings (Van Maanen, 1988; Arksey and Knight, 1999) (see section 4.7 for details).

The narrative approach that this study takes is complemented by a set of repeat interviews. A sequence of repeat interviews with individuals with MHCs in employment was chosen as an appropriate method for studying identities for a number of reasons. On a theoretical level, repeat interviews can serve as a useful way to gain insight and rich data over a certain period of time instead of a 'one off' interview interaction. Second, conducting a set of repeat interviews means that the interviews are viewed and analysed as a case in their own right. This then allows for identifying a multiplicity of subject positioning within each case of repeat interviews as well as the possibility to compare, contrast and identify patterns throughout the data set (Chase, 2005).

Third, this approach allows for building a trustworthy relationship with the researched which consequently encourages openness and a greater ease in discussing what might be personal and sensitive concerns. Fourth, it might allow for fewer interruptions resulted from the interview situation such as impression management or providing a 'satisfying' answer (Alvesson, 2003). It also allows for the interviewees to become more familiar with the reflection being done during the interview process which will in turn allow revisiting comments made in the first interview and delving deeper into the process of producing identity meanings, with minimum constraints resulting from the interview situation.

Fifth, the long term relationship with the interviewees also allows for establishing a sense of commitment from both the researcher and the researched. This in turn could help to ameliorate some of the potential power asymmetries between the researcher and the researched during the process of the interview because the interviewees become more engaged and involved in the study. Sixth, the repeat interviews also allow a better insight into the pattern of circumstances for the interviewees. This is because of the unpredictable nature of MHCs in which a long term view into the experiences of the interviewees is deemed essential. This approach thus serves the study's aim to produce robust materials for theorising identities within this understudied area. Although there are benefits to conducting

repeat interviews, it was necessary also to conduct some additional one-off interview with certain individuals in order to gain greater institutional and contextual information on employing organisations' approaches and attitudes towards MHCs. More details on the interviews are provided elsewhere in this chapter (in sections 4.4, 4.5, 4.7).

Another possible alternative method may have been one that is related to ethnographic work such as participant observations (Atkinson and Hammersley, 1994) given its benefit of gaining access to behaviours and talk as they accrue (Boden, 1994; Barley and Kunda, 2001; Alvesson et al., 2008). However, this method was not deemed ideal given the sensitive nature of this study. For example, it would have been inappropriate to 'sit' in peer-to-peer mental health support groups because access to these meetings are limited to facilitators and people with MHCs and their families. Likewise, accompanying individuals in their daily routine would also be problematic, incurring a number of ethical dilemmas. Nor would it have addressed the purpose of the study because many of the identity issues being examined refer to certain situations which could have been missed during the course of ethnographic observation.

However, whilst conducting interviews is deemed appropriate for this study and although it is a popular method for studying identities, as is evident from its use in many identity studies (Jackall, 1988; Parker, 2000; Thomas and Linstead, 2002), the nature of the interview as a way of accessing 'accountable identity materials' can be criticised for a number of reasons. On a prosaic and practical level, the process of conducting semi-structured interviews, including transcribing, sorting and analysing the large amount of data generated, can be time-consuming (Bryman, 1989; King, 1994). On a theoretical level, the question of whether or not an interview reflects reality (e.g. Blaikie, 2000; Howarth, 2000; Fielding and Thomas, 2001) and provides insight beyond the interview is questionable (Silverman, 1993; Mason, 2002b) because the interview setting may produce a number of attributions that are not always experienced in daily routine (e.g.

performative aspect, providing a 'satisfying' or rehashed answer; or the process of reflection which is not always available in day to day life (Alvesson, 2003)). In addition, the authoritative role of the researcher in the production and the presentation of meanings (Alvesson, 2003) as well as their skills and ways of 'reading' the interview texts, will inevitably impact upon the process of generating empirical materials (Arksey and Knight, 1999; Legard, Keegan and Ward, 2003).

However, as the purpose and aims of this study is to explore how individuals with MHCs construct an identity at work rather than making general statements, the above is not considered a concern. In a similar vein, the criticism directed towards the role of the researcher within the process of generating data is not considered a limitation but is rather incorporated into the methodological approach adopted (see section 4.7). Thus overall, interviews are deemed the most appropriate method for data generation in this study because they provide an effective setting to discuss sensitive and personal topics openly. They serve well the subject of inquiry, whilst allowing the space for participants to draw on the experiences and the reflections which are most important to them. Additionally, the ease with which interviews can be conducted is also considered a benefit due to their quality of portability and flexibility and because it allows for the evaluation of a wide range of views and for generating rich data (Alvesson et al., 2008). Furthermore, as will be seen in the discussion below, interviews as a method are in alignment with the overall ethical considerations accompanying the study design and the sensitive topic being investigated.

4.4. Ethics

The sensitive nature of studying human beings directly draws the attention to the ethical side of which any methodological enquiry of social research is comprised (Benton and Craib, 2001). These are related to the entire research enquiry from the emergence of the research plan and throughout the research process

(Zikmund, 1997; Ghauri and Grønhaug, 2002; Saunders, Lewis and Thornhill, 2003). Ethical considerations frame the research design and reflect on choices related to methodology and method, negotiating access, data collection and analysis, as well as writing up and presenting the findings.

The responsibility of the researcher to collect data accurately and to deal with the empirical materials confidentially and anonymously from the stage of data generation all the way through to the analysis and presentation of the findings is regarded as a primary consideration for ethics in social research (Ghauri and Grønhaug, 2002). Another predominant consideration in that sense relates to the relationship between the researched and the researcher. Ethical considerations concerning this relationship include informing the research participants about the nature of the research they are involved in and obtaining consent for participation in the study. The voluntary agreement of the research participants to take part in the study also bears within it the researcher's accountability to conduct a study that will not harm the participants in any way (Saunders et al., 2003). Likewise, study participants are also expected to be aware of the duration, methods, possible risks and the purpose or aim of the study (Soble, 1978; Veatch, 1996).

At the same time this study's sensitive topic and methodological approach also necessitate a certain ethical approach to research. Other studies on sensitive issues consider an ethical stance which is relevant within the frame of this study. These studies consider the importance of trust within the researcher-researched relationship. Whereas one significant issue between the relationship between the researcher and the researched relates to informed consent, this issue is intensified in studies on sensitive topics. The way in which the researcher presents the aims of the study and the method employed to potential study participants is important. But, at the same time this also raises a dilemma for the researcher in that they must consider what effect a detailed description of what the study is going to do will have on the process of data generation. Likewise, the institutional pressure to analyse and present findings in accordance to a specific genre can lead to a

manipulation of the findings generated and to the potential misuse of the trust that participants have in the researcher (Finch, 1984; Cotterill, 1992). These concerns illuminate the ethical dilemma as to whether or not social studies can be ethically valid when utilising inadequate informed consent (Kelly, 1988).

Another ethical issue for researchers studying sensitive matters requires them to consider the political interest of their study and ways to avoid any possible harm. This then raises the question of the interest of the participants and accountability of the researcher for generating and presenting knowledge claims which could harm the vulnerable position of study participants (Stacey, 1991) in that it may reveal an account of their personal experiences (Ramazanoglu and Holland, 2002).

In addition to that, the positioning of the researcher within the research and the study's relationship to both the participants and the researcher trigger a number of ethical issues. Studies on sensitive topics highlight how important it is for the researcher to make visible their own positioning and identity to the participants (e.g. Dunne, 1997). Although the visibility of the researcher's positioning makes the research process more transparent, it also raises other ethical issues. What the researcher aims to explore may differ from what the subjects of the research find important within their own experiences. This then draws attention to the dominating position of the researcher over the research process. Fine and Weis (1996) highlight this point:

we are still a couple of White women, a well-paid Thelma and Louise with laptops, out to see the world through poor and working-class eyes... we write through our one race and class blinders, and we try to deconstruct them in our multiracial and multiethnic coalitions (p.270-1).

In attempting to ameliorate the ethical challenges faced in the course of this thesis, a number of steps were taken. The research went through rigorous ethical

committee approval at Cardiff Business School⁷. All the participants were made fully aware of the research concerns and gave their consent to participate in the study (Saunders et al., 2003). A detailed research outline (Appendix 1) was presented during the process of negotiating access, and the participants were informed that during the interviews they could refuse to answer any questions or stop the interview at any time. The data collected was dealt with carefully, providing anonymity and confidentiality throughout the process of transcribing, coding, saving, analysing and presenting the empirical materials. All personal identification or other details that could have violated the anonymity of the participants have been removed (Ghauri and Grønhaug, 2002).

The choice of method also has its ethical bearings. Not only were semi-structured interviews considered suitable as a method given their ethical advantage of sharing personal and sensitive information with one individual only (unlike other methods such as focus groups which require sharing information with wider audience), but the repeat interviews were also useful for establishing trust. Given the sensitive topic examined, this was extremely important for 'opening up' during the interviews. Furthermore, the wide and open narrative style interview questions have an ethical bearing because the interviewees could speak about what was important to them without being asked direct questions that would make them feel uncomfortable (Churchill, 1999).

In addition to that the fact that the interviews were conducted in a safe environment (interviewees' home or workplace, university premises or the premises of a mental health charity), provided comfort and reassurance that the questions and analysis relating to the subject being studied was taking place in an appropriate location. The non-judgmental nature by which the interviews were conducted also allowed for maximising the comfort required for reflections on sensitive and personal issues. This was conveyed in a number of ways by utilising both verbal and non-verbal signals such as the use of non-jargonised language

⁷ A copy of the approved ethics form is attached to the appendixes (Appendix 5)

(Ghauri and Grønhaug, 2002); casual clothing; nodding; active listening in a way that illustrates full engagement; asking probing questions and encouraging the interviewee to continue drawing on their thoughts and experiences and complimenting them for dealing with challenging life experiences. Furthermore, in terms of the topic being examined, the purpose of the research was to examine identities in the context of mental health and employment and to illuminate the experiences of an understudied population in organisational studies. This aim coincides with the micro-political struggle of the study participants and with their interest in making their experiences visible.

However, as *'decisions on how to control the complex situation of the research relationship through best ethical practice may be naive'* (Ramazanoglu and Holland 2002, p.157-158), and as some ethical considerations are complex and cannot be 'neutralised', a reflexive account (section 4.7) is essential to allow for the further transparency and accountability of the research. Further ethical concerns arising from other areas of the research are also examined in the discussion below, as the different elements of the research process are presented.

4.5. The research process

The primary method for data generation was through 60 interviews. This included 8 pilot interviews with individuals with MHCs, 4 of whom were working and 4 who were not. Additionally, 32 repeat interviews were conducted with 16 working individuals who all had MHCs; each person was interviewed twice. The sample also include 13 individual interviews with health professionals and managers (comprising 3 interviews with occupational health professionals, 3 interviews with HR managers, 7 interviews with line managers and senior partners). Finally, 7 interviews with charity workers and support group organisers (comprising 4 interviews with mental health charity workers and 3 interviews with those organising mental health support groups who had a MHC) were conducted.

All interviewees were provided with the following information: the study aims; the funding body and authorised institution and the approximate length of interview. Interviewees were told that they could stop the interview at any time or refuse to answer questions. All the interviewees were briefed as for the ethical concerns taken throughout the research. All were promised confidentiality and anonymity and reassured that the study follows the ESRC and Cardiff University ethical guidelines. In addition, I informed the interviewees about my previous role as an employment specialist serving those with health conditions and disabilities, thus reassuring the study participants of my professional experience in a similar setting.

The recruitment of study participants took place over a number of stages. Initially, first contact was made with Mind⁸ and, following a meeting with the regional manager, the study was given the support of the local Mind branch and regional office in providing materials and training, committing to meet me during the course of the study, allocating a venue to conduct the interviews and distributing information about the research throughout the organisation and to other mental health organisations.

Additionally, I contacted and met with a number of organisers of peer-to-peer support groups who, apart from distributing the research outline (Appendix 1) via email, also allowed me to introduce the study at the beginning of one of their meetings, to distribute the research outline handouts and to take the details of anyone who was interested in participating in the study. Individuals with MHCs who were interested in participating in the research and were either working or had an employment history were interviewed for the pilot.

⁸ Mind Organisation is a leading mental health charity for England and Wales. The organisation promotes campaigns to create a society where people with experience of mental distress are treated fairly, positively and with respect (<http://www.mind.org.uk/about>)

Following the pilot and the analysis of the data, a decision to conduct repeat interviews with working individuals with MHCs took place and those from that group who consented to participate in the study were asked in advance if they would agree to be interviewed twice within an eighteen month period during May 2009 to November 2012. Apart from gaining access to interview employees with MHCs, I conducted a number of interviews with charity workers and support group organisers in order to gain the institutional perspective on what this study examines. In addition I negotiated access enabling me to interview a number of line managers, Human Resource (HR) personnel and Occupational Health (OH) specialists. This part of the research process took place after I had already conducted a substantial number of the interviews with employees who had a MHC. The purpose of these secondary interviews was to examine the organisational perspective with regard the studied topic.

The overall sample of participants in the study was heterogeneous in terms of age, gender, race, as well as in occupational, professional, seniority, and hierarchical mix. All the participants had some professional qualification and occupational backgrounds (from both private and public sector organisations) in the following areas: administration, cleaning, higher education, gardening, the arts, retailing, pharmaceutical, marketing, insurance, care, engineering, IT, sales, hospitality and business, accounting, architecture, charities and education. Participants with MHCs had persistent and ongoing MHCs including bi-polar, depression, OCD and schizophrenia (see Appendix 2 for further details).

The sample was considered to be suitable for a number of reasons. Firstly, the heterogeneity of the sample helped in gaining a wider perspective of the way in which mental health and illness in the workplace is manifested for individuals from a wide range of backgrounds. The size and heterogeneity serves the purpose of the study both in terms of generating theory on identity and in terms of engaging with the struggle of an under-represented population in organisational studies.

Additionally, conducting supplementing individual interviews was also useful for gaining broader insight from the institutional perspective.

It might also be worth noting that recruiting individuals who use the services of mental health organisations may imply that participants' MHCs are an active part of their identity, compared to individuals who do not use that service. Additionally, the willingness to participate in the study also suggests that these individuals were comfortable to talk about their experiences and possibly felt that they had 'something to say' and were keen to reflect on their personal experiences. The involvement of the interviewees with their MHCs suggests that the findings may be more applicable for those with MHCs who are more actively engaged with their MHCs than for those who are not. At the same time, however, the involvement of the interviewees with the issues concerning their mental health experiences serves the aims of the study to explore identity in relation to MHCs and these issues are addressed in the proceeding sections (4.7, 9.2).

All interviews began with a quick introduction (names, background, research funding bodies, and the broad aim of the study to examine the notion of mental health and illness in the workplace). This was followed by a 'broad' question about the experiences of the interviewees in relation to mental health and employment. The broad interview themes enabled the interviewees to draw on whichever aspect they believed was important without being asked direct questions or being interrupted. This contributed for the production of rich data and for accommodating the reflections of the interviewees and gaining knowledge of their employment experiences. At the same time the informality, ease, comfort and flow which took place during the interviews (Legard et al., 2003) and the space to speak about whatever it is that the interviewees found significant in their own experiences is particularly important given the sensitive nature of the topic being studied.

This sense of 'flow' meant that each interview was different and that issues were addressed in different orders and were based on the points raised by the interviewees. The interview themes were thus only used as a guide or a 'reminder' to address the main area of interest that had not been covered in the initial discussion. These themes were refined and reflected upon on a number of occasions. As some of the analysis of the data took place during the time between the pilot and the repeat interviews, it was possible to reflect on, revisit and amend (Arksey and Knight, 1999) them.

The use of probing questions encouraged the participants to elaborate on a particular point or to ensure that the topic was well covered (Rapley, 2001). In addition, probing questions proved useful for addressing the discourse approach and theoretical aims of the study to understand how things come into being through the reflections and the experiences of the participants. Most of the interviews took place in offices provided by Mind and in interviewees' workplaces, in various locations across the UK. This flexibility of the location and time of interviews allowed greater ease for the interviewees throughout the interview process.

Semi-structured interviews, which lasted approximately one hour (between 50-75 minutes) per interview, were conducted and recorded by the researcher, following the consent of the participants. Whilst recording the interviews enabled me to focus on eye contact, nodding, and the interaction during the interviews (Bryman, 2004), transcribing the recorded interviews was useful for the process of coding, reflecting on and analysing the data. Additionally, having the detailed account of each interview and the wording of the interviewees (Legard et al., 2003) provided an opportunity to reflect on the data during the analysis and presentation of the findings and to identify preliminary themes. Having the detailed account of each interview was also useful for the presentation of the empirical materials in a transparent way which allows the reader to make their own interpretations of the findings.

Apart from conducting interviews, the research also included collecting documents which supplemented the interview materials and provided information on the wider context of the way in which mental health is viewed in policy documents, legislation and other documents. These documents were collected between 2010-2013 from a number of sources including: news articles, mental health websites (charities and peer-to-peer support groups), the NHS website, mental health policy documents of local councils, the Unison website, the Welsh Government website, reviews and legislation documents (Marmot Review, Disability Discrimination Act, Equality Act, Unison site, and documents that were given to me by a number of organisations which participated in the study). All these documents were categorised, saved and filed according to date, subject and source.

Furthermore, I was also invited to participate in a two-day 'mental health first aid' training event, delivered by Mind, and to come along to the launch of the regional anti-stigma campaign Time to Change. Taking part in these two events (During February, 2012) was useful for engagement with practitioners, networking and for gaining access to materials. This participation was influential in the research process as a way of gaining information that would help in contextualising the study and locating it within the broader 'picture' of mental health campaigning.

The documents and supplementary materials collected were useful throughout the entire process of data generation and analysis. As the documents included consideration of how mental health is captured in policies, legislations, advocacy work and in the media, they provided direction for the construction of the broad interview themes as well as for the analysis of the data in relation to wider contexts (e.g. legislation, related policy, social movements and actions of advocates). Building on that latter point, the discussion below proceeds by dealing with the way in which the empirical materials were analysed.

4.6. Analysing the data

The aim of the research suggests a discursive and context related approach for analysing the data (McKee, 2003). Overall, this process took place whilst being mindful of the main aim of the study and the attempt to identify subject positions and discursive resources. As explained in details in section 4.1, the analysis of the empirical materials is consistent with the study's aim and theoretical framework and took place in a number of discourse analysis stages.

As such the process of conducting and transcribing the interviews was followed by general identification of recurrent themes in a number of phases (Potter, 2004; Coffee and Atkinson, 1996). After transcribing the pilot interviews, I began coding the transcripts. The repetitive pattern emerging from the analysis of the pilot mainly concerned three issues. The first one related to the importance of work for a positive sense of self. The second one highlighted the struggle in the workplace resulting from experiences of stigma and discrimination and the third one related to the struggle which resulted from the nature of the illness and the difficulty of gaining support at work. Following the analysis of the pilot, and in light of the study aims, it was important to examine further how individuals with MHCs cope with employment and how the discourse of mental health and illness in the workplace is being conceptualised through the participants' reflections and experiences. These concerns were then addressed in the proceeding interviews and the analysis of transcripts.

Subsequently to the analysis of the pilot and prior to analysing the entire data set, I examined a sample of individual and repeated interviews in order to try and identify recurrent themes which could have then been examined across the data set. Following the examination of each set of narrative style repeat interviews, the identification of themes took place across the examined sample whilst listing all recurrent themes related to the main research concerns which were visible

through the analysis (Appendix 3). This list was then utilised for the process of 'readings' of the entire interview texts and the identification of themes across the dataset. This process was accompanied by revisiting the list until achieving a comprehensive set of themes across the entire data.

This process was followed by placing the main themes into separate files and identifying patterns in the data through a repetitive process of reading and coding. The reiterative process of reading the coded material helped for identifying sub-themes and the nuances of patterns in the interviews as well as for the identification of the discursive resources that the interviewees drew upon (Marshall, 1994). This allowed for identifying subtleties and patterns within each theme and in accordance with individuals' subject positions. Whilst the themes are presented 'stands alone', they are inter-related and were developed in relation to one another. The next stage of analysing the data was identifying vignettes that can best represent each one of the themes emerging from the analysis. This study utilised the medium of manual analyses as opposed to conducting the analysis with the aid of computerised methods.

While using Computer-Assisted Qualitative Data Analysis Software (CAQDAS) has a number of benefits, such as a flexible coding system and an option for analysing data in many ways and formats (Rath, 2011), there are a number of reasons for not utilising computerised software for the analysis. CAQDAS training in NVivo 8 and ATLAS.ti was undertaken during the course of the PhD research. However, there emerged a significant difficulty in creating easy to read output files as those produced proved time-consuming to use (Rath, 2011) and introduced the risk of deviating from the study aims because of the system's independent hierarchical ordering of the data (Atherton and Elsomore, 2007). These difficulties led me to conduct manual analysis using Microsoft Word.

Finally the aim of the analysis to generate context bound meanings was another reason for using manual analysis because there was no option to conduct such analysis with CAQDAS and the programme's features (e.g. as mapping key words) did not meet the purpose of the study and its epistemological underpinnings. The final discussion in this chapter, to which we now turn, provides a reflexive account of the methodological discussion presented so far and, by so doing, it gives another layer of transparency to the way in which this research was conducted.

4.7. Reflexive account and extracts from a research diary

Extract from a research diary:

If you'd have asked me what is my personal relation to people who have an ongoing MHC then I'd say that between my family and a very few close friends I can report on, without thinking too hard, the following conditions: paranoid-schizophrenia, severe depression, OCD, post-traumatic-stress-disorder, and bi-polar. I feel reluctant to provide further details on my relationship to the individuals who suffer from these conditions because I wish to maintain their anonymity. After all, I didn't ask for their consent to be part of this study. At the same time, however, I will note that their struggle with their MHC has been significant in my life and for my own identity. Mental health is an issue which is also significant within my professional identity, my previous occupation and academic qualifications.

In my previous role as an employment specialist for individuals with health conditions and disabilities, who were either looking for employment or needing support whilst in the workplace, I became aware of the notable struggle involved in having a MHC. The struggle experienced by those who have had MHCs motivated me to further explore these issues in this research. What struck me most, however, on both personal and professional levels, is that individuals with MHCs tend to suffer in silence. Only their nearest and dearest would be able to see, feel and hear their pain. Not only do they cope with a severe and enduring condition with many possible debilitating symptoms, but their struggle is not widely recognised in society.

This thesis brought all my links to mental health to my forefront, making me work my identity in this context in an intensified manner. The late diagnosis [as experienced by many of those who receive a diagnosis of a MHC], the rapid worsening of the condition and the impact this has had on the lives of these individuals, for those who are alive. Clearly all these experiences are mine and this then just makes me wonder: well, what about your experiences in that relation? If you look close enough at your own environment, what will you be able to find? If the statistics show that one in four people will experience a mental health episode during their life, then each and every one of us must have come across mental health suffering within their immediate environment, which makes me wonder. Mental health suffering is all around us but is ever so silent.

Undoubtedly this silence only reinforces the vicious cycle of reduced recognition, misunderstandings and delayed treatments. This also has a number of moral implications. By allowing the silent suffering of those experiencing mental health issues to continue, we are all becoming partially responsible. This makes us all 'guilty' for not being able to offer more help and support to the ones we care for most, people in our environment, or even for ourselves. If we continue 'not knowing', 'not sharing' and 'hiding', we will eventually end up with more pain or even 'no way back situations'... This all can be preventable, however if we only allow for breaking this detrimental cycle of silence. **[Dairy Note 26 April 2013]**

'Researcher confession' (Van Maanen, 1988), reflexive writing, reflexive methodology and epistemology, disciplinary reflexivity, and inter-reflexivity (Johnson and Duberley, 2003; Cunliffe, 2003); reflexivity in qualitative approach is deemed a significant aspect of social research and one that can shape its outcomes (Hardy, Phillips and Clegg, 2001). Whilst reflexivity in qualitative research can be understood as criteria for the validity and the accountability of a study, it is also considered an integral process of conducting a study (Meriläinen et al., 2004) and a creative (Pacanowsky, 1995; Rhodes, 2001), responsible (Rhodes and Brown, 2005), and ethical practice in social research (Guillemin and Gillam, 2004). This then suggests that there could be a number of levels to reflexivity and a number of ways into a reflexive account (Hardy et al., 2001).

Disciplinary reflexivity can be provided through an account that explains how the theoretical framework serves the purpose and aims of the study and what are the

limitations and constraints embedded within it. Likewise, epistemological reflexivity focuses on aspects related to the process of knowledge production whilst methodological reflexivity may provide an insight into the dynamics related to the research process and choice of method and its relation to ethical concerns and the research aims (Johnson and Duberley, 2003) (Chapter 9 provides a detailed reflexive description on the reflexive stance adopted in relation to these three levels).

One significant issue for this study relates to the epistemological level of reflexivity, which is often being related to the level of power relations within the 'process' of data production (Thomas et al., 2009). In the account presented at the beginning of this section I draw on my own positioning as a 'product' of study. Hence, how did my own history, background and relation to the studied topic impacts the entire research process?

My own positioning within the study not only provides information about my motivations and identities. From the epistemic point of view, the reflexive account of the author may also challenge the power relations between the researcher and the study participants. This illustrates how, as the researcher, I am not attempting to maintain a neutral position (Brady, 2000; Fine et al., 2000), nor do I ask other people to reveal their own personal experiences without revealing my own relation to the subject of study (Behar, 1993). Additionally, my reflexive account touches the inter-subjective reflection (Cunliffe, 2003; 2008) of my relationship with the interviewees:

The commitment of the research participants to the study enthuse me... This commitment makes me, as the researcher, feel less isolated in regards to the entire study... the idea that there is a fairly large amount of people who are committed to the study... informants who are engaged, and who believe in the importance of the study and its contribution. Ones who wants their voices to be heard, ones who are happy to do the extra. **[Field Note 4 Nov 2011]**

My own understanding of the contribution of the participants to the study illustrates how the dominance of the researcher within the dynamic of the researcher-researched relationship is being slightly destabilised. Not only did the commitment of the study participants make me view them as active partners within this project but also my view of their self-expertise, from which I learned, illustrates how it was ‘shaking’ that power dynamic between the researched and the researcher and how this was manifested throughout this work:

I find this process of talking with the interviewees to be very empowering. This is particularly the case during the PhD process. Although I never suffered from a prolonged MHC, the occasional anxiety crawl does get me from time to time. I found talking to the interviewees helpful for managing my own stressful work circumstances because they have all the tools, techniques and self-expertise which were required for good mental health self-management... I felt empowered by the interviewees and little by little tried to implement their techniques [mental health self-management techniques] into my own ‘mental diet’. When things get too overwhelming, I looked at the way in which the participants deal with their own self-management and tried to apply some of their techniques to stressful or worrying situations. **[Field Note 22 Nov 2011]**

The interviewees’ engagement with and commitment to the study, their willingness to talk about a topic which is not widely legitimised or openly talked about, and my endorsement of their self-expertise in mental health management, made me think of them as active and partners within this research process. Shaking the researcher-researched power dynamics is also manifested through choice of the word ‘informants’ for describing the participants in the study. The term *informants* is used in my field notes diary in a positive way and seems natural to me in serving the purpose of illuminating the understudied experiences of the study participants by recognising their willingness to be open and honest about a subject that is not widely discussed.

Whilst the popular definition of the word ‘informant’ is: *‘providing information about a thing’* (Collins English Dictionary, 1991), *an informant is also defined as: ‘a person who provides privileged information about a person or organisation to an agency’* (Wikipedia, 2013). This use of the word therefore illustrates how the interviewees here are understood as ‘more’ than study participants *per se*; they are committed and willing, devoted and brave. They share their experiences of dealing with a stigmatised and not talked about condition at work. By drawing on the interviewees as experts; as courageous, heroic and committed individuals who are willing to make an impact, to open up ‘a Pandora’s box’, to be engaged and to have voice, my use of the word informants addresses my recognition of the active and significant role of the interviewees in the process of producing meanings in this study (Ramazanoglu and Holland, 2002).

This transparent account on my relation to the interviewees and my reflection on the sample (Johnson and Duberley, 2003; Cunliffe, 2003) may have made clearer some of the issues linked to the research process and how the traditional power relation between the researched and the researcher was challenged (e.g. Rhodes, 2001; Thomas et al., 2009). However, as Rhodes and Brown (2005) argued: *‘to author research texts is to embrace multiple sets of responsibilities to varied constituencies. In part, it implies being ‘true’ to ourselves in the sense of writing texts in which we have confidence’* (p.484). The reflexive account of the author thus illustrates my empathy towards the topic being studied (Humphreys, Brown and Hatch, 2003) and during the process of conducting the interviews. Accounting for the process by which the study has been conducted provides a flavour of my research encounters with the research participants and enables access to some of the anecdotes during the process which comprises this research. The diary notes throw light on the emotional experiences which were shared between the interviewees and myself:

Taking into account the possibility that interviewees could get emotional during the interview process, I ensured that interview questions were not direct or intrusive and that the predominant focus on the workplace was

being maintained throughout the interview. I never pushed the interviewees to say more than they wanted, and relied on all signals, both verbal and non-verbal to reassure that general comfort and ease is maintained throughout the interview. At the same time, however, bearing in mind the sensitive nature of this study, I could not be naive to think that none of the interviewees would get upset. In fact I was happily surprised that most of the interviewees did not get sad or excessively emotional. Some of the interviewees even commented how they found the interview process therapeutic. Still, one of the interviewees became upset and started crying... I was trying to make us feel comfortable within that uncomfortable moment and pain. I didn't change my position or facial expression. We had a quiet moment. I suggested another cuppa and some tissues. I asked if he was OK to continue or wanted to stop. He said that he was fine. By then we had covered most of the interview themes and we continued for a bit longer before we went our separate ways. It was a sunny Friday afternoon. It took me a while to fully acknowledge what had happened. An experience I will never forget. **[Diary Note 27 June 2013]**

These moments of pain, struggle, frustration, humour and fortitude that sum up the day-to-day lives of the participants reflect on the inter-subjective dimensions within the researched-researcher relationship (Cunliffe, 2003; 2008). Thus overall the reflexive account provides some more insight into the research process, how the interviews were conducted and my relations with the interviewees. However, this account also reflects on other perspectives within the data collection stage. For instance, this process reveals issues related to the expansion of the line of enquiry. Whilst initially the study aimed to look at matters of MHCs at work, hence focusing on severe and enduring conditions, the reflexivity during the process of data collection and in analysing the interviews illustrates the process of re-shaping the boundaries of the studied topic:

Drawing on the organisational perspective in relation to stigma, it is noticeable that both stress and MHCs are regarded as being stigmatised... widening the discussion into dealing with stress and the way in which stress is being understood in organisation. How do I locate this [stress at work] within the discourse of mental health and illness? And what does it have to contribute to the discussion in that sense? **[Field Note 16 Oct 2011]**

This reflective process during the stage of data collection and analysis impacted upon the strategic decisions to expand the line of enquiry from dealing with MHCs *per se* into examining more common concerns related to mental health in the workplace. Another issue which was reflected upon during this process relates to the way in which both the empirical data and the theoretical framework incorporated into the research process (Alasuutari 1995, p.175):

It was good to hear that an HR manager in such a high pace firm is throwing into the air ideas around self-regulation and self-management which are indeed very similar to the Foucauldian concept of care for the self... the organisation might be [operating in a] high pace demanding, customer oriented environment. But it also goes forward and makes a good move in advocating mental health training and provides all the services in place for the ones who need them. On the other end there is also the appreciation that people with prolonged mental health conditions can self-manage their condition very well without much support from the organisation. **[Field Note 19 of Aug 2011]**

The way in which the theoretical framework adopted had an impact upon the analyses and the reading and the interpretations of the interviews makes reflection a vital component within the process of data production. By making explicit the way I have dealt with the analysis of the data, the limitations of the analysis become clearer. Also this process gives the reader the opportunity to consider the perspectives used in this study and the way in which it can be linked to other studies or theories (Wood and Kroger, 2000).

The importance of recognising that the interpretation of the empirical materials and the presentation of the findings are only one way of approaching the studied topic (Bryman and Bell, 2007), suggests that there are a variety of possible alternative meanings to the empirical data (Alvesson, 2003) (see also chapter 9 section 9.2 for more details). Overall, the reflexive account presented illustrates important anecdotes related to the interpretative nature of this study as well as the cultural and theoretical 'boundedness' of the author (Clifford, 1986; Watson, 2010) and their relation to the sample and studied topic overall. In this vein it

might be worthwhile noting that apart from the discussion in this section, other reflexive accounts are introduced in other parts of this thesis (see section 4.3 above and chapter 9 section 9.2. for more details).

Furthermore, the thesis is written in a reflexive manner (Berg, 1989; Knights, 1992; Rhodes, 2001). This illustrates transparency during the process of the research design in a way that allows the researcher to illuminate how the studied phenomenon was constructed, as well as to identify the principles which guided the analysis. Reflexivity was also presented within the overarching 'story' style narrative (Dyer and Wilkins, 1991; Phillips and Di Domenico, 2009) of the thesis in a way that presents multiplicities of meanings. For instance, the literature chapters examined the wide range of perspectives to studying identities and on mental health concerns. Likewise, reflexivity during the writing process provides an account that represents reality in a problematic and complex manner (Rhodes and Brown, 2005). In that sense the analysis and presentation of the findings not only throws light on the main patterns coming from the analysis but also on the 'alternative story' that opposed the dominant one (Alvesson, 2003), allowing the space for a multiplicity of subject positions and a broad representation of the participants' voices (Denzin, 1997). Overall, this reflexive process illustrates the motives and boundaries (Riley, 1991) of a study and rejects the assumption that research can ever be done in a neutral, accurate, innocent, 'clean' or adequate manner (Lather, 1991).

4.8. Concluding remarks

This methodology chapter covered a number of core aspects, which together indicate how this thesis was carried out and identifies the main theoretical foundations underpinning it. The chapter covered the core concerns of ontology and epistemology, drawing specific attention to the Foucauldian approach adopted. The discussion illuminates the choices of qualitative methodology and

stance for interviewing as the predominate method. The chapter provided detailed information as to the way in which the study was carried out and how the data was generated and analysed and the main ethical considerations that the research process entails. The way in which reflexivity is incorporated into my own positioning within the studied phenomenon and into the methodological approach, the research process and the writing up of the thesis was drawn upon.

Overall the chapter illustrated how the research design addresses the aims and theoretical underpinnings of this study and how these influenced the entire research process, methodological choices and the analysis and presentation of the empirical materials. As such this chapter illuminates the inter-relation between the previous literature chapters and the findings chapters which are presented next. Bearing in mind the main issues which guided this methodological enquiry and the analysis of the empirical materials, the discussion will now move on to deal with the three data chapters. The first findings chapter (Chapter 5) discusses how the mental illness discourse and subject position is constructed through the empirical materials of this study.

Chapter 5: The stigma of mental illness

5.1. Introduction

This chapter explores and analyses the mental health discourse and corresponding subject positions by gaining the reflections of the informants as for their understanding of what it means to be mentally ill. In doing so it highlights how contemporary discourse and practices continue to carry a stigmatised subject position for the person with a MHC. The reading of the texts generated from the interviews suggests that a common theme is that being labelled as ‘mentally ill’ carries a lot of stigma. As was discussed in the literature review, the genealogy of MHCs draws attention to the various ways in which the discourse of ‘madness’ in many societies carries with it a stigmatised and a marginalised subject position (Szasz, 1961; Hunt, 1966; Chamberlin, 1977).

While taking on different hues across cultural and historical space, ‘being mad’, ‘lunatic’ or ‘the mentally ill’ is a consistently pejorative and problematic discourse. This discourse is also tied together with the subject position of the ‘mental health sufferer’ as being marginalised, discreditable (Rose, 1985; Blackman, 2001) or discriminated against (Clinard and Meier, 1992). The focus of this chapter is to tease out in greater detail and nuance the experiences of the respondents in regard to this discourse. The chapter evaluates how salient the discourse is to the informants in their everyday lives. More specifically, it draws attention to the following points.

Firstly it explores the way in which the discourse of mental illness is associated with negative attributions such as fear, ignorance and misunderstanding, and with the derogatory and trivialised use of mental health language in everyday speak. This discussion will illustrate the ways in which the mentally ill subject position is a negative constitution (5.2.1). Second, the discussion will turn to illustrate how

and in what ways the discourse of mental illness and the subject position of the mentally ill is circulated in the workplace (5.2.2).

5.2. The mentally ill discourse and subject position

In the first part of the chapter, the informants reflect upon how mental illness is viewed in contemporary society, especially the media and everyday language. Two areas are discussed. First of all, the negative association with mental illness is seen as being the result of fear and ignorance as well as embarrassment and anxiety over how a mental illness might become manifest. Accordingly, 'the mentally ill person' is treated as dangerous. Secondly, this negative view of the mentally ill person is compounded by the portrayal in the popular press and common day language, which associates mental illness with subterfuge, danger, even criminality ("nutters"). Alternatively, and particularly associated with the mentally ill worker, there are associations with weakness, inauthenticity and being 'work shy' and 'skivers'.

In the second part of the chapter, the informants then reflect on how mental illness is understood in the workplace. Here, what is apparent is that mental illness is seen as antithetical to the productive worker. Being mentally ill is associated with being delicate, weak, vulnerable and handicapped and people with mental illnesses are most suited for low status, undemanding work. Alternatively, and reflecting the portrayal in the popular press, there is also a feeling that the hidden nature of mental illness raises suspicions of distrust over the genuine nature of an illness. This section highlights how the nature of the mental illness and the type of work influences the constitution of the mentally ill co-worker.

5.2.1. The mentally ill subject position

Fred⁹ draws on the way in which fear is linked with the negative portrayal of the mentally ill subject position in the public eye. He argues: *‘the killer with the psychotic condition. And so therefore they are always portrayed in very, very bad light. And drug addicts or they are alcoholic, or this and that, or whatever!’* Melanie draws this observation out in more detail, on the way in which the mentally ill are captured in the public eye. She states:

People don’t talk about it or aren’t aware... and feel embarrassed to talk about it, and feel it’s a secret... it’s almost a fear factor... people who don’t have mental health problems almost have a superstitious fear that it’s almost like they might catch it. It’s almost as though - ‘if I acknowledge the mental health condition exists then I might be at risk of it. So I just have to pretend that it’s all nonsense and that these people are simply weak, and somehow dysfunctional. But if I acknowledge that this might be a real condition - then it becomes a possibility for me.’ And I think people find it quite scary so they just pretend they don’t want to know about it.

Melanie’s comments highlight the association of mental illness with fear and anxiety. Fear from the unknown about the illness and anxiety over what might happen if the ‘public’ were to encounter someone with a mental illness. The anxiety over MHCs and the overall public ignorance about mental illness, points to the ongoing unawareness within society over MHCs so that the most common and ordinary experiences of someone with a MHC remains unfamiliar.

As Chris observes: *‘they see the people who are really manic or suicidal depressed whereas most people who have bi-polar either never get that bad or they only swing that far two months at a time. And they are quite well in between.’* Similarly, Fred argues: *‘we don’t have any normal people [presented in the press] with mental health conditions who just don’t affect anybody... they are not all raving murderers.’*

⁹ Please see appendix 4 for information about all the research informants, whose quotes appear throughout the data chapters (chapters: 5, 6,7).

Likewise, Beth comments:

There is nowhere a model of: 'he is schizophrenic and he raised a million pound for charity' or something. You never hear that in the press do you? Something good about schizophrenics, you only hear the bad...the only models of schizophrenia that are mentioned in the press are when something bad goes wrong.

The informants' comments also suggest that more dread and misunderstanding are attributed to some MHCs than others and how this overall leads to greater confusion and mystification about MHCs within the public eye. Roger argues:

I think there's probably a lot more social fear of things like schizophrenia I think... there is a lot more fear. I don't think people think that somebody with bi-polar is going to come to them with an axe and try to kill them or something. They are more afraid that someone who's schizophrenic is. But that's not a correct assumption either

Patrick's comments on this portrayal of extremes and the lumping together all people with MHCs into generic, stigmatised stereotypes:

In essence, you know, mental health can be anything from someone who suffers from mild depression to someone who is an absolute sociopath, some sort of serial killer then, you know. And you think then: 'Oh it's too broad a category really to use as an identity marker then.' So I think possibly I think the term is too broad, too catch-all.

This portrayal within the popular press of people with MHCs as sociopaths and psychopaths feeds back into the construction of the mentally ill person as someone who is dangerous and with potentially criminal tendencies. This, together with general ignorance over MHCs within the public at large reinforces the association of mental illness with danger and the mentally ill person as the outsider. As Patrick

observes: *'If I'll say to people I have mental health issues they'll all go saying: "Mmm what's wrong with him? Is he schizophrenic? Psychopath? Is he going to be dangerous? Can I trust him? You know, around me and around my family?"'*

Jack emphasises the general ignorance around mental health and the dismissive use of the language of mental health in common day speech:

I have noticed people talking about it all the time, but in sort of misunderstanding way. Like when I was in the pub on Saturday the barmaid, she came and tidied up the table and she said: 'Oh I am a bit OCD' and I thought: 'No you are not, you are just doing your job tidying up the table'. [...] I don't think people really understand much about mental health still. I don't think people know what an obsessive compulsion is. They think like they'll say, someone has OCD 'cos they're 'tidy, tidy', or something like. They say someone is schizophrenic when they're confused or they can't make their mind up. I don't think a lot of people understand. Or someone is depressed when they're grumpy or sad.

Similarly Melanie comments:

I did have a colleague who told me once: 'You have got nothing to be depressed about.' How ridiculous. Because people have that idea that if you get depression it must be because your life is terrible. So people don't realise that actually depression can be a more chemical thing, can have clinical tendency and so on.

Other examples cited by the informants include referring to having OCD¹⁰ for being tidy or controlling; calling an idea 'schizophrenic' when it has contradictory positions; being bipolar, or on a 'low' or 'high' to describe daily mood or energy changes; being in a 'crazy' or 'mad' situation, for busy or overwhelming circumstances. James, for example, observes: *'OCD is becoming like a "watered down" subject, when they refer to someone tidying things up... shows people's misunderstanding of how bad it is. It's not a funny thing.'*

¹⁰ Obsessive Compulsive Disorder, see Appendix 2 for details

The dismissive use of the language of mental health is something picked up by Fred, who elaborates on the way in which the portrayal of extreme forms of mental illness has an impact upon the negative attributions associated with the mentally ill person. This is particularly apparent in the popular press, where negative accounts of mental health are often accompanied by pejorative labels. Fred recounts:

I have got an axe to grind with the tabloid press. The *Sun* newspaper, *The Mirror*, *The Daily Sport*. I get sick to death of when we're called 'nutters', 'schizophrenic nutters' or 'bi-polar people nutters' or you know. And just tarring us with the same brush and just not paying attention to details, you know. And assuming we are all the same. And assuming we are all psychopaths, sociopaths or whatever

The pejorative language around mental health influences the construction of the mentally ill subject position as someone who is portrayed as unpredictable. Reference to MHC is seen as dismissive; referred to in a jocular and flippant manner, which the informants comment on with both indignation and distress. Referring to people with MHCs as 'nutters', 'mental cases', 'off their trolley', 'having a screw loose', 'insane', 'barmy', 'mad', 'lunatic', 'crazy' and so on, confirms the negative and stigmatised association of MHCs with the public. Again, such language use is indicative of ignorance, the research informants argue: *'I felt weighed down by the stigma and by being called the local loony'* (Beth); *'I feel that it's done by people not understanding what I am feeling'* (Melanie); *'people just don't get it about mental health... they just don't understand what mental health conditions are and what they mean'* (Jack).

Moreover, the often invisible nature of MHCs was commented on by the informants. This highlights a different strand to the negative association with mental illness, where the ontological presence of a genuine illness is questioned,

rendering the mentally ill person not so much the 'dangerous other' but someone who is really simply lazy and dishonest. For example, Bret observes:

One of the boys (colleague) got a leg problem and, you know, there is a leg problem and you can physically see somebody physically limping, can't you? You can't look at somebody's mind and see that something is broken off and not working properly, can you?

Melanie similarly notes: *'Like if somebody got a wheelchair, it's obvious, isn't it, that they are disabled? And people accept that. But if you have got something mentally wrong, it's invisible and nobody knows about it.'* The invisible nature of much of the MHCs thus renders the person untrustworthy. Either they are unpredictable and dangerous, or they are weak and lazy. Beth comments: *'Some people think I am just lazy. Some people think, you know, why don't she pull herself together? You know, why can't she just carry on, you know?'*

Similarly, Chris says:

I feel sorry for members of families who have a bi-polar relative and they just, they don't realise that that person actually has a health condition. They just think it's their personality that their personality is awful and they are just really hard work.

Thus the invisible nature of the condition throws a question on the relationship between the illness and the person and whether it is the person themselves who is problematic, rather than the illness. Unlike many other illnesses, mental health has a bearing on the presentation of the self, such that answers to questions of 'who I am' and 'how am I feeling' become entangled. Jack observes:

It relates more to the essence of what you are, I think, you know, to what you are. 'Cos like, you know, I have got, like, a plastic shoulder, and like busted my knee from playing football; it's kind of part of me. But it's not part of me as much as like something that controls my every move.

Furthermore, the ebb and flow of the condition, with degrees of illness accompanied by degrees of health means that what others understand as 'who you are' can appear profoundly inconsistent and unstable. As Melanie observes:

There are people who think you should pull yourself together. Because they think that they experienced high and low mood and that they manage, so why shouldn't you? So they don't see a difference between somebody who has a mental health condition and somebody who goes up and down a bit... So there is a lot of that, the 'pull yourself together' lot... that can be a real problem. Because, you know, I have had friendships just fallen apart because they haven't understood that when you are unwell, that your behaviour is different and it's part of your condition. And it's not a part of who you are. So that's been the breakdown of a few friendships.

Therefore, having a MHC calls into question who you are in relation to others. The entangling of the illness with the person's identity and the inconsistent presentation of self as a consequence of this, results in the sceptical or dismissive receptiveness towards mental illness. We can see how these factors, manifest in the informants' texts, construct the stigmatised and marginalised status of the mentally ill subject position. This negative construction of the 'mentally ill person' tips over into work settings with profound consequences. In the following section, how such general views on mental health and the mentally ill are manifest in work organisations is examined.

5.2.2. The mentally ill subject position in the workplace

The analysis of the findings illustrates how these broader, societal meanings to mental illness and the mentally ill person translated in the workplace. The informants highlight again a negative portrayal, where ultimately, having a MHC is seen as antithetical to the productive worker. There are two branches to this portrayal, however. On the one hand, there is a putatively caring approach where the weak, delicate and ill person should have work provided for them but only that which is undemanding, safe and therefore low-status. In other words, the mentally ill person lacks the mental resilience to be a fully functioning employee. On the other hand, there is a more sceptical association, where the invisible nature of the illness discussed above leads to suggestions that the illness is not genuine and that those declaring a mental illness may be merely work shy or 'unable to take the pressure'. Here the suggestion is that someone with a mental health issue lacks the mental drive to fully participate in employment.

The informants' comments portray a picture of how the societal view of MHCs is transferred into the workplace, with the assumption that people with MHCs will be unable to work. Melanie recounts:

Quite often doctors do say to me: 'Are you managing to do any work?' And I say: 'Well yes I work partially¹¹ full time.' But there is an assumption that people with mental health problems will either be dependent on somebody or either claiming incapacity benefits of some sort. And there was a doctor last summer who said to me: 'You should be very proud that you are not in prison... you are actually out in the workplace.'

Likewise, Tony's comment illustrates the effect of becoming unwell on a professional identity:

¹¹ Working full time in certain months of the year

Very often a person considers to be what they are by the work they do... And if you become unwell you lose all that. And then you become possibly “oh he has a mental breakdown” or “he is very nervous” or “he is very anxious” so yeah, it can affect people.

There is an assumption, therefore, that having a MHC precludes someone from being able to work or being fully engaged in the workplace. What becomes apparent in the informants’ accounts is that there is a clear disassociation of the subject position of the ideal worker and that of the person with a MHC. The ideal worker, i.e., the productive worker, someone who is willing and able to show a strong commitment to the organisation (Acker, 1990, 1992), and who gives primacy to the organisation’s needs over and above aspects of their personal life, family and wellbeing (Meriläinen et al., 2004) is thus a highly problematic subject position for the informants.

James states: *‘Whatever is affecting performance potentially... I think it’s just the animal kingdom. You don’t want to appear to be the weaker one so you’ll do what you can to keep something that’s pressures to you. So whatever it takes.’* Furthermore, Patrick comments: *‘there is an expectation that we’re all should be doing more and we all should be grateful for the position we find ourselves, this kind of stuff. And I think it’s quite unhealthy really so... you know it’s quite scary really because of this.’* Likewise Chris comments: *‘they expected everybody to work 50-60 hours a week and you know. Not to take time off and that’s kind of thing.’*

Moreover, the disassociation of the mentally ill person from the productive worker has a strong influence on attitudes within the workplace towards colleagues with a MHC. Brian observes: *‘Somebody thinks someone has a mental health condition—the only thing they think he is capable of is—he can clean the floor, he can stack shelves.’* Similarly, Melanie recounts: *‘I don’t think people associating mental illness with people who are functioning in high status jobs... People associate mental illness with people who can’t work.’*

From the comments made, it is suggested that the societal view on mental illness works as a 'blanket discourse' that overrides and colonises other work based subject positions such that first and foremost the person is mentally ill. Thus, when in the workplace, the mentally ill person is portrayed as someone who is incapable of performing fully within the demanding parameters of skilled work.

What is also apparent in the informants' accounts is that some conditions carry more negative association than others, when it comes to work. Melanie observes: *'I think many people in the workplace wouldn't necessarily think that this person [an employee] had manic depression or schizophrenia. They just don't expect to find somebody, you know, there at all.'* Similarly, Chris recounts: *'you say to me—I am manic depressive—they might assume that you are completely nuts and that you have never done anything with your life. Whereas I have been to university. I have held down good jobs.'*

These comments suggest that the mentally ill subject position which has prevailed in society is intensified in relation to certain MHCs (schizophrenia, bi-polar) more so than others and how the mentally ill subject position is captured as stigmatised. This prevailing view of the mentally ill in the workplace seems to be intensified in relation to depression, where the nature of the illness comes up against prevailing management ideas about the productive worker. Jo recounts: *'people and organisations and society like people who are either happy or fine... It's a platitude isn't it? Happy people are productive people... seeing depression as a weakness.'*

James' comment illustrates this point in more detail when he argues: *'I find that [depression] has stigma because people are sort of, they seem a bit more wary of people who are depressed.'* Thus while mental illness is associated with a lack of productivity, this is more so for some conditions, with depression being something

that carries a particular weight of stigma in this regard. Furthermore, the quotes illustrate how depression is also captured as something that is misunderstood in the workplace: *'I was trying to explain to my colleague that a lot of depressed people are quite cheerful... they feel weighed down by hopelessness, but to the world, you know, they're cheerful, they smile, they're polite.'* (Jack).

From the quotes we can see how the medical state of depression is associated with the day-to-day use of the term (as being 'fed up'). This seems to contribute to the stigma associated with the condition where depression is viewed as a weakness or even indulgence. What is apparent therefore is that the mentally ill worker is a highly problematic subject position and more so when that illness involves depression since it comes up against the discursive constitution of the happy worker being a productive worker.

Further, there are some conditions that seem to have less negative association. OCD, for example, given its public association with obsessiveness and attention to detail might complement constructions of the productive worker. So while the discussion on OCD comes through the informants' texts as the least stigmatised, it still appears restricted in the workplace: *It's funny I am probably more comfortable talking about the OCD than the depression that accompanied it.'* (James); *'I am quite happy to tell people I got OCD but if I go: "Oh I've mental health issues," I think there is a different stigma to it'* (Patrick); *'there is probably a bit of a stigma. I have never noticed anyone talking openly about OCD at work or anywhere really.'* (Jack).

The single mental health matter referred to in the texts as being the most openly discussed in the workplace is that of suffering from stress. Nonetheless, stress is still problematic. It is seen in society at large as the least extreme mental health situation as it is seen as transitory and a commonplace mental health matter, which is often accompanied by anxiety (Fryers et al., 2005). Stress emerges in the

texts as a common feature in many work situations and is often captured as an integral part of work within organisations. Jack expresses how stress is openly discussed at work: *'Stress seems to be quite acceptable actually; everyone's got stress, which is odd actually... It's totally acceptable.'* Similarly, Jo adds:

Stress is widely discussed in social work. And very much the physical effects of the job. I was just talking to a colleague this afternoon, she was reporting that she is taking next week off all of a sudden because she is anxious; she is not sleeping; she is not resting; she is forgetting things. And I would imagine that's not uncommon in social work.

Although stress is openly discussed at work and appears to be an accepted occupational hazard, stress-related absence on the other hand is highly problematic in some organisations. Again, we see in the informants' texts that despite some organisations and some roles being more receptive to experiencing periods of stress, there is still an association with weakness. Jack recounts:

Junior staff in charities, they're all bloody stressed out. Or they think they are, yeah. There always seem to be people who are stressed out... If you went to work in a private company, where they are like making demands on you all the time and they want you to work 70 hours a week... you are not going to have a job. And you'll be all right in a charity, they'll say: 'Oh bless you, take a day off,' you know...

Thus, a further factor influencing the reception of MHCs in work is the organisation, being tolerated in certain work situations (charities) more than others (private sector). The nature of the employment is also a mediating factor, with managerial work bearing less receptiveness to declarations of stress. Jo observes:

When people say 'I am stressed' - you wouldn't see managers saying that - it doesn't seem particularly positive. I would imagine it seems a sign of not

coping, not managing your own workload on time... [it is] sometimes seen a weakness as well - that people should manage themselves better.

Jack continues: *'It [stress absence] might stop you getting to the top actually. Yeah, probably among senior managers it'll be considered as a weakness.'* In a similar vein Melanie comments:

There is this view that even if it's unspoken, that the real career teachers who are going to go up into the super teacher league, and the managers, and the heads and so on, aren't going to be showing weakness. They are going to be shiny perfect.

Likewise Patrick states:

I have had conversations with people as if: "oh I don't want people to know I am off on stress it makes me feel as if I am weak, you know"... a lot of institutions maybe the more macho institutions that people have to work in are more like that, I think.

So whilst being tolerated in certain work contexts, the quotes illustrate how absence due to stress appears less accepted in others and how expressions of suffering from stress at work are considered a weakness. The attribution of a reduced ability to perform is, as with other MHCs, associated with absence due to stress or with other expressions of suffering with stress at work such as inability to cope with the work or to deal with the workload, or of having the sufficient organisational skills required for a managerial position. This is seen as conflicting with the expectation that employees be committed and able to perform to a prescribed standard.

This link between having a MHC and reduced performance in the workplace also seems to be associated with the invisibility of the condition. As Carol, an

occupational health doctor involved in the study argues: *'You have got people who are using stress as an excuse... So it is difficult for people to identify the difference.'* Carol's text illustrates how, absence from work due to stress may be seen by some as an illness of convenience, when they want to get out of work. She continues:

One of the problems with people who generally suffer stress is the fact that other people use it as a lever to attack an employer for a financial settlement... Now, if you are an employer, you are tearing your hair out. [...]They [employees who are pretending to suffer from stress] create the stigma because it becomes associated with playing things for your own benefit. If you are a HR department it's very, very difficult to not allow that to colour your thinking about somebody who is genuinely unwell... [So] who is really suffering and needs my help?

This derogatory view on stress-related absence is evident in relation to other MHCs. Hence, we see this association with scepticism in the mentally ill person at work. Kevin, (a company doctor), comments that: *'This idea that they [employees] are using a medical problem to use it as a state for them not being able to work or underperforming.'* Kevin continues by suggesting that this medical problem often tends to be related to MHCs: *'Getting away from work with mental health.'*

Carol also adds by reflecting on the way in which, due to its self-reported nature, mental health can be used by employees as an excuse to get away from work: *'So we regularly see people who will use a mental health as leverage for something they want to achieve... because a lot of mental health's are self-reported... the symptoms are self-reported.'* Fred continues: *'I didn't want people thinking I was someone pulling a fast one, you know—trying to get out of work... I am manic depressive. I didn't want them to think that I was a slacker. I didn't want people to think I was [just] suffering from stress at work.'*

So we can see how the disassociation between the person with a MHC and the productive worker is being constructed through the analysis of the quotes. This is being the case either given the association of the mentally ill with lack of mental resilience when they are seen as needing extra care in the form of undemanding work (or no work), or, alternatively, when mental health issues are being treated with scepticism. In this instance mental health issue is merely understood as an excuse to cover lack of motivation and drive. Overall, we can see how the ‘mentally ill worker’ is being portrayed as someone who is dysfunctional and incapable, and how this subject position is associated with low performance and commitment to work as well as shrinking and dodging. This view of the ‘mentally ill worker’ is captured from the quotes as another element in the complex set of factors contributing to the mental health subject position that prevails in contemporary society as being problematic and tarnished.

5.3. Chapter summary

This chapter has shown how the discourse of mental illness which prevails in society contains within it a subject position that is not only offering a devalued and marginalised identity for the person with a MHC but also how this works to distance them from the identity of the fully performing worker. Overall the chapter illustrated how the societal view on mental illness is constructed from ignorance and misunderstanding borne of the portrayal of extreme cases in the media; the invisible and unpredictable nature of some MHCs; and the circulation of dismissive and pejorative mental health language. Consequently, the mentally ill subject is constituted as someone who is captured either as the ‘dangerous other’ or as the weak and lazy. This societal portrayal is then taken up in the workplace to either present the mentally ill subject as someone who needs extra care, someone who is dysfunctional and incapable of working; or as someone who is not ‘genuinely ill’. Accordingly, the ‘mentally ill worker’ is captured as someone who is unable to perform as well as the ‘normal worker’.

So far, the informants' texts have shown therefore how the discourse of mental illness presents a set of negative meanings both in society in general and in work organisations specifically. What this means for the informants in this study, and what effects it has on their ability to thrive in the workplace, is the focus of the following chapter. Specifically, the chapter explores the dilemmas around 'owning' a mental health identity and 'becoming a mentally ill person' at work. Thus, overall illustrating the complex set of factors contributing to the mentally ill subject position that prevails in contemporary society and at work, as being problematic and tarnished.

Chapter 6—Dilemmas of disclosure

6.1. Introduction

Given the negativity and stigmatisation associated with mental illness, as discussed in the previous chapter, this chapter explores the informants' decision making processes around the declaring of their illness in the workplace and in other parts of their life. The chapter addresses two main issues. Firstly, it explores the informants' decision to let others know about their MHC. Secondly, the chapter examines the extent to which individuals identify with the mental illness discourse as part of their construction of self, and with what consequences.

In particular, the chapter focuses on the informants' experiences in their management and negotiation of the mental illness subject position at work. From the previous chapter we could see how the mentally ill subject is constructed as someone who is dysfunctional and incapable of living up to the employers' expectations of the fully functioning employee. Furthermore, the chapter also illustrated how the invisible nature of many of the MHC symptoms creates distrust and, in some cases, dismissal.

This invisibility of the symptoms, accompanied by the associated stigmatised discourse and subject position, then presents a fundamental dilemma for people with MHCs: whether to disclose their condition at work and, if so, then how, where, when and to whom? The decision to declare a MHC is complicated further by the importance that disclosure is given within the practices of self-management, recommended for living with a MHC. Thus concealment potentially carries costs for one's health, as well as presenting personal dilemmas over trust, being open at work: being one's self at work.

The chapter begins with the case of Martin (6.1), a customer complaints manager in a bank who has bi-polar. Martin's text is illustrative of the main themes of the chapter. The case illuminates the struggle of gaining and maintaining employment when facing the ongoing dilemma of disclosing the MHC in the different employment settings.

Following this, the chapter will explore in more detail the main theme running through the informants' texts—that of concealment: to 'pass' for 'normal' (Goffman, 1968) and to live up to normalising discourses (6.2). The chapter will then move on to discuss those moments when disclosure did take place at work and non-work settings (6.3). Overall the discussion on concealment and disclosure, will illustrate the different costs embedded within these practices and their interrelation to individual notion of self.

6.1.1. The case of Martin: The dilemma over workplace disclosure

Martin, a customer complaints manager in a bank and in his early fifties, has bi-polar disorder. During the period of this study, Martin's employment situation changed rapidly. From a job seeker and volunteer in a mental health charity, he became an agency worker, working in a bank. Within a few months of appointment, Martin moved from a data entry clerk to a senior customer complaints manager. During all of this period, Martin kept quiet about his MHC. Neither the employer, nor any of his colleagues were aware of his MHC.

Martin explained his decision not to declare his MHC: *'I know there is stigma out there so I won't put it [on the application] if they don't ask.'* Martin's decision to remain silent was based on previous experiences. He refers to a particular incident when his MHC became known during the process of a previous job application:

There was an agency that wanted to know all my details, 'cos they said: 'Oh this is brilliant, you are the sort of person that need to work for us. This is great, you are doing this and so give us all your details'. So I gave them all my details, and then they needed my doctors' records for me to work for them. So then I mentioned my bi-polar and they said they would be contacting me during the evening, and then nothing happened. I sent them two or three emails and they haven't even replied.

By the time of the second research meeting with Martin, he said: *'I joined a few agencies. I did actually ask their advice on whether to disclose that I have an illness or not and they said that by law I didn't actually have to disclose.'* Martin decided not to reveal his MHC to the employer and got the job with the bank:

I think it's not good for me to say what's wrong with me 'cos then you are vulnerable, they can play on the fact that you are not well sometimes... because I am actually a temporary worker I don't feel as if I can... They can just say: 'OK if you don't want to do this job then go back to the agency'. I am stuck really. I do want to work but I know that there is prejudice there and stigma, so I feel as if I have got to be normal all the time. I can't let myself get ill. And of course, 'cos I work for an agency, you don't get sick pay. So if I did mention it to them, I will end up with no support.

So we see in Martin's text his decision to maintain his silence over his health situation in order to maintain a good employment record and the need to ensure continued wellness. However, Martin emphasises how concealing his MHC is not something that is done lightly. He presents a graphic account of his ongoing struggle to 'pass for normal':

I happened to work whilst unwell in the past... But I have to [work] 'cos I have to earn some money. It's not very nice. I try things with my diet and exercise and control, getting as calm as possible before I get there [to work] and then when it's over I feel quite relieved. It's quite tiring I suppose... I feel the stress getting to me. It hasn't actually triggered my condition as far as I know. But I can see why it may be a problem in the future. I dread each day and arrive at work in pools of sweat but I'm hanging on in there. I tend

to hide the fact that I am down so I try to do what I have got to do and hope they don't notice.

Martin's daily struggle to maintain a routine of health at the workplace without revealing his condition is then further heightened by the requirement to socialise with work colleagues:

My colleagues have actually asked me to go out with them next Monday but I am not going to... that always happens everywhere I go. I never go out 'cos I find the big groups of people stressful. And I can't have a drink to relax 'cos that would affect my mood later so. It's the whole social side of it 'cos they have a team drink and a team meal but I just have to say: 'no thank you'. It probably is dangerous for me to go out with them because of the way it affects me. But I can't tell them that because they don't know about my condition... Because to me it's an illness, just like any other illness, only that it's seen differently by employers, which is why I can't mention it to workmates, because they might say something to my employer.

Martin's account presents some of the problems facing people with MHCs in concealing their condition. He points to the need to maintain a level of subterfuge with co-workers. There are suggestions too in his text of the costs of concealment for his own health, with heightened psychological strain brought about through hiding his condition:

If I was comfortable with disclosing I would. I am still trapped. Sooner or later it may come to a head when I have to say either that: 'look I have this condition and I am not sure if I can do this job' or: 'look I have this condition that's why I can't come out'. But I think it would come out eventually it will have to... but it best to find the right moment, I suppose, to do it.

Martin's text thus is illustrative over the decision of other informants to conceal their MHC at work. This practice of 'passing as normal' however comes at a cost. It means that no reasonable adjustments can be requested in the workplace, putting the care of the condition firmly on the shoulders of the individual. It requires often

complex forms of subterfuge in work. It engenders feelings of isolation from colleagues. And it can cause significant psychological strain. Moreover, it can result in feelings of inauthenticity. In the next part of the chapter, the decision and consequences of concealment are discussed. Following this, the chapter examines the decision to declare a MHC and the consequences this has for the individuals' sense of self and employment.

6.2. Concealing a mental health condition

The ongoing struggle to live up to an 'ideal worker' subject position (Acker, 1990; 1992) is evident in the texts of the research informants. In many cases this means engaging in a series of 'passing' practices, concealing the stigmatised MHC in order to 'pass for normal' (Goffman, 1968). This concealment, however, is not achieved without a cost.

Some informants said that they had made the decision to hide their MHC at work and 'pass as normal' (Goffman, 1968). They commented on how such a decision was a difficult one but that it was necessary in order to avoid jeopardising their employment chances by disclosing their condition. Fred for example stated that he *'wasn't willing to take the chance, you know, I thought I want this job and I can do it as good as anyone else.'* Likewise Chris comments:

If people don't know then they can't judge you. Because if you say to me 'I am a manic depressive', they might assume that you are completely nuts and that you have never done anything with your life [...] It's just selling myself because other people do, so you have to. It's the way interviewers think, and they look for anything to dismiss you or check you, compared to other people.

The informants highlighted the selection and recruitment stage as being particularly problematic, given the dilemma on the one hand of the need to present the best possible image to secure employment and maximise their career chances, and on the other hand the need to declare a MHC in order to receive allowable adjustments to terms and conditions of work, covered in employment legislation, in order to function effectively in the role. Melanie comments:

When I was looking for work a few years ago the companies had started to put down health information in the application, which I have never known before. And somebody said: 'Well you really do have to disclose on that form otherwise the disability act wouldn't count. You have to disclose before you get the job otherwise it counts against you'. So I wrote I have manic depression but it's well controlled. And I didn't get asked for the interview, and that happened at least three times, and I didn't get asked for the interview, and I didn't get short-listed for the post. They didn't even ask for my reference even though I was qualified for the job. And whenever I applied for the job and I haven't written that, I have always got short-listed for the job.

Similarly, Chris notes:

I would never disclose my health condition. No way! Because I wouldn't get a job... I am not going to reduce my chances of getting a job. It's hard enough to get a job anyway. I am not going to throw my chances to the wind by telling somebody. And if you say, 'Oh but if you tell them you are covered by the DDA¹², I wouldn't use the DDA as my security. If you disclose the chances of getting a job are not so great. I mean, I know with the Equality Act now if they have offered you the job and then you write down on a form you have a mental health condition, then it's hard for them to withdraw, but I am sure it's very easy for them to do it. They would have lost the form or something. Or they'll find another reason. They'll say 'Oh actually this job is not available any more' even though it is, if they discovered that you are bi-polar. You know, it's 'Oh god we don't want that person here'.

¹² Disability Discrimination Act (2005)

Not only do the informants comment on the need to conceal a MHC in order to be successful in gaining employment but also that the bureaucratisation of decision making around discrimination legislation is insufficient protection against the prevailing stigmatised attitudes towards MHCs in the work organisation. However, attempts to conceal at the interview stage are not always possible, as Albert explains:

I was interviewed... and they kept pushing me and pushing me and pushing me. There were long gaps in my CV and they kept pushing, until they found out what was causing that. They said: 'What were you doing all this time?' I said: 'I was out of circulation for a bit.' They said: 'What exactly happened?' I said: 'Oh I was in hospital.' They were saying: 'Why were you in the hospital for?' I said: 'Just a little problem I had, nothing to worry about, I am fine now.' They said: 'Oh what hospital was it?' I said: 'It was Blackwood hospital' and they then said: 'Oh right you had a mental illness'. I said: 'Yeah, I had a little break down, nothing to really to worry about. I am fine now.' And they kept pushing and pushing and pushing, until in the end I said: 'Look I was diagnosed with schizophrenia and I hope it won't prejudice my application.' They said: 'No, no, no!' but in the end I could see where the interview was going. They kept asking personal questions and they kept pushing and pushing to ascertain what my condition was, so in the end I thought to myself: 'I am not going to get the job'.

Albert did not get the job. As with Martin's text and Melanie's, Albert's text here illustrates again how concealment is seen as essential in order to present oneself as employable. As Fred sums up: *'I lied to them. I just tried to impress them that I was able to do the job that I was qualified. I mean they could have called my medical record because I signed the form. I kind of felt like I couldn't be particularly honest about my illness.'* Melanie comments on her feeling of vulnerability resulting from her having disclosed her condition to her employers illustrates further the way that this will jeopardise her employment chances:

Now what's happening is that the university's cutting some of their courses... I have applied for a new post [internally] but I suspect that there might have been a lot of internal applicants for that post and I hope that the people involved in the interview process won't hold the manic depression against me. But it's very difficult to tell because they can say

'well I am sorry there were too many applicants'. They don't need to say that they held that against me even if subconsciously they might hold that against me I don't know.

Likewise Patrick notes: *'I wouldn't be comfortable for example going to personnel saying I am really stressed give me reduced hours because I think personally that make me feel slightly vulnerable'*. Concealment and passing is not merely a one-off occurrence in order to secure employment, however. It is necessary, as we saw with Martin, to maintain 'the lie' while in employment. This means participating in complex forms of subterfuge in order to conceal the stigmatised illness. Kim explains:

I have never used to disclose. A lot of employers stereotype you. The reason why I stopped taking the medication is because I didn't want it to be on my record for so long. Because if anyone wanted to see my medical record at any point in the future I didn't want it to be something that was noticeable on there.

The informants point to the necessity of this ongoing concealment in the workplace, due to a belief that there would be very little employer support if their condition were known. Tony, who continued concealing his condition whilst in employment, argues: *'I don't think they [employers] would have been that compassionate 'cos they have had the pressure from the managers above so they wouldn't have the resources to accommodate me.'* Similarly Martin claims: *'Although they say, and I hear them talking, 'cos I am seated near some people from the HR department, they are forward-thinking company and they don't want to discriminate against anybody, I just know that they would.'* So we can see how ongoing concealment entails a cost which is not only related to the preoccupation around hiding, but also means being unable to access any support from the employer. The quotes also illustrate the scepticism over employers supporting them in a way promoted under equality legislation.

At the same time that the informants experience a dilemma over disclosure, there are occasions where they have been ‘pushed’ to disclose their condition to the managers or HR department due to illness absences. Tony comments on how he ended up having to disclose following a period of absence: *‘I did have to go to a back to work interview, to tell them what happened.’* Similarly, James had to disclose his MHC when he *‘had a medical certificate of what was the problem [that he] had to present to HR’*.

Clearly, disclosure is not only a dilemma during the recruitment process. The decision over whether or not to disclose a MHC is something that is constantly present for the individuals who took part in the research. This is despite their being protected legally over time off work from illness and the existence of workplace support, statutory pay and a vacancy to return to after a long period of absence. James explains, for example, how there is a lack of support from employers, who tend to only want to consider those workers unencumbered by health issues:

No follow up on ‘How can we avoid it from happening again?’ It was kind of: ‘Right, hope you are better now’ sort of thing. Then you are expected to perform to the level of everybody else so... it’s full speed ahead and it’s kind of forgotten so that’s what the problem is. It kind of assumed that it was dealt with. I suppose they don’t understand it’s a chronic condition... that’s why I don’t go on about it at this moment because we are all worried about our jobs, so I wouldn’t like to appear to be the weak link.

The comments illuminate how the vulnerability arising from those moments whereby the interviewees had to disclose their MHCs due to illness-related absences was also accompanied by experiences of stigma and prejudice. Tony, for example, states that his manager *‘more or less said, “If we’d known you were unwell we would have never employed you.”’* Similarly Fred comments: *‘Actually, they told me I was lucky to have a job because if I had told them [about the MHC] they might not have given me a job.’*

The reduced support from the organisation and increased vulnerability as a result of revealing their condition led the informants to feel reluctant to disclose their MHCs to colleagues. James argues: *'It's a mystery to most of them why I was away for eight weeks.'* Similarly, Jack also thinks that his colleagues *'would be sceptical if I went into the office and said "Oh you know I have got obsessive compulsive disorder."'* Likewise, Tony *'didn't really want to say anything'* to his colleagues. Equally Melanie adds that *'It's even more difficult [not to reveal to colleagues] 'cos people know you have been unwell so that adds the stress.'* Chris also explains:

My concern is that when I get back to work people will say: 'Where have you been? What's wrong?' That kind of thing. I am really concerned about that... It can be used against me in so many different ways... I will lose my credibility in my job and in the role that I have. It's very, very important. If I will lose credibility I won't get anything out of people... so if they know I have got manic depression and they have got a bad opinion on manic depression... they might use that against me saying 'Oh there is no way he can do that. He is a bit of a lunatic,' you know... So I don't intend to tell them... I know how narrow-minded people are and how discriminatory they are, and I don't want my reputation to be affected 'cos that will affect my job. My reputation is based on how well I do my job and I receive other job offers based on that, and I receive credibility based on that. Now if I start telling people I was bi-polar then it will be a problem.

So we can see how the informants are continually worried about revealing their MHCs across the different employment settings and to their colleagues. Similarly to the case of Martin, who described how he felt obliged to lie to his colleagues, fearing that revealing his MHC to them would jeopardise his employment, Chris's account illuminates the worry that revealing his MHC would affect his reputation and credibility to do the job or to receive further job offers. Likewise, Melanie recounts further: *'I used to say that I had a migraine because that's something that people understood... [or] say "it's domestic, it's relocation it's children". So I never had to say: "I am unwell".'*

This pressure to pass can be seen throughout periods of employment, from recruitment through to resignation and leaving the organisation. For Brian, concealment, subterfuge, having to lie about, and hide his condition, became so difficult that in the end he decided to resign his post:

I felt very restricted, very constrained, within the working environment... I kept it quiet; it's not something that is widely accepted... I haven't told the employers about it... I told them that I was leaving to go back to my old company again but the real reason was that I just couldn't cope with the situation. If I would say I was leaving due to ill health reasons that would be on my record for any future employer, so you know, I didn't disclose anything.

Brian felt compelled to resign from his role whilst keeping secret the reasons for his resignation. Chris also explains how he *'wouldn't leave [a job] due to a health reason [but would] say 'I am going travelling' and, you know, I have done that before.'* Retaining a clean career record, to maintain the identity of the 'normal' employee thus needs to be maintained in all aspects of employment.

Common to these texts is the highly individualistic nature of the employment experiences of the informants. There is a strong tone of self-reliance in relation to managing their MHCs in employment with informants commenting on being on their own when it comes to managing their career and their health. As Melanie sums: *'It was very difficult taking medication and feeling unwell and working in that environment. Especially if people don't talk about it or aren't aware. People are very ignorant about mental illnesses and feel embarrassed to talk about.'*

The struggles around concealment were compounded by some with a feeling of being fraudulent over who they were. Although, for some, the tension around hiding their MHCs was experienced as a form of *'fabrication and being selective about the truth, not lying, just selling'* (Chris), for others concealment presented a great deal of discomfort, especially in relation to how they would like to be in

work, when there is less stigma associated with their MHC. James, for example, reflected on his feelings of tension over *'who I really am'* and *'how I can be at work'*. He argues: *'I wouldn't like anyone to, sort of, not like me because I was depressed, yeah, but it's such a big part of my life... and if I didn't talk about it, my life would be a massive lie.'*

Likewise, Sam explains: *'I found it difficult to tell them [employer] I had schizophrenia so I didn't actually tell them I had it and then I kind of felt bad about that.'* Melanie also comments how *'It felt wrong that if I had periods of absence I would have to lie'*. Likewise Jo talks about the mixed feelings over concealing in light of new duties at work: *'I am doing a piece of training for the role of improving mental health professional services, it's part of the assessment team for admissions. But I have mixed feeling obviously because of my double statuses as both service user and practitioner.'* Clair's comment further illustrates this tension over disclosure at work by stating that one is *'really stuck between a rock and the hard place'* since *'you can [also] get the sack if you don't disclose.'*

The discussion so far illuminated the challenges involved in concealing the MHC. It illustrated how passing as normal is not an easy option and how for many of the informants the choice to conceal their MHC is constraining. It seems that the informants are attempting to occupy a subject position as healthy/'normal' workers while at the same time concealing an aspect about themselves which carries with it a stigma. This stigma, it is apparent spills over from the illness (it's not the same as a broken leg, as Jack comments) into a subject position. Identifying with this subject position has costs but also benefits, as we shall see in the next section of this chapter.

6.3. Disclosure

From the informants' texts, it is apparent that there is a complex relationship between understandings of self as 'being mentally ill' and declaring a mental illness to others. For some, there are moments of what might be seen as self-stigma (Goffman, 1968), whereby they have identified with what is a negative, stigmatised subject position. Other texts, however, illustrate how disclosure is a claim for ownership of the illness, authenticity and legitimacy. Moreover, there are some texts that draw on the therapeutic and restorative process, as part of the desire to gain recognition, support and the ability to be 'who one is' in various settings. These different processes throw light on issues such as self-stigma, recognition and therapeutic disclosure which are explored below.

Whilst the predominant themes illustrated at the start of the chapter illuminate the practices and costs involved in concealing, there were also informants who, for a variety of reasons had disclosed their MHC in work. The motivation to disclose is partly based on the desire to be honest and open, to engage in 'truth telling' and to present an 'authentic self' at work but also to emphasise the genuine nature of the condition. Moreover, disclosure was also seen as a necessary part of therapy.

Melanie illustrates the tension between trying to achieve recognition for the illness, being honest about her health condition and, at the same time, living up to the employer's expectations and to the 'performing worker' subject position. She shows how 'telling the truth' and being open at work is a value she wants to uphold as part of her identity construction:

It felt wrong that if I had periods of absence I would have to lie. And I said: 'this is what I have got, and this is why I am not so well sometimes,' and that's fine... I wanted to explain to my line manager because I thought if there are going to be times that I am unwell she should know but I think she understood why I didn't say it up front when I applied for the job.

In a similar manner, Jo explains how she felt the need to be honest with her employer before being seconded for a mental health related position:

In order to apply for this training and for the secondment I felt that I had to be up front and say, 'I am a service user on my own right'. 'Cose I thought it probably was both unfair and unprofessional not to. And that also means that if needed, if my behaviour becomes a bit peculiar that also other people be alerted to it as well.

Similarly, Roger comments on his preferred 'way to be', centred on being open and honest:

I had a big manic high... And I went off work... They kept my job open. I went back to work... I worked part time in the mornings for a month... and since I have been working in the same company... I have got good relationship with them... And all my colleagues know about my condition as well... and I don't make any secrets about it and I think that it's the best way to be.

Likewise Fred presents an account of disclosure:

I work hard for the company. I didn't want to let them down when I took my three weeks off, when I had the minor episode. When I came back I told everybody at work that I am manic depressive. I have a health condition, I wanted people to know the truth. I didn't want people thinking I was someone pulling a fast one, you know, try to get out of work. I wanted to be honest you know... I thought, sort of, you know, I spend 70 per cent of my time in work, why can't I tell people I work with I have got that condition? There is no harm in it, I am not ashamed of it, you know. In fact if I tell them, then my life might improve, and I think it has, yeah certainly... Sometimes I burst into tears at work. I'll come find my work mates and say: 'look I can't handle life at the moment.' And they're like: 'things will get better'. They look after me. They are really good. They are always there for me.

Each of the informants had made the decision to disclose in order to be open with their colleagues and honest about their MHC. However, disclosure is clearly not an easy decision. There are costs to disclosure, insofar as it runs the risk of reinforcing the negative subject position of the mentally ill person, which may in turn reinforce the beliefs that those with mental illnesses are weak and lacking the mental resilience or are lazy and work-shy (as discussed in chapter 5).

Thus there are costs embedded in this practice. As Fred comments: *'It's so hard to tell someone or to admit that it's [part of] your condition—literally you can't think of anything to say to anyone. Nothing is good enough. It's awful [when experiencing depressive episode].'* Fred's text illustrates the delicacy of the act of disclosure. Disclosure as an act of openness at work, and the need for recognition and legitimacy, appears as even more constraining when receiving negative or derogatory responses from colleagues. Melanie argues: *'I have certainly had absences because of depression and depression-related illnesses which make colleagues and employers look down on you.'* Bret also points to the struggle to maintain a feeling of legitimacy as a co-worker when colleagues make derogatory remarks about his MHC:

When you come down a bit [with depression] and you are not feeling the best, and somebody is getting you down, then they don't respect the feeling sometimes, you know... I feel that they are sort of judging me on personal basis... Sometimes when I wanted to do the bi-polar thing [support group meeting] they say: 'Oh you are going to the loony club' and different things like this. I mean I just take that as people, you know, that basically don't understand.

Likewise, Fred recounts: *'I mean they don't respect me at times when I make mistakes. And I am sure they think "He makes mistakes 'cos he is a loony" or whatever. But I am only human and everyone makes mistakes no matter whether they have got a condition or not.'*

So we can see how the attempts to gain recognition by disclosing the MHC in the workplace are by no means a straight-forward process. Similar to the discussion earlier (in section 6.2), where we saw how the informants did not want to ‘go on about’ their MHCs or to be seen as the ‘weak link’ (James), there is a fear that disclosure will jeopardise their employment chances. The texts of Melanie, Bret and Fred highlight the deep concern and ambivalence over the act of disclosing a MHC for fear of the repercussions in day-to-day work experiences and careers. At the same time, however, we see here how not declaring creates considerable struggles over feelings of inauthenticity and duplicity.

The act of disclosure is an ongoing process contingent on many concerns related not only to questions such as whether or not to disclose and to whom, but also ‘how much’ to disclose, ‘how many times’ and where to disclose. Although the informants highlight the benefits of disclosure, they also illustrate the struggle, costs and risks entailed within such declaration when in work. A number of informants, however, show that disclosure can be a therapeutic act, where being recognised as having a MHC contributes to processes of healing. Disclosure in certain environments, such as self-help groups, family and friends and, to close colleagues is manifested in the accounts as a non-judgmental setting where the informants could declare their mental health experiences with fewer constraints.

Martin, for example, comments on the therapeutic nature of declaring his MHC to family and friends: *‘I was so relieved I got a name to what I had, so I’d just tell everybody, I told all my friends. I have no problem mentioning it to my friends ’cos they would have seen my mood swings over the years anyway.’* In a similar manner, Fred’s text reflects the benefits of disclosing and owning a legitimised identity:

I am very open about my condition. I tell people... If I have got to know them and they are my friends, I don’t see the shame in it so I tell them about it. And often they want to know, they ask questions and I tell them,

you know. And they go 'oh you know, how do you do that?' I think sometimes, I don't think they realise how strong a character you are because they don't have any reference because they never suffered from it themselves.

Likewise, Roger comments: *'I don't make any secrets about it. And I think that it's the best way to be.'* And similarly, Patrick argues: *'I'll tell people I got OCD and then I am not worried about it, well those who I know well enough obviously.'* This recognition which is gained through the declaration of the MHC illustrate the receipt of appreciation for coping with the condition and for being 'authentic' about one's own identity and life experience. These less constraining contexts appear as opportunities for the informants to gain this recognition and to legitimise the mental illness subject position within themselves, and in their interactions with others.

Such declarations and the benefits gained from disclosure are easier in those situations where one is not being judged. Chris explains:

All my family talk openly about it... a number of people at work who I get on with very well do already know actually. So they already know 'cos I can trust them and they are fine about it. People who know me for long time, I'll tell them about it 'cos they know me for who I am. People who don't I am less likely to tell... People who know I am bi-polar respect me anyway 'cos I have known them for years, friends. And you know, they don't judge me on that because they know me.

Similarly, Fred comments:

I told my friends. And my best mate when I was first diagnosed looked into magazines and articles and looked at ways that I could help myself. He was brilliant, so his insight into my condition was brilliant... he was so positive, really one of the first friends that looked after me.

Similar benefits gained from disclosing the MHC in contexts such as trustworthy close relationships are also reflected in other settings, one of which is a mental health support group. Fred continues:

You are not judged. You are a level player in the field. Everyone knows what the illness is about. They are getting better themselves in understanding the illness. So you feel at peace, you feel at home. And you don't have to explain yourself. You have to explain yourself but you don't have to experience all the negativity... I find that very therapeutic.

The informants' comments are illustrative of the therapeutic nature of disclosure in this context of support groups, gained through discussions, sharing experiences, giving and receiving advice. Grace comments: *'You get something out of it and you meet people like yourself which is nice 'cos I can't talk to everyone... I like to talk to people that go "Yeah I know, that happened to me!" or "I've done this and I've done that".'*

This therapeutic nature of disclosure also takes the form of giving help to others. Tony, who facilitates a self-help group, explains: *'You feel as if you have helped people when they go to the meetings and they say that it was beneficial. So you feel that you have helped a little bit... so there are a lot of people out there who need help.'* Tony's text illustrates the way in which the therapeutic aspect of taking on the subject position by helping others is a positive disclosure experience:

We normally talk in a circle, we normally say: "Hello my name is Tony I have been diagnosed since 1999. I have been currently well for two years. And, you know, I hope it stays that way." And then somebody else'll say their name and then a little bit of a brief of their medical condition.

Tony's account illustrates the benefits derived from disclosure in mental health support groups and reflects the experiences of many other informants. The benefits experienced included gaining ownership for one's own living with the

illness and recognition for maintaining wellness through good management of the condition. By so doing, it is apparent from the accounts that, in context, the proclaiming of a chronic illness and a stigmatised subject position can be both therapeutic and empowering. Through declaring, individuals gain recognition for their pain and for the way in which they 'care for themselves' (Foucault, 1988a; Frank, 1998). The ancient tradition of 'the confession as one of the main rituals we rely on for the production of truth' (Foucault 1978, p.58) is displayed in the accounts as therapeutic and purifying both for the teller and the other (Frank, 1998).

Nonetheless, the quotes illustrate the costs entailed within this process of identification. They point to the constraints entailed when in certain moments this leads to the inevitable association with stigmatisation. Cliff states: *'I think self-stigma is a very complicated thing. Which, because of stigma in society, it's very difficult to rinse out of your mind, and you tend to come back to it in moments of weakness or moments of illness.'*

To what extent do the informants in this study take on or identify with the negative and stigmatised subject position of the mentally ill person? The comment by Cliff shows the difficulty expressed by the informants of being able to dis-identify with this stigmatised subject position. Chris argues: *'I am ashamed of it and embarrassed... you feel like there is a big label you wear in your head.'* Jack comments: 'I am crazy yeah, I feel like a lunatic'. Equally, Jo recounts: *'I suppose I had fallen into the trap of seeing depression as a weakness. And I assume that if I feel that about myself, other people must see that too.'* The construction of self, drawing on the mental illness discourse means coming to know oneself as abnormal, weak and inferior. Grace, for example, sums up this point with the comment: *'I just feel I am like a nutter... because of stigma and that... I just don't feel as I am worth the same as normal people.'*

Sam's account also shows the process of coming to know oneself as 'less important':

I felt like I was of lesser importance than everyone else. If I was just, you know, if I didn't have any work experience I would carry on feeling like I was just like an invalid stigmatised. I mean, how can you deal with that? Maybe it's the way I have been treated in the past so it's kind of still with me. Like they are normal and I am not.

This self-stigmatisation draws attention to how the research informants often struggled to maintain a feeling of worth and legitimacy in work. By taking on the stigmatised subject and internalising it as part of their self understanding, this can serve to reinforce the stigmatising discourse. So we can see how the process of self subjugating also feeds back the decision over: whether or not to declare a MHC and if so, then when, where and to whom.

Overall, the process of identification with the mental illness subject position is complex and influenced by a variety of experiences. While disclosure reduces the complications over the presentation of the self at work and duplicitous with colleagues, this process bears some costs and in many cases leads to a sense of vulnerability. At the same time that the declaration of the MHC, either at work or in other settings is therapeutic and an empowering process which reflects a claim for recognition and authenticity, other moments reflected the struggle over negative responses and the incorporation of stigma into the individual's understanding of self.

6.4. Concluding remarks

This chapter dealt with the dilemma over disclosing the MHC and the identification with the mental illness subject position. It illustrated the main theme of

concealment and ‘passing for normal’ and the costs that this process entails. This meant that no reasonable adjustments could have been requested in the workplace, putting the care of the condition firmly on the shoulders of the individual. The complex forms of subterfuge in work which accompanied concealment were also discussed, delineating how this often incorporated feelings of isolation from colleagues, psychological strain and a sense of inauthenticity.

The second part of the chapter examines the decision to declare a MHC and the consequences this has for the individuals’ sense of self and employment. It delineated the benefits and costs of workplace disclosure and the broader implications of identifying with the mental illness subject position—thus overall illustrating the ‘pleasures and pains’ within this process. The therapeutic essence of disclosure was discussed at both work and non-work settings and was shown to be an important aspect of the informants’ health management. The next chapter builds on this final note. It illuminates those practices of self-management at work in a way that illustrates further matters of identity construction as well as the attempts to challenge, change and rewrite the prevailed view on the mentally ill subject position.

Chapter 7 – Agency, resistance and self-management

7.1. Introduction

Chapter five illustrated the way in which the discourse of mental illness contains within it a mentally ill subject position that is not only presenting a devalued and marginalised identity but also operating to distance someone with a MHC from the subject position of the fully functioning, committed and performing ideal worker. Following that, chapter six explored the discursive and material dilemmas over declaring or concealing a MHC at work. It was shown, in particular, how declaration has benefits in terms of feelings of authenticity and being open with work colleagues, while at the same time serving to reinforce the ‘mentally ill person’ subject position as someone who is less capable of thriving in work.

This final empirical chapter moves on to consider practices of agency, resistance and change of meanings within the mental illness subject position as they were presented so far in the previous two chapters. The engagement of the informants with agential practices bears a specific importance given the fact that most of the informants did not disclose their MHC at work. Thus their engagement with agential acts which helped them to self-maintain their wellness and thrive at work was critical.

This chapter addresses these issues. First, section 7.2 shows how, through practices of ‘self-management’, informants resist the mentally ill subject as passive, weak and dependent, to present a more empowered and knowledgeable self. This resistance arises from drawing on the alternative discourse of mental health management, found in chapter 3. Second, section 7.3 considers resistance through recrafting of the stigmatised subject position by introducing alternative and positive meanings into the discourse of mental health at work.

7.2. Self-management and the agential self

As was set out in chapter 3, self-management takes the view that patients are the experts of their own bodies and minds and are therefore best positioned to manage their own health conditions, drawing on appropriate knowledge to gain new skills and feel empowered and in control over their health, in a way that they find best for them. Self-management challenges the passive subject position of the mentally ill person as weak and dependent, emphasising agency and self-control (Foucault, 1986). As the informants' texts in this chapter will demonstrate, by being engaged with practices of self-management and gaining the expertise to control their MHC within the different contexts of life and work, the informants were resisting this passive subject position. Self-management takes a number of forms. However, central to this practice are two issues: self-knowledge and the application of self-management in the context of work. These are discussed in the following section.

7.2.1. Knowing one's condition

Self-management, and the importance of understanding one's condition, was seen to be a critical act of empowerment for the informants. The quotes illustrate how the engagement with self-management emphasises taking control, being responsible to self-medicate, and gaining the expertise to know the condition, as well as the best ways of managing it. In doing so, a distance is established between the subject position of the passive patient and the empowered individual taking control of their life. Given the individualised response brought about through not having access to organisational support or not declaring the MHC to the employer, self-management was critical in order to maintain continuity of both good health and employment.

The different techniques applied to self-managing, such as self-management courses, self-help groups and books, alternative healing methods, mood diaries and

the regulation of thoughts, as well as any other intuitive techniques (such as 'mental workouts' or controlling the voices in one's head) are all evident in the accounts, as is the elevated awareness and the self-expertise to control the MHC. Crucially, engaging in practices of self-management of the MHC as an active subject position enabled the informants to maintain wellness and sustain their employment.

Diagnosis is the first step to self-management. Tony argues: *'I wish I would have had a proper diagnosis then [when he was working for 18 years for a large telecommunication firm]. It would have changed the course of my life.'* Chris was also *'relieved to be diagnosed 'cos I wondered why all the stuff that had gone on through my teen age.'* Bruce points:

I have been kind of using every element of the skills as I have learned, in a sense, over the years, to try and manage this, what's happening to me. But I didn't know what it was, to be honest. I didn't know what it was. Only in retrospect did I realise that it was depression and that these are symptoms of depression.

Tony, Chris and Bruce comment on the importance of being diagnosed as the first step to self-management. The need for self-diagnosis is illustrative through the quotes as crucial for taking on the active practice of self-managing the MHC and for the interviewees working lives and maintenance of continued employment. This is reflected through the text of Martin who talks about his employment history:

I didn't have a job for longer than 3 years. After 3 years it used to get very stressful and I ended up leaving the job because I was ill. I never knew. I know what it is now because I suffer from the bi-polar and hopefully in the future I will be able to spot the signs and deal with it in that way.

Likewise Tony comments:

Well I worked for 20 years without realising that I had the condition. I would go into work and I didn't feel well but I wasn't sure that there was anything wrong with me like anxiousness or not being worthy to do the job... I did suffer from depression and more emotional issues but I didn't realise there was anything wrong... I just thought that everyone else are just the same as me, that there wasn't anything wrong with me

Followed by the recognition/diagnosis of the condition, self-management is strongly associated with taking psychiatric drugs. Glen recalls: *'It was a hard struggle. I think I am a lot better now with medication. I thought I might as well take the tablets and have quality of life. I went through a period when I didn't take the tablets. It's quite hard to accept that you have an illness.'* Tony also argues: *'It's [MHC] always there because I need to take tablets every day so I don't forget.'*

The relationship between the physical act of taking psychiatric drugs and identifying with having a chronic MHC appears as a part and parcel of the process of acceptance, commitment and self-management of the illness and is by no means a straight forward process of compliance with medical norms. Rather, as this discussion will reveal, it is a reflection of an active practice of self-controlling and of ensuring continuity of good health, essential for the working lives of the interviewees. At the same time however, the uptake of psychiatric medication carries a stigma and also the struggle of having to cope with its side-effects.

The informants reflect on the way by which the actual physical act of drug taking has both physical and mental side-effects: *'it was medication hell'* (Tony); *'the doctor put me onto lithium (a popular medication for bi-polar) but I didn't feel that it was me'* (Martin); *'that medication I had from the hospital, I felt very stigmatised about it.'* (Cliff); *'the side effect of the Olanzapine [a popular medication for bi-polar], I put on loads of weight so I had self-image problems and self-esteem which led to depression really.'* (Fred).

As Beth comments on her own medication:

It's anti-psychotic, but it's also a tranquiliser, it slows you down. It slows your brain down. It slows your muscles down... and there are a lot of people who take the medication and they cannot exercise... It's very unhealthy as well, you know, to take medication and you feel low as well... But then I have to take medication, and I do take medication.

Thus, the emphasis is on taking control; self-medicating and deciding when to do this, involves the application of skills and expertise to come to know the condition and identify with the need to regulate it. As Chris comments: *'I have been doing that for years. I self-manage myself by taking mood stabilisers, anti-depressants. I have got a cocktail of those at the moment so it's finding one that works to get you up to a level where you can function.'*

Likewise, Fred describes how he is particularly skilled in knowing his illness:

I tend to feel lower, more down in the winter. So I think I pre-empted the winter, and thought: 'Right, I am going to get down,' feel myself coming down so doubled my medication. So I can feel less down which is really great. I pretty much do it myself. I do let my people know, my psychiatrist knows, my CPN [community psychiatric nurse] knows that I am doing that. I can self-medicate pretty much, which is because I know my condition.

For these informants, self-management thus represents self-expertise and self-knowledge. They present an identity of individuals who are in control of their condition. So that self-management involves identifying and accepting the MHC; committing to self-management with psychiatric medication; taking responsibility for, and gaining the skills and expertise to, self-medicate. Crucial to effective self-management therefore is self-knowledge and this calls for skills in self-reflection, awareness and understanding. James, for instance, describes the move away from

'punishing yourself for your own condition' to self-managing his MHC through self-expertise. He recounts:

I have dealt with it for so many years now I feel like I am an expert in what it is, what it feels like, what is obsessive, what is not obsessive. And identifying what is probably is an obsession even if it feels very real. So I am getting better at that all the time.

This continued process of improving the self-management of one's MHC is illustrated also in the text of Fred:

I am trying to better myself and make myself more healthy, and I have done. I think that my condition is improving year upon year. It really is and I am seeing the benefits. I feel differently, you can actually look out for yourself more, which is good, and you learn not to feel that way, sort of. I think there is almost some Darwinian thing we are evolving to not feel down. Your body is saying: 'now I have learnt it' and your mind is saying: 'now I have learnt it from that'. I think I have done that definitely.

Whilst self-management of the ongoing MHC often entails learnt, accredited and medically recognised tools, it also involves intuitive methods of becoming one's own expert in their knowledge of their own MHC. James observes:

Your brain will tell you: 'well if you don't think about it, someone in your family is going to die.' And ignoring thoughts is pretty frightening but you've got to because it isn't real. If you are put in a sort of stressful position, you know, it's like going to the gym, its burning agony but you know in the longer term you'll see the benefits. You are doing it for a reason so I am applying that to my mental state... I suffer from a huge mental disorder which I find impossible to deal with really. I can, on a day-to-day basis, break it down. So it's not something I have had to learn: 'this is how you deal with OCD [Obsessive Compulsive Disorder].' It's something I have to trust in and it's kind of instinctive, a bit more than learning something.

The numerous practices and learnt methods used for self-management are further

illustrated by Chris:

If I have got a high mood then I make sure that I don't go out and socialise too much, I try not to drink too much, I try and do boring things. Depression on the other hand is much more difficult to control so if it's not too bad I just sit through it, I don't push it away. Distractions are good ones. Spending time with people and trying to get out of the house. Regulating sleep is probably one of the most important things. I had a series of counselling sessions. I monitor my thoughts a lot of the time so I know quite quickly if I am thinking quite negatively and then I'll take action. So I have a whole range of things from the general, you know, the breathing and the meditation, all the way up to anti-psychotic medication basically. So in terms of self-management I am quite advanced. I think that's what kept me well for years, having an action plan when you see warning signs, learning to relax, learning to pace myself. More tools are problem-solving skills, support network of family and friends and professionals. I got a lot of insight into the illness. I know what the triggers are; I know what the warnings are.

Continuous practice of self-management, thus involves both the acceptance of the illness but also the strong commitment and determination to improve one's circumstances. Chris continues:

I am not willing to, I tend not to be willing to accept the illness, I want to do something about it. But I accept the illness 'cose that's part of living. But I don't accept that I'll always be very ill you know. I am sort of quite determined that I can help myself.

The attempt to lead a balanced life with minimal interference from the illness, therefore, illustrates how the informants bring new meanings of self-control into the mental health discourse, their working lives and their identities. As Bret sums up: *'As you educate yourself and learn about the condition and learn about who you are and time goes on, you can improve your situation'*.

7.2.2. Self-management and employment

It is apparent from the texts that all these practices of self-management had a critical impact upon the working lives of the informants. What is also apparent is the way by which self-management was practiced at work to ensure a delicate balance between continued wellness and sustained employment. Practicing self-management within the work environment is complex. This was even more so the case given the individualised response brought about through not having access to organisational support or not declaring the MHC to the employer. The challenge of self-management is compounded by the need to maintain wellness for sustained employment. Nonetheless, the informants also emphasise the need to employment as part of this self-management. Sam says: *'If I wasn't working, if I was just you know, if I didn't have any work experience, I would carry on feeling like I was, just like an invalid.'* Likewise, Roger highlights the importance of work for his self-management:

If I wasn't working now I would probably feel depressed; and I was depressed then, when I didn't work because there is no meaning to your life. I always believed that manic depression is best treated by me working full time. It gives me structure in my life, less time to think about things, and of course more money. And of course because I live on my own, I socialise at work, I think it gives me purpose in life. I tend to stay in work because when you are not in work things tend to fall apart a little bit then.

Glen similarly recounts:

It's good to be at work really. I get my self-respect type of thing. I feel much better now coming to work rather than having nothing to do and sitting at home all day. It makes me feel better when I am holding down work. I get on with the people I work with, even when it's not a perfect set up for me, I enjoy it. You know I still get, like, down moods and anxiety, and don't want to turn up to work and stuff, but I sort of grin and bear it, drag myself through it type of thing.

Work provides an important resource for informants' self-understanding and self-management: they gain a sense of value, purpose, and benefit from a structured routine, income, and the social interaction that then helps them to self-manage. However, for many of the informants the engagement with work and the performing worker subject position involves struggle. At the same time that their engagement with their own self-management created a platform from which the informants were capable of maintaining a subject position as performing workers, many felt the pressure to over-perform in order to prove their value as employees.

James refers to this as *“sheer hard work”*. *Just absolutely I feel like working twice as hard as anyone else in the place to achieve the same level of output.* Similarly, Martin comments: *‘I probably wasn’t well all the time but I still didn’t have any days off sick.’* Melanie likewise observes: *‘My line manager happens to be very open minded and very open to work with me and I think they see that a lot of people with disabilities actually work harder than other people.’* Chris comment: *‘The people I worked with really liked me because I used to work so hard.’* Hard work, demonstrating commitment and selfless dedication, is seen as a necessary aspect for self-managing and performing at work.

However, certain employment settings appear as more constraining, heightening the need for self-management whilst restricting the opportunities to do so at the same time. Still demonstrating their unfettered commitment to work, the informants' texts also illustrate struggle to endlessly over perform and the excessive pressure involved. Martin reflects:

I look back on periods in my life and stress seemed to be the trigger. Usually, after a couple of years or less, I will probably find stress where I am working. Sometimes I arrive at work and the anxiety will cause me to be sweating. It's not very nice. I try things with my diet and exercise and control, getting as calm as possible before I get there, and then when it's over I feel quite a relief. It's quite tiring I suppose... I wasn't expecting such a good job or such a high-powered, stressful job, which is part of the problem. I am hoping that it either becomes less stressful over time when

I'm more used to it, or if it gets really bad I'll have to say: 'Is there anything else you can give me?'

Like Martin, the text of Roger also points to his engagement with the continuous demand to perform whilst demonstrating simultaneous struggle to deal with excessive pressure:

The first year [of working for his current employer] was exceptionally stressful because we were on a small team and we were taking quite a lot of calls. We had five calls waiting continuously all the time and we would always answer the phone. And you couldn't deal with the files between calls 'cos other people were coming through... That's why I was very ill after 18 months. That could have possibly triggered something. Even though there are targets now, because I am used to the job, they are not so bad for me really... I don't mind pressure. I don't think there is anything wrong with pressure. Pressure can help you to work, it structures your day and I don't mind a certain amount of pressure. It's when it's an excessive amount of pressure when it becomes a problem.

Although complying with the demands of work and maintaining their subject position as performing employees, a number of the informants illustrated their resistance to this subject position at times when the unfettered engagement with work performance did not allow for sufficient self-management. Chris recounts:

I was doing quite a responsible, busy, cognitively difficult job; management consultancy is difficult, that's why it pays so much, and also doing a master's degree at the same time. My cognitive ability was fantastic... my work ethic was 'work as much as you can, earn as much money as you can and go crazy on the weekend', you know. And live that sort of busy life style, if you like: work hard play hard. I can't do it because of my mental health condition. It's not something I can really do, it doesn't work for me... I'll never work in a stressful job again and if I find myself in a stressful job I'll leave it, 'cos I know the consequences and they are: once you get to that position, that's a few years of your life gone, you know, to recover from it, if you do recover.

So we can see how although the informants are being engaged with excessive commitment to highly demanding roles, they also demonstrate resistance to this very same subject position when the need for self-management is being violated by these work demands. A number of texts highlight how in those instances, the engagement with self-management may overtake the unfettered commitment to thrive at work. James comments on how his resistance to the excessive demands of work involved with becoming a fully qualified architect. Resulted in him prioritising his self-management and thus deciding to remain at the part-qualified, assistant level for the past eight years, he argues:

If I am going to be a qualified architect, I'll be expected to perform to that standard every working day, and then to manage others and I am not feeling good myself, I am not sure that I could even fulfil that role. So the whole thing is to put everything on pause, because of these two aspects I guess. The first one is the extra layer of work in my life [to complete the degree and get fully qualified whilst working full time and managing his MHC]. And the other one is what happens when I actually finish? I'll have a huge amount more responsibility than I have got now when I am struggling already.

The quotes thus illustrate resistance to the performing worker subject position when self-management becomes an alternative resourceful subject position. A number of texts also illustrate how the meaning gained from self-management and the engagement with other subject positions recount the meanings gained from living up as performing workers. For example, Chris's account illustrates how his identity as a volunteer and part-time worker, and the sense of purpose gained from exploring his spirituality, are not only essential for improving his self-management, but also illustrate resistance to the performing worker subject position:

That [facilitating and evaluating mental health self-management courses] gives me a purpose and keeps me busy and keeps me involved really. So yeah with the cafe and the charity work... after working and being in a corporate environment I am quite happy to go in the direction of hippy for a while and explore my spirituality.

For Fred, the benefits gained from playing in a band, running a mental health self-management course, getting married, and being a father provide him with a set of resources for the construction of a legitimate self-understanding and the continued practice of self-management:

It's nice to feel responsibility, and that's what I thought I was lacking from before [in his employment]. And this is why I, sort of, find my vocation [running mental health self-management courses], which is really good yeah... I know that I have been let down by the world of work generally speaking and I haven't really find my niche but I think I may be a good Dad. I love kids and I just know that I'll make a great Dad and you know. And if I could do that for a couple of years whilst the kids are young until they start school or whatever then I think I'll manage that, I'll really enjoy that.

Similarly, Tony comments:

You struggle along doing jobs 'til you weren't able to cope. So you had the condition for a long time. And you have got to compare yourself to other people and say: 'Hang on, I am not in a bad position.' I have got my own house, I have got my own car, I am not in financial trouble, I have got a circle of friends, so yeah, I have to say to myself things haven't turned out bad after all.

Although expressing resentment towards the performing worker subject position and at times even giving up some of their employment potential and advancement in order to maintain their self-management and engage with other aspects of life, identifying with other subject positions confers on the informants a sense of resourcefulness which was supportive of their self-management. Thus the engagement with self-management suggests an active self where the informants feel they can be agents for positive change rather than being stuck in a passive subject position.

So the practice of self-management allowed the informants the wellness to engage in continuous employment and to maintain a subject position as performing employees. Equally however, self-managing also gave the informants the resourcefulness of a significant subject position which at times recounts the dominancy of the performing worker subject position in their lives. Nonetheless, as opposed to the pejorative subject position of the mentally ill which we saw in the previous chapters, the resourcefulness gained from self-management as a salient subject position demonstrate an embracement of the mental illness subject position.

Thus through the dalliances of resourcefulness and resistance to the performing worker subject position, we can see how the engagement with self-management has a crucial part in the identities of the informants, both as a discursive device but also as an agential practice. The section below now moves on to more radical responses of resisting the mentally ill subject position. The discussion illustrates how these responses are incorporated into the mentally ill discourse in a number of ways. Normalising the mentally ill subject position; embracing the MHC as a positive identity source and rewriting of meanings within discourse of mental health and illness at work.

7.3. Rewriting mental health at work and the stigmatised subject position

The second theme of the chapter illustrates how, through certain practices of public disclosure and mental health promotion at work, the informants illustrate their resistance to the stigmatised subject position and attempt to change and rewrite the meanings surrounding mental health at work. The chapter concludes by highlighting how the facility to reshape the meanings of the disempowered subject position within the mental health discourse creates new and positive images and attitudes toward mental health at work.

Whilst the previous discussion illustrated how practices of self-management allowed the informants to engage with an active agency to stay well and maintain work, the discussion in this section illustrates a more radical attempts to rewrite positive meanings into mental health and into the stigmatised subject position. This involves 'taking on', and embracing mental illness, as a way of resisting the stigma so as to legitimise and normalise mental health at work.

7.3.1. Normalising mental illness

One form of resistance can be seen in the attempts to challenge the special status afforded to mental illness as a putative identity category. Here, we see attempt to 'normalise' mental illness. For example, as Chris observes:

People with manic depression are not mad. They are normal people who have a health condition like anybody else. I mean people have chronic fatigue, lupus, a dodgy leg. I think most people have something wrong with them. There are so many conditions out there, what percentage of people are really well? But while bi-polar is a chronic condition, you'll only actually be ill for certain periods of time. So I had a period when I was 19. I have a period now. And in between I will be a normal functioning member of society.

Likewise Fred refuses to be defined by negative attribution surrounding the illness:

I am very open about my condition. I don't see the shame in it. But I wouldn't like to take necessarily all the bad crap, you know the jargon 'oh he is a nutter' or 'he is', newspaper tabloid stuff, you know. Like all the negativity surrounding the illness. I wouldn't like to take that on-board I wouldn't like that to define me as a person.

Ironically, despite the tabloid press being singled out as perpetuating the negative stereotypes about mental illness, the media is also identified as playing an

important role in contributing to the emergence of a counter-discourse around mental health. Chris argues that *'bi polar is pretty much being de-stigmatised now'*. In particular, the resistance of well-known public figures have been very important, according to the informants in challenging the negative discourse circulating in the tabloid press. Chris comments on the importance of celebrities' disclosures in shaping the public's judgment on mental health: *'Stephen Fry has come out but he is obviously well respected already because of his job in TV. So that does make a difference to people's judgment.'* Tony expands:

It's not nice that anyone has suffered stigma or been treated unfairly because of the illness but recently the fact that a lot of famous people have stated, such as Stephen Fry stated: *'Oh I suffer from bi-polar,'* I mean, it makes the general public think: *'Oh he has got bi-polar but look at him. He is a successful person. He has got a job; he is doing a lot of things on television. He is very, you know, so it can't be that bad.'*

Disclosure by celebrities thus feeds into this counter discourse on mental health to present it as merely an illness and no more. Melanie explains the extent to which this factor is crucial. She says: *'I hope somebody does for schizophrenia what Stephen Fry did for manic depression. I think that needs to happen.'*

However, some informants, rather than denying the subject position as salient or relevant to their lives are seen to embrace it and assert a strongly enhanced and advantaged self by virtue of the experience of mental illness. Here it was argued that having a MHC provided a source of special knowledge and a particular unique 'voice'. A number of interviewees referred to their special skills gained from the management of their MHCs and the experiences of living with the condition as well as the specific features linked with MHCs. Having a MHC is seen as a life-challenging experience and also one that leads to special skills of reflexivity. Moreover, it was seen by some to lead to greater creativity and empathy.

Some respondents argued that the life challenge of living with a MHC meant that they had developed unique skills and insights, which were of benefit to themselves and in their work. For example, Chris points to his coping skills, derived from maintaining work and staying well: *'I don't see my manic depression as an illness; I see it as a challenge, when I try to get the best out of it really. So I'd tell people that have a wider perspective of what life is, about it.'* Fred argues:

I am pretty strong character, you know. I am a tough cookie. So I can be weak, tearful but that's part of the condition, but I am a strong character. I think sometimes, I don't think they [friends/colleagues] realise how strong a character you are, because they don't have any reference, because they never suffered from it themselves.

This emphasis on having special skills and the mental toughness present a strong contrast to the mentally ill subject position discussed in Chapter 5. By positioning their experience of coping with their MHC as a life challenge and as a struggle that needs to be recognised, both Chris's and Fred's accounts challenge the stigmatised mentally ill subject position and introduce positive and empowered meanings into their identity. Jo takes this argument further by suggesting that those with a MHC are particularly resilient in the workplace, able to deal with the demands of the job while self-managing:

Stress sometimes seemed a weakness as well, that people should manage themselves better. And I am probably guilty in that point of view, because I think 'well if I manage it everybody else should manage it'... It's about having the responsibility... so I tend to take a couple of days off a month mainly for study but so that I am not doing weeks and weeks and weeks without a break.

Similarly Melanie argues:

Employers probably need to be able to learn from people with mental health conditions. Because we are quite self-aware, we have to be. So we probably understand ourselves because we have to be self-aware. So we are probably the right people to be looking at work patterns and so on.

Their presentations of self in these accounts stand in a sharp contrast to the self-stigmatised constructions shown in the interviewees' accounts in the previous data chapters. In addition to emphasising the importance of these skills for their own employment, it is suggested that the informants' self-management skills can also assist in developing this in others. This different but advantaged self is a position more likely to be associated with certain types of MHCs, notably bi-polar disorder. Reflecting wider assumptions about the condition within the media Fred recounts: *'I am very creative. I mean a lot of creative people are bi-polar... I mean there are benefits there, but you need to learn to control, to harness them. And that take a lot of skills and a lot of insight to yourself. So at the moment I am writing a lot.'*

In a similar fashion Tony states:

I read so many good books on bi-polar. A book called 'You Don't Have to be Famous to Have Bi-polar, But it Helps', I mean lots of philosophers, artists, I read in a recent article, some director said: 'You have to be something or someone to get into Hollywood? No. You just need to be bi-polar.' 'Cos there are so many actors, so many creative people are bi-polar, that people with bi-polar will tend to be, they either very ill, or they are very creative and live a very different life. They don't live a regular life.

The embracement of the creativity attached to MHCs is a positive identity source. By drawing on the lives of people with MHCs as different but positively so, we can see a move away from viewing one's 'difference' as stigmatised into viewing it as a unique 'advantage' which can benefit the employer and is equally empowering for the individual. Overall we can see how by embracing the meanings of creativity, self-awareness and unique experience, the informants introduce new meanings

into the mental health discourse and a counter discursive move. Building on this counter discourse, they also present the case that rather than being less productive workers, they have special skills and insights which can be advantageous in the workplace.

The discussion so far has highlighted two ways in which the informants in the study challenge the discourse and subject position of mental illness. These have thus far focused on the individual level. In the section below, resistance at the organisational level is examined, in a way that both legitimises mental illness in the workplace and embraces disclosure as an act of self-care.

7.3.2. Disclosure, self-care and the organisation

Public disclosure is an act of resistance, challenging the stigma and secrecy which is often attached to having a MHC. In addition, public disclosure is an act of generosity, encouraging others to discuss and be open about their mental health experiences. Those who declare see themselves as champions and pioneers. Patrick recounts: *'A lot of people I talk to, say: "oh I think my wife got that", or "my friend's got that" or "I think I have got that as well", when you have a little chat.'* Melanie comments:

It didn't occur to me that I could talk about it. And I think that just makes it worse for the next person who assumes that they can't talk about it. So I think that for everybody who does speak out, it will help other people... I do find also that quite often a lot of people tell me about their own conditions or about their own experience of it. So people will say 'oh my daughter', or 'my sister', or 'my son', or 'my mum', or whoever or 'my dad has had depression', or something. And they'll tell me about it because they'll know that I'll understand about it. So I do quite often get people disclosing things to me... so people kind of tell me of their own experiences of breakdown or mental health problems.

By publicly disclosing in a number of localised settings, such as self-help groups or other contexts within the environment of friends and acquaintances, the informants strongly identify with the MHC as a legitimised health condition, thus resisting stigma. Disclosure as an act of generosity and sharing is recounted by Bret:

I am very open person, you know, I don't force things down people's throats but if somebody says, you know: 'What are you?' I just say, you know, 'it's bi-polar, manic depression', whatever you want to call it. I have got no problem with being, you know, having a badge on me (laughter). I think it's part of me. Why should I hide away? I am not a freak you know; I have got a condition. And then if I see other people and then I think if I gave them a bit of insight and knowledge, maybe that'd save them from going through some of the things.

So we can see how by publicly disclosing their MHCs, the informants recount the mentally ill subject position and attempt to legitimise it so that others could share their experiences and knowledge and be supported. A number of the informants have taken disclosure to a more public setting to open up the discussion on mental health and to encourage other employees to talk about their own experiences. For example, Melanie comments:

Now I am sort of happier for it (disclosure) because now I am more unconcerned if you like and I have got work. I get on with people and feel good where I work and encourage people to talk about their invisible disabilities. If somebody got a wheelchair it's obvious isn't it that they are disabled and people accept that. But if you have got something mentally wrong it's invisible and nobody knows about it and they are not aware of what you are experiencing. And if it was just made the same, it was just as acceptable to everyone... I am just setting something up so that more people involved in appraisal can kind of encourage support and disclosure about mental health and invisible disabilities if you like. So I am just gradually putting feelers out there and hoping people will come forward. It's because I know that there are some people, there are 7,500 associate lecturers and I know that some keep their diagnosis to themselves... I think it's wrong that lecturers should feel that they need to keep their disability secret because if we'd supported them they could do their job even better. I put a letter in our work newspaper, so a few people were interested in

that. And I thought about setting up a forum for tutors with disabilities and invisible disabilities. And I just wonder. I have got this theory that it might be the tip of the iceberg.

The accommodating responses and organisational support Melanie received with the management of her MHC, as well as her secure employment situation, led her to encourage other employees to share their own experiences of illness. Similarly Bruce, a partner in an international corporation, states that his personal experience of a MHC motivated him to encourage other employees to come forward:

If it happened to me then I suspect it happens to an awful lot more people. And understanding that, kind of, one in four people some time in their life will have it [mental illness]... Because I have been treated very well on my return, you know, I was very engaged with the firm. I won lots of work, and I have done that mainly because I feel so good about the place. So that led me to think about what I could do to make it even better here, and potentially also, with other sorts of organisations, to get that awareness culture. If more people were prepared to talk about it, then I might have recognised what was happening to me [depression episode] earlier, and colleagues may have recognised it, and we may have been able to, through that awareness, instead of me going, basically falling off an edge and having three months off and really going... If we could get more onto the front foot around preventative, awareness-raising issues.

Bruce and his colleagues have been putting into place a large organisational campaign which they named 'mental health champions'. He explains:

We came out with the idea of mental health champions... that initiative is quite ground breaking. And what we did was to identify a number of senior partners, not necessarily who's suffered from mental health issues themselves or not, I don't know, but who were interested and prepared to put themselves forward to the firm publicly as a mental health champion... This is like a big step forward, that it's all right to come and talk. And then when that person [employee] comes and talks to you, I mean, it's just to give them two messages: 'You are not the only one, and it's not the end of your career, you think it is, don't you?' [Laughter]. And the third thing: 'Here are some people you can then go and talk to which we have got within

the firm...' It's very powerful to be a senior who knows the business and saying these things... it's a big demonstrator that there are senior people in the firm on the right direction... to legitimise, to give people confidence that there is support... by saying that we are doing this, means that actually there is a proper business reason to treat people better in this way. And you are actually irrespective of you know, the human kindness element put that to one side, it will be better for your own business. That's the point I always wanted to raise. It's better to your own business to do this.

Bruce raises a number of issues, all related to the attempts to bring change, rewrite meanings within the mental health discourse and resist the stigmatised subject position. What is also apparent in the account is that Bruce utilises his senior position in the firm to help less senior staff who struggle with mental health issues. Given his senior role, Bruce's disclosure of his condition throughout the organisation may have been easier than it would have been for someone in a less advanced position. However, Bruce utilises this position by making clear that the aim of the organisation is to encourage employees in all career stages to come forward. His text recounts the mentally ill subject position by saying '*you are not the only one, and it's not the end of your career*', referring both to the marginalisation and to the stigma attached to mental illness. Bruce also raises the 'business case' for campaigning mental health at work, linking the performing worker subject position with the awareness to mental health.

Similarly Cliff, a founder of a mental health charity, also uses his mental health experiences as a platform to promote mental health at work. Mental health campaigns supported by senior managers are presented as a powerful method for de-stigmatising the view of mental health in work organisations. Cliff says: '*Having high profile role models within the organisation is a good way of establishing cover for more junior stuff so that they can see there is a commitment and it doesn't affect your career in that way.*' The 'visibility' of senior managers in organisations is therefore heightened in his text as a way of promoting mental health and diminishing stigma. Cliff continues:

People who are prepared to be visible within the organisation... people who want to be a 'listener', who then can be contacted and identified by people who want to 'come out' within the organisation. And we have a fairly tightly defined engagement, where it's about providing reassurance: this is quite common, that the person is likely to get better, that the organisation will welcome them back if they take time off, and to provide a personal account of how the individual is being supported and able to continue working, in their own experience.

Disclosure by senior managers within the organisation provides reassurance, comfort and legitimacy, according to Cliff, and as such it encourages employees who are less senior in the organisation to come forward. Similarly, Bruce's and Melanie's texts convey how the visibility of senior employees as 'role models' within the firm is a useful method for promoting the move towards the embracement of mental health at work. Having 'role models' within the workplace to provide support and reassurance and encourage disclosure, contributes to the shift in meanings with the mental health discourse and the move forward to legitimise and open up the discussion on mental health at work.

Mental health training also contributes to challenging the negative discourse and can provide some movement towards strengthening of the counter discourse. Cliff, in particular, highlights the benefits provided by mental health training for line managers:

Helping line managers to respond positively and with awareness and intervene early if a colleague is unwell. And also to help them look after themselves. So it's about mental health promotion in a broader sense... the line manager isn't being asked to do anything other than be a good 'listener': to facilitate access to support and to direct the person to that support. It's not trying to become a psychiatrist, counsellor, or social worker.

Bruce explains the importance of mental health awareness at the managerial level as a good practice of self-management at work:

We're starting with the managers training which is going to be rolled out. So moving into kind of personal awareness of helping people as individuals to manage their own mental resilience, be more aware of when there are problems that they are facing.

So we can see how apart from assisting in dealing with mental health issues, mental health awareness at work also helps employees to become more mentally resilient and thus more productive. Attempts to incorporate this practice into the ordinarily working lives then both legitimises the presence of mental health at work whilst providing employees with tools to manage their mental health or MHCs. This point is further discussed in the text of Kerry, who works for a large mental health organisation. He highlights further the benefits of mental health training in the organisational context, by saying:

The organisation may have trained you because their focus was: 'We want to look after you, we want to ensure you can look after yourself. And we want you to look after your colleagues.' Other organisations are saying: 'This can save us money. It's going to stop people turning up and just being present. It's going to allow us to support them better. But the benefit to our organisation of this investment is that we will save money. Save hours. Save time off on the sick...' I think everyone that's been on the course [mental health training] is taking something away in terms of: 'Yes, I am not very good at doing that when I am stressed and I think I need to look at that myself,' so you become more aware.

Methods of early intervention and support, and mental health training thus exemplify 'good' self-management within the organisational perspective. By increasing the awareness of mental health, providing care and support, we can see the move away from a passive organisational approach to an active one. Thus not only dealing with illness and MHCs, but rather recognising the 'business case' for embracing mental health at work in a way that repositions the 'productive worker' as someone that also has good mental health awareness.

Thus, these respondents are presenting disclosure as a positive benefit not only for the individual but also for the organisation, making a case for championing mental health at work. Doing so offers, they argue, increased commitment to the workplace as a response to being cared for by the organisation, as well as reductions in the length of absences from work. Through rewriting the mental health at work discourse, these respondents are attempting to normalise MHCs that, if embraced and accepted, can be beneficial to the business.

Overall we can see from the individuals in the study attempts to embrace and legitimise their MHCs, to bring new meanings to the mental health discourse and to oppose and contest the stigmatised mentally ill subject position. New positive meanings for the mental health discourse were achieved through: embracing the MHC as a beneficial experience, a workplace advantage and a positive identity anchor; practices of public disclosure; and championing mental health at work. These new meanings legitimise and open up the discussion on mental health, bringing together the interests of the individual and the organisation. At the same time, however, the individuals' accounts also illustrate how disclosure and mental health awareness are generous practices which aim to help others, share experiences and, provide support.

7.4. Concluding remarks

This chapter introduced aspects of resistance and agency into the mental health discourse. The chapter illustrated how self-management is a significant aspect of informants' lives. It provided a sense of an active self to maintain wellness, and sustain employment, as well as a resourceful subject position within their identity construction. Equally, the chapter highlighted a more radical form of resistance which pointed to attempts to rewrite the meanings within the discourse of mental illness. Disclosure and mental health awareness as practices of health management were constructed as forms of resistance which addresses both health care as well

as the societal legitimacy of the mentally ill subject position and within employment discourses. The 'business case' for embracing mental health further suggests that mental health awareness is an essential skill for 'being a productive worker'. In the following chapter, a summary of the main findings of the study is set out, followed by a discussion of the contributions.

Chapter 8: Discussion

8.1. Introduction

In the previous three findings chapters, the work experiences of people with MHCs were explored, focusing on how this affected their self understandings and their daily lives. Specifically, the analysis focused on how individuals negotiate meanings around mental illness, throwing light on how prevailing discourses of mental health and employment affect—and are affected by—individuals with MHCs. Three broad areas were examined: the meanings within the discourse and associated subject position of mental illness; the struggle to reconcile the mental illness and ideal worker subject positions and the associated dilemmas around concealment and disclosure; and practices of resistance through challenges to the negative meanings of mental illness. This analysis has been inspired by critical poststructuralist (Hassard and Wolfram Cox, 2013) thinking on identities, particularly the ideas of Foucault (1982; 1986).

The study asks three interrelated questions: (1) What is the relationship between an individual's notion of self and the discursive resources available to them in constructing their identity? To what extent does their MHC influence this construction? (2) What are the paradoxes and struggles experienced during the attempts to secure employment and a legitimatised identity at work? (3) In what ways do individuals with MHCs take on, resist or challenge the discourse of mental illness in the workplace? The study has been conducted during a period of financial constraint, growth in unemployment, and a prevailing discourse of austerity, with demands for employees to do more for the same rewards (Costea et al., 2012). Concurrently, the study has been executed in the context of the widespread and growing prevalence of mental illness worldwide (WHO, 2007). Thus the increasingly competitive and pressurised experiences of work, together with the prevalence of mental illness emphasises the importance of understanding better the employment experiences of individuals with MHC, for the wellbeing of not only the individuals

concerned, but also for wider society and the long term effectiveness of work organisations.

Moreover, the study also has a political focus in that it wishes to improve our understanding on how the stigmatised subject position of the mentally ill person might be challenged and changed. Therefore, a focus of the analysis has been on how individuals with MHCs have resisted the negative subject position, and attempted to rewrite the meaning of mental illness, and with what effects.

In exploring these research questions, repeat interviews with individuals with MHCs were conducted over a period of eighteen months. The interview texts generated in the research provide the main source of empirical material for the study. These are accompanied by additional interviews with employers, mental health professionals and charity workers. Before discussing, in detail, the contributions that this study makes, the following section draws together the key findings from the three empirical chapters.

8.1.1. The mental illness subject position and employment

Chapter 5 examined the prevailing meanings and identities in relation to mental illness in society and, more specifically in work organisations. Interviews with the research participants asked them to reflect on how they felt mental illness was understood. The participants' texts present an overwhelmingly negative association with mental illness: the discourse promotes a stigmatised mentally ill subject, someone who is either dangerous or dysfunctional, incapable performing effectively in work.

The chapter considered the meanings around mental illness in society and the media. These were overwhelmingly negative. On the one hand, the language around mental illness was highly pejorative, based largely upon ignorance. The popular press portrayal of mental illness reinforced and perpetuated this, with talk either of dangerous ‘nutters’ and insane criminals, or suggestions that the claim to mental illness in work was often an excuse for being ‘work shy’. The lack of knowledge about mental illness and its often invisibility contributed to the public reaction of fear or embarrassment.

This construction of mental illness and the mentally ill then translated into the workplace, coming up against the putative high performing ‘ideal worker’, with negative meanings. On the one hand, the person with a MHC at work is viewed as sub-normal; someone who is incapable and unable to perform as effectively as the ‘normal’ worker, and requiring less demanding work. Conversely, the person is viewed as being non-genuine, lazy and work-shy. The analysis illustrated how the meanings of mental health relate to more than the illness alone, being a complex discourse carrying with it a stigmatised subject position that clashes with the productive worker subject. The ‘mentally ill worker’ is thus seen to either lack mental resilience or the necessary drive to be a fully engaged member of the organisation.

Chapter 6 then focused on the extent to which individuals with MHCs negotiate their identity in the workplace and to what effect. The chapter considers the extent to which informants ‘came out’ and disclosed their MHC. For some, the decision to conceal their condition at work was a necessary one, passing as normal so as to minimise their association by others with the stigmatised subject position. This concealment often involved complex forms of subterfuge. Not being one’s self at work, alongside not being able to explain absences or unusual behaviour, created considerable pressure and strain. Moreover, the individualised response brought about through not having access to organisational support exacerbated feelings of isolation.

Chapter 6 also explored the informants' decisions to declare their MHC. There were both costs and benefits from disclosure. Disclosure was seen to be beneficial in that it engendered feelings of honesty and the ability to 'speak the truth' about themselves when relating to their MHCs. This truth telling also connected with therapeutic practices enabling participants to feel more in control of their condition and in some contexts, be supported. However, there was also a cost to disclosure in the form of negative responses as well as self-stigma, arising from the embarrassment of their condition and identifying with the stigmatised subject position, leading to questioning over self and work.

The final empirical chapter, chapter 7, examined issues of agency and resistance. Starting with the idea of self-management, the chapter showed how an 'empowered and in control' identity is constituted from the contrasting mental health subject position of the self-managing person. Rather than being a passive 'sufferer', this represented a reconstitution of the person as someone who is skilled, knowledgeable and reflexive about their health. Thus through techniques of self-management, the participants expressed an active agency in relation to their illness, rejecting the passive subject position of the 'mental health patient'. The chapter also illustrated how practicing self-management was an act that enabled the interviewees to live up to organisational discourses and maintain a positive sense of self. At the same time however, when faced with excessive demands at work, self-management was a significant subject position and an identity resource from which the informants could also resist the ideal worker subject position. In those cases self-management also meant being able to resist the strictures of the ideal worker subject position and to be comfortable with not attempting to live to this ideal. The informants demonstrated the skill of maintaining a balance between employment and wellness in a way that enabled them to be positive about themselves and their role in the organisation.

Chapter 7 also considered how the discourse of mental illness was being rewritten at work. It showed those attempts to either normalise or promote mental illness as an advantaged position. Public disclosure was seen as a generous act by pioneering individuals which aimed to help other people with MHCs to come forward, together with other practices which aimed to increase awareness to mental health and to encourage disclosure at work. Through challenging and changing practices, a counter discourse of mental health emerged that presented mental illness as being both normal but also emphasising an important skill set of those with self-management expertise, and thereby emphasising their mental resilience and association with the contemporary employment discourse of emotional wellbeing and mental resilience at work (Business in the Community, 2013).

The remainder of this chapter will now turn to consider the contributions of these findings in relation to the three research questions of the study and related literature.

8.2. Mental health at work: a critical poststructuralist lens

The first research question asked: What is the relationship between an individual's notion of self and the discursive resources available to them in constructing their identity? To what extent does their MHC influence this construction? In addressing this question, the study aims to make a contribution to literature on identities in organisations, specifically the literature on identity regulation by (1) highlighting greater nuance to understanding marginalised and stigmatised identities at work, and processes of identification; and (2) understanding mental health and wellness at work. This is set out in detail below.

8.2.1. Studying mental health from a critical perspective

This exploration provides a contribution to organisation literature on identities in the context of mental health by giving a more nuanced understanding of the experiences of mental health at work and how people with MHCs construct an understanding of self and the discourses drawn on in the processes of identification. Thus far, the research exploring mental health at work and that concerned with identities in organisations has neglected to appreciate the identity implications of mental illness in work (Corrigan and Matthews, 2003). The dominance of occupational health (Honey, 2004; Tse, 2004; Leufstadius, Eklund and Erlandsson, 2009) and psychosocial approaches in research on mental health at work literature (Muir, 1982; Rinaldi and Hill, 2000; Manning and White, 1995), with an emphasis on positivistic, broad brush understandings of mental illness and identity, means that the potential insights from taking a critical poststructuralist approach have yet to be realised. Taking such an approach provides a richer, more complex pattern of individual experiences and how individuals with MHCs themselves engage in the co-construction of meanings, which are important for their working lives.

In particular, the research focused on the dynamics of discourses and the construction of the self, to illustrate how individuals respond in different ways to prevailing discourses on mental health at work. This allows for a better appreciation of patterns and behaviours of identification that goes beyond a broad brush image of mental health stigma and victimhood. Thus, while the literature shows the stigma of mental health and how this is played out in the workplace, and that individuals with MHCs tend to be trapped in low paid jobs (Marmot Review, 2010), what has yet to be appreciated is how employment is experienced by individuals with MHCs and how this is affected by different contexts, and in relation to different MHCs. Moreover, while the extant literature shows the impact of stigma on people with MHC, what is less understood or appreciated is how individuals with MHCs actively engage with the stigmatised discourses and with what effects. By taking a critical poststructuralist approach greater insights are possible over how individuals with MHCs might thrive in work situations, throwing

light on what strategies they might utilise in order for them to stay well and engage in full time employment and in challenging the negative associations of mental illness. The approach taken in this study therefore offers a new perspective into the practices utilised by people with MHCs in a way that embraces agency and resistance.

The study highlights a variety of responses at work, mediated by different MHCs, contexts, work situations, positions in the hierarchy, employer organisations and actual work undertaken. Rather than providing a specific pattern on how a particular MHC intersects with a particular work setting, the study shows how people with MHCs negotiate identity in a way that also suggest how change can take place in the future and how others in similar situations can better their own circumstances. The study thus provides a multilayer and multifaceted set of meaning construction around mental health and illness. By providing insight on the different strategies by which individuals with MHCs engage with at work and act upon a mental illness subject position, the study makes available new knowledge on how individuals with MHCs negotiate their identity in different times and places.

8.2.2. Mental health, wellness and performance

This study also provides a contribution to understanding how meanings around mental health and illness at work are regulated through normalising discourses in organisations and society at large. The analysis of the empirical material points to two main ‘problematic’ and interrelated themes in the regulation of mental illness within organisational discourse: health or wellness management; and the expectation for unfettered performance and commitment at work. These themes are indicative of a significant normalising discourse at work, namely the ideal worker discourse and subject position (Rose, 1988; Acker, 1990; 1992). The ideal worker discourse embeds within it the expectation that a good employee is

someone who is able to engage with commitment and performance to work, unfettered by any other non-work commitments (Kerfoot and Knights, 1993). This discourse can be seen as a 'master' discourse, which is also implied in other discourses circulating the workplace.

While the critical identities literature has explored identity regulation and control in organisations (Thomas, 2009) in relation to this 'ideal worker', and has also considered the specific challenges it presents for marginalised groups (Acker, 1990; 1992; Kerfoot and Knights, 1993; Meriläinen et al., 2004), little consideration has been given to its relationship with people with disabilities and long term illness (Foster and Wass, 2013), especially where such conditions are less visible (Beatty, 2011) such as with mental health conditions. Studies have shown for example, how those constituted within identity categories of gender (Acker, 1990; 1992; Alvesson and Billing, 1992; Meriläinen et al., 2004; Calas and Smircich, 2006), older age (Fineman, 2011) and race (Holvino, 2010), experience greater struggle in relation to the meanings embedded within the ideal worker subject position, these identities are all visible.

This study is concerned with a potentially invisible or concealed identity. As with sexuality, mental illness is often less visually apparent and thus presents the individual with a complex set of decisions over whether or not to disclose this aspect of their self. For people with a MHC, concealment, while protecting them from negative stereotyping that can expand the distance between their subjectivity and the ideal worker one, also results in the denial of workplace support, or to explanations for the inability to perform certain tasks, rendering them more likely to be criticised for poor performance. The study also suggests that people with other marginalised identities at work such as race or gender may face an even more complex set of constraints in their attempts to maintain an ideal worker subject position, if they were also to have a hidden stigmatised identity such as a MHC.

An additional constraint might be noted with the growing popularity of wellness discourses at work and the way that they accommodate illness or un-wellness. Whereas the wellness discourse has been critically explored (Jackson and Carter, 1998; McKinlay and Starkey, 1998; Thanem, 2009), drawing on the embodied nature of managerial regulation (Conrad and Walsh, 1992; Zoller, 2003) and the regulation of physical health, wellness has not been appreciated in relation to mental health. The analysis provided in this study illuminates how the discourse of wellness feeds in and reinforces the ideal worker subject position, which has specific and important implications for hidden identities.

The discourse of wellness promotes forms of societal and organisational regulation whereby a good employee is an employee who cares for their own health and wellbeing (Goss 1997; Haunschild, 2003; Maravelias, 2009; Dale and Burrell, 2013), thus reflecting a wider trend towards individualism in employment (Brown et al., 2000) and the individual's responsibility to maintain their own employability (Costea et al., 2012). This discursive regulation is seemingly very effective because a 'well employee' is considered a productive employee (Lupton, 1995; Koelen and van den Ban, 2004). In other words: *'[w]ell employees are physically and mentally able, willing to contribute in the workplace and likely to be more engaged at work'* (CIPD 2007, p.4).

The discourse of wellness however, is indicative of the potential struggle for the individual in times of un-wellness. Because the discourse incorporates the assumption that it is the individual who is responsible for their own wellbeing, un-wellness, sickness, illness or disability are then rendered stigmatised (Gabriel, 2008), as they are considered a failure at the individual level to stay well. This also reflects the refusal of the organisation to take responsibility for disability or any health issues even when caused, or triggered within the work circumstances (Abberley, 2002). These constraints in conjunction with the mandate to work longer and harder (Green, 2008) not only lead to the potential for far greater occupational stress amongst the overall working population (Green, 2001), but also

intensifies the struggle for employees who may have health conditions or forms of impairment (Foster and Wass, 2013).

Thus, given the normalising discourse of wellness (Lemke, 2011) working together with the ideal worker discourse, the individual with the invisible health condition faces greater struggle and potential distance from the prevailing workplace discourses relating to employability and performance. Given that illness is not only seen as something that interferes with performance but also as an individual failure to care for health, the pressure not to disclose the MHC is intensified since disclosure renders ones stigmatised subjectivity even more stigmatised.

At the same time that this discursive regulation affects the individual with the MHC, this also raises broader questions regarding mental health and work. The stigma surrounding mental health at work does not allow the possibility for the most frequently occurring and minor forms of MHCs, such as stress, to be accepted, or for employees to be able to talk about mental health with their employer (Mind, 2011). The growing figures of mental health absence from work and the organisational loss of millions of days every year (Mental health foundation, 2007) as well as the increased prevalence of mental illness worldwide (Üstün, 1999; WHO, 2003; 2007) may thus bear significant implications for a wider population of employees and for organisations more broadly from identity regulation of wellness and the ideal worker. The detrimental consequences of denying un-wellness have potentially damaging costs for the wider population of worker as well as for organisations.

8.3. Stigmatised identities and struggle: nuances of identification

The second research question asks: What are the paradoxes and struggles experienced during the attempts to secure employment and a legitimised

identity at work? This analysis contributes to the literature on mental health at work and on invisible stigmatised identities by understanding processes of identification through a critical poststructuralist lens.

In answering this research question, the study provides a better understanding of the *process* of identifying with a stigmatised subject position. The literature highlights how individuals with invisible and stigmatised conditions manage information about the self (Rosenfeld, 1979; Schlossberg, 2001) and focuses on the dilemmas and decisions that lead to disclosure or concealment (Harry, 1993; Moorhead, 1999). There are few studies, however, which show how and why individuals might identify with a stigmatised subject position. This study goes beyond existing literature by examining how individuals engage in processes of identification and how they relate to a stigmatised subject position in different ways.

Three issues in relation to identification processes are pertinent. These relate to: (1) the social construction of mental health stigma; (2) the transient nature of mental illness and; (3) the crafted nature of identity. It is the way that these three issues interact with one another that makes identification processes so complex. From the empirical analysis it is suggested that mental health stigma differs from other invisible and stigmatised identities insofar as the stigma of mental illness interacts with a complex set of issues that make it particularly problematic to be associated with the condition. The stigma attached to mental illness, because of the behavioural symptoms, is also at times related to the capability of the individual to perform at work, to manage other people, to interact, or take on certain roles. The study suggests that identification processes are far more complex, multiple and transversal than the case of simply identifying or dis-identifying with a particular subject position. Identification and 'declaring' the mental illness subject position brings with it the associated stigma; not declaring yet identifying with the subject position can limit the range of explanations for different behaviours and performance while having to 'live a lie' at work; not

declaring and refusing the subject position may result in inhibited self-management practice, and have a potential negative impact on health and recovery. Moreover, these processes of identification are rendered more complex by the ebb and flow of the MHC, suggesting at times that the condition and associated subject position are more or less salient, and that some conditions are more or less salient in a person's identity makeup. The study shows how mental illness can have a variety of degrees in its importance and significance for identity and daily experiences, and how this can be more or less salient in different contexts.

The study also throws light on how identification with the subject position intersects with the decision over concealing or disclosing a condition. This study supports other literatures which consider the factors affecting non-disclosure (Cox, 1993; Tsui and Gutek, 1999). For example, the analysis showed how previous disclosure experiences have an impact upon future disclosure, when negative responses tend to generate a reluctance to disclose (Clair et al., 2005). The study also supports studies drawing on the benefits of disclosure for building close relationships at work (Jourard, 1971; Derlega et al., 1993; Greene, 2000), educating colleagues (Bernstein, 1997), having access to explanation/accommodation/support (Matthews and Harrington, 2000), or creating social change (Taylor and Raeburn, 1995). In addition to this, however, the study also provides insights into how disclosure practices can go beyond organisational and individual contexts *per se* (Clair et al., 2005). For example, this study shows how someone might attempt to dis-identify with the stigmatised subject position but may disclose their condition to obtain workplace support in self-management. This pattern may then point to limited disclosure to managers and possibility to fewer colleagues. In addition, taking on the stigmatised subject position may be an act of resistance or attempt to recraft the meanings associated with the stigmatised identity more broadly. Thus, whereas the literature shows the different motivations for disclosure (e.g. Friskopp and Silverstein, 1995; Ely and Thomas, 2001), this study draws attention to the linkages between identification and

disclosure and illustrates how disclosure is the end result of more complex processes of identifying with a stigmatised subject position.

By providing a better understanding of how individuals with marginalised identities act upon an invisible and stigmatised subject position, the study also gives a better insight into when disclosure takes place. The study demonstrates, overall, how regardless of work circumstances (job type; seniority; type of organisation; profession), the general trend was to conceal rather than disclose and when individuals did disclose, the reactions were largely negative. Whilst the empirical chapters do not propose a definitive pattern of when disclosure is more possible, as it pertains to specific sectors or specific jobs, it is suggested that certain contexts make it more possible than others to disclose at work. For instance, the empirical chapters illustrated how disclosure of OCD is less problematic, while the disclosure of schizophrenia, for example, is more problematic than other conditions such as bi-polar or depression. Similarly, mental health absence seemed to be more normalised in the third sector than in the private or public sectors.

Furthermore, the study also provides insights into understanding the relationship between disclosure and authenticity. This study supports other findings showing how disclosing a stigmatised subject position can provide a sense of authenticity and the ability to be one's self at work (Creed and Scully, 2000). It goes further by providing a better understanding on the struggle with identifying with a stigmatised subject position and the need to be authentic. In the study, for example, for some, the struggle over whether or not to disclose, was driven by concerns over being open and honest with colleagues and developing a high trust relationship. For others the struggle over authenticity related more to issues of ethical practices—i.e. not lying over one's condition. For others still the claim of authenticity—the ability to be yourself at work—was an important claim to be understood and to have your daily struggle recognised. Finally, for some, authenticity was an act of resistance, in order to raise awareness, educate, and as a practice of generosity in recognition of the struggle of others. Overall, this

critical inspection of invisible and stigmatised identities provided insight and greater depth into, both, the tension around identification with an invisible and stigmatised identity, and in terms of how this leads to different forms of responses and struggles.

8.4. Third contribution: identities, agency and resistance

The final set of contributions relate to the third research question: In what ways do individuals with MHCs take on, resist or challenge the discourse of mental illness in the workplace?

8.4.1. Resisting identities

This study makes a contribution to the critical analysis of resistance in organisations. It contributes to understanding on how individuals respond to prevailing workplace discourses. The study adds to existing knowledge in this respect, by understanding how resistance is manifested in the context of stigmatised and marginalised identities; how different practices of resistance occur; and what impact they have on normalising discourses. Two main forms of resistance were notable in the study. These can be understood as practices of ‘resistance to survive’; and practices of ‘declaring, normalising and championing’. These are discussed, in turn, below.

Resistance to survive can be understood as a micro-political form of resistance aimed at improving the experiences of the individual but with little notable impact upon normalising discourses more broadly. Two patterns are notable. The first one illustrates how by both concealing and engaging with self-management of the MHC, the informants are able to ‘pass’ as a potential ideal workers, without being

subjugated as mentally ill. This type of resistance illustrated a refusal to take on the stigmatised identity of mental illness. Through concealing and self-managing, those participating in this study bettered their own position in employment and within the ideal worker discourse but did not challenge the discursive regulation of the discourse more broadly.

Relatedly, a second pattern of ‘resistance to survive’ can be seen in moments when the ideal worker subject position clashed with the self-management of the MHC. Here, some informants drew on self-management as a discursive resource to negate the ideal worker, presenting a modified form of careerism (e.g. by accepting delayed career progress or reducing their career chances). Thus the meanings gained from the ‘managed self’ subject position indicated a resistance to the ideal worker subject position and the ‘careerist self’. This pattern showed how by constructing themselves as ‘managing selves’—capable of maintaining good health as well as employment—the interviewees maintained a balance between work and health as a preferred way of being. This also can be understood as resistance to the mental health subjectivity, where the passive subject position of the mentally ill person as someone who is dysfunctional and incapable of working is challenged.

However, at the same time that the engagement with the ‘managed self’ as a preferred subject position betters the individual life, and allow them to maintain a balance between health and work, the effects that this pattern of resistance has at the collective level is problematic. This is particularly so given that both disclosure and concealment of the MHC bear problematic consequences for the individual and for the discourse more broadly. The engagement with the ‘managed self’ when concealing does not allow for an individual explanation for reduced career chances or for low performance. Thus the individual may be looked at as someone who is a less committed worker, not fully participating or performing well. Disclosure however is also problematic within this type of resistance. Although it provided the individual explanation for modifying their career

chances/performance, it reinforces the stigmatised subject position of the mental health worker as less able to work.

Thus, overall 'resist to survive' is an effective strategy at the individual level which provided the individuals in the study with the resources for resisting the ideal worker subject position. This micro-political resistance may indeed better the daily lives of individuals but can reinforce the normalising discourse at a collective level (Collinson, 1992; 2003; Jermier, Knights and Nord, 1994; O'Doherty and Willmott, 2001; Fleming, 2005). For example, the female cleaners in Holmer-Nadesan's (1996) study expressed their resistance to the normalising organisational discourse of class and sexuality by introducing alternative meanings related to caring and maternalism. In doing so, these new meanings bettered their own experiences yet reinforced the discourse of paternalism and class at the collective level. Likewise in this study, although the participants drew on self-management as an alternative subject position, they still positioned themselves in relation to the normalising meanings around performance. Thus although resistance at a micro-political level challenges the dominant discourse, it also reinforces it.

This pattern of 'resist to survive' although important for individual lives, might be considered a 'softer resistance' (Contu 2008, p.374) because it tends to reinforce the meanings within organisational discourse. The study however, also throws light on an alternative, more radical form of resistance, which might be termed 'declaring, normalising and championing'. This type of resistance involves identification with an empowered self, where resistance involves attempts to rewrite the meanings in normalising discourses through the embracement of the mental health identity. This resistance illustrates an embracement of the mental health subject position as equal (i.e. normalising) or better (i.e. differentiating).

In their attempts to introduce a mental health subject position into normalising organisational discourse, those participating in the study attempted to normalise

MHCs. For instance, mental health training and championing at work operated on the bases that mental health is not different to physical health, and thus is 'normal'/acceptable. Those 'normalising' practices were often accompanied by 'differentiating practices' which highlighted the advantages resulting from having the MHC. For example, the participants drew on the advantage gained from the experience of living with the MHC, having self-management skills, and life skills developed through their MHC which put them in an advantaged position to other colleagues.

This coexistence of 'normalising' and 'differentiating' was illustrative of the attempts to resist and to recraft not only the prevailed meanings around mental health at work but also those around the ideal performing worker subject position more broadly. In other words, the embracement of a mental health identity is illustrative of rewriting the mentally ill subject position as well as the ideal worker subject position. For example, one organisation in the study introduced mental health awareness as important for the financial gain of the business and for better performance and commitment of employees.

This attempt to rewrite the ideal worker subject position and to incorporate the mental health identity into it feeds back the wellness discourse. Ironically, those who self-manage and disclose their MHC might in turn lead to a strengthening of the salience of the wellness at work discourse. Thus at the same time that the discursive regulation of wellness does not accommodate illness, the embracing of mental health self-management skills and identity for the 'well and performing employee', repositions the mental health identity as a preferred subjectivity. Thus resistance through, 'disclosing, normalising and differentiating' shows how by drawing on the experience and the responsibility of mental health management as an advantaged difference and, by normalising mental health matters more broadly in work practice (i.e. through different mental health campaigns and encouragement to disclose), we can see a more radical attempt to resist, change

and rewrite the meanings within normalising discourses and the ideal worker subject position.

This study shows how the dialectic of normalising and differentiating practices form a potentially 'strong' strategy of resistance for rewriting organisational discourses and stigmatised identities. The literature on identities at work shows how embracing a stigmatised identity at work can be a useful practice which serves to introduce the 'difference' as either equal or better. For example in their study on LGB in the police Rumens and Broomfield (2012) illustrated how gay police officers normalised their homosexual identity by adopting the predominant heterosexual culture, thus drawing on the sameness between the gay identity and the heterosexual identity. Bernstein (1997) illustrates how LGB academics in sociology departments during the seventies and the eighties fought to reshape their sexual identities by celebrating their sexual identities as a preferred difference both inside and outside academia. Similar pattern of resistance can be seen in more recent organisational literature showing how for example, gender difference is embraced as an advantage at work. Thomas and Davies (2005a) show how Kate, a civilian member of the UK police service, exploits her differentiated identity as a mother and as a personnel professional to challenge the macho culture of long working hours. By embracing her gender difference as an advantage for her work situation, Kate describes how her position as a carer helped her introduce wellbeing policies into her management role and thus made her a better manager. Nonetheless, although Kate positioned her role as a mother as a difference that was advantaged for her work, she simultaneously drew on the sameness between herself and other employees, who do not have caring commitments.

The study thus provides a contribution for studying resistance in organisations by illustrating an attempt to recraft and reposition the meanings within mental illness. Whilst resistance has been studied in the context of social and organisational change in other settings of marginalised identities (both visible: i.e.

gender, age and race; and invisible: i.e. illness and sexuality and race), matters of illness at work are still understudied (Foster and Wass, 2013) and this is even more so in the context of invisible conditions (Beatty, 2011). By addressing how practices of resistance manifest themselves in an understudied area of MHCs, the study provides support for understanding the similarities and differences between resistance patterns of illness identities and other identities at work more broadly. This then serves for a better understanding of the challenges for resistance and change within the context of a subject position that is particularly problematic in the workplace.

8.4.2. Theorising agency and resistance: acts of self-care

This study contributes to the theorising of agency and of resistance in organisations by developing the Foucauldian concept of ethics of the care for the self (Foucault, 1986), an aspect of Foucault's work which has not been widely studied empirically nor taken up extensively in organisational analysis (Starkey and Hatchuel, 2002). As discussed elsewhere (chapter 2 section 2.3.1), in his examination, Foucault illustrates how, whilst the practices of the care for the self differed throughout history, common is the reflexive nature of self-caring for 'transformation of one's self by one's own knowledge' (Foucault 1988b, p.14). This allows for a sense of an 'authentic being', freedom and new knowledge (Foucault, 1984b), which in turn challenges the boundaries of discourse (Foucault, 1985; 1986).

One example of these practices is self-disclosure. Foucault (1986) draws on the way in which, throughout history, self-disclosure was considered a purifying practice and an ethic of 'truth telling'. While taking different turns throughout history, disclosing information about one's identity, self-disclosure of ills, or confession of 'sins' and troubles, is considered a purifying (Foucault, 1997a), and an 'authentic' act (Frank, 1998). Equally, throughout history and until modern times, disclosure is captured as a call for help and support and an opportunity to

share knowledge and make improvements in the way that people live their lives, both within themselves and within their environment (Foucault, 1978; 1997a; Rose, 1996).

Other organisational studies have illustrated how the disclosure of a stigmatised or marginalised identity can be a practice which entails within it a number of benefits such as: space for openness about a significant aspect of one's life (Moorhead, 1999); a challenging practice of existing diversity policies and a micro-political act (Creed and Scully, 2000); and how it is also linked with job satisfaction and with effective performance/commitment to work (Croteau, 1996; Driscoll, Kelley and Fassinger, 1996; Day and Schoenrade, 1997). Studies have also illustrated how workplace disclosure of marginalised or even stigmatised identities is a platform for micro political change, an attempt to educate colleagues and to gain workplace recognition (Creed and Scully, 2000).

This study adds new knowledge in this context by illustrating how self-management practices can be understood in terms of agency and resistance as ethic of the care for the self. The study provides empirical support demonstrating how these practices are significant for individual life as well as creating greater space for action within the macro levels of discourse (Foucault, 1986). At the same time that the practices of the care for the self are characterised by their agential nature to create space within discursive and material constraints (McNay, 1994) they can be more or less radical for changing individual circumstances or discourses more broadly at their collective level. This study provides empirical and theoretical contribution for understanding the ethics of self-care at their more or less radical forms signifying in turn, both agency and resistance.

In terms of agency, the practices shown in the empirical material resonate with the work on the ethics of care for the self (Foucault, 1986; 1997a) (see chapter 2 section 2.3.1). The study shows how through self-management practices, the

participants created the necessary space for them to stay well and to gain sustained employment. Self-care as a practice of agency was seen through the acts of self-management explored in this thesis, suggesting an active agential self, working at the interface between various subject positions and the person's reflexive understanding of self. This provides insights into how agency within a discursive, non essentialised understanding of identity can be understood (Weedon, 1987; Sawicki, 2005).

Self-management practices involve establishing a distance: distancing one's self from the illness. These practices included increased self-awareness, reflexivity and self-knowledge skills (e.g. self-medicating and identifying mood patterns), and the self-expertise pertaining to one's own MHC and experiences. The responsibility to self-manage, as well as the skills, insights and knowledge which are related to that, enabled for maintenance of wellness and employment. These practices created a space for independent self-management in a way that both minimised the possibility for episodes of illness or the need for support at the workplace. This latter concern was particularly important in light of the prejudices experienced by the participants and the consequential decision not to declare their MHCs. As such, their engagement with self-management created a space for agency from which the participants could reposition themselves in employment discourses.

Additionally the empirical analysis of this study points to a number of more radical practices of self-care, illustrative of resistance. A more radical emphasis of the ethics of self-care was visible in empirical material illustrating how self-disclosure, mental health awareness and other organisational practices which encourage disclosure (i.e. mental health champions or 'listeners' at work) can be looked at as attempts to resist. Primarily, disclosure as a practice of self-care for oneself and for others illuminates how resistance is acted upon as a practice of self-care. Disclosure was seen as a practice that not only provided the individual with support from the organisation in self-managing their MHC but also it is captured as an act of resistance and the rewriting of meanings within organisational discourse

on ideal workers more broadly. Together with other practices of mental health awareness at work, disclosure reflected resistance in a way that exceeds the self-care of oneself and introduced meanings related to the self-care of the other. In their interview extracts, the participants have illustrated how their self-disclosure reflects a generous act of concern for the care of the other, and the attempt to open up the discussion on MHCs in order to share experiences and provide help, support and advice for the other in their own mental health experiences. This then brings new meanings into organisational life which introduces the importance of mental health self-care for people in organisations.

Furthermore, the care for 'the other' was captured through the findings as important or equal, rather than inferior, to 'the self' (McNay 1994, p.152). This then provides a contribution to the Foucauldian theorising of the ethics of the care for the self in their inter-relation to the care for the other. Building on one significant criticism in the theorising of the care for the self is the reluctance to refer to the relation to the other in self-caring as well as the inferiority of the other in the practice of self-care (McNay, 1994). By addressing this criticism, the thesis illuminates how practices of self-care are not only important practices for one's own self-care in a way that better individual life and a sense of autonomy within constraining discursive regulation but also, how these practices can be then applied as agential acts for the self-care of the other.

This then provides support for the importance of engaging with care for the other in self-caring. Referring to this engagement as 'a true social practice' (Foucault 1986, p.52), Foucault (1986) draws on the significance of receiving help or helping others as a practice of self-care: *'The care of the self—or the attention one devotes to the care that others should take of themselves—appears then as an intensification of social relations'* (ibid., p.53). This important aspect within the care for the self suggests that when intersected with caring for others (i.e. through practices such as self-disclosure and alike) these ethics reflect on acts which exceed the individual life *per se*: *'The care of the self appears therefore as*

intrinsically linked to a “soul service”, which includes the possibility of a round of exchanges with the other and a system of reciprocal obligations’ (ibid., p.54). This study then provides an empirical support for understanding how whilst self-care practices primarily take place at the individual level, they are powerful acts insofar as they bear within them greater scope for changing meanings more broadly. This is because the engagement with the care for the other at interpersonal, social and organisational levels bears a potential impact for creating change at the collective and organisational spheres.

Overall the contribution for studying agency and resistance as a practice of self-care provides an illuminating insight into the empirical and practical application of Foucault’s later work on the ethics of the care for the self (e.g. Foucault, 1988a). Due to the understudied nature of this concept in organisational studies (Starkey and Hatchuel, 2002), this study illustrates how the ethics of self-care can be understood as beneficial for the theorising of both agency and of resistance. The study illustrates how the theoretical framework of Foucault’s ethics of self-care addresses practical concerns in mental health management for maximising agency and for resistance (Brewis, 2004; Randall and Monro, 2010). This study thus illustrates how, overall, the ethic of self-care as a concept (Foucault, 1986) and as a practice, can be understood as a platform for inclusion as well as resistance and change.

8.5. Concluding comments

This chapter provides an account of the contributions that this study makes in three areas. It addressed the contribution to theorising on identities in the context of mental health and identity regulation by critically examining the identity construction of mental illness at work and its interrelation to identity regulation more broadly. The chapter also addresses the contribution that this study makes to literature on invisible stigmatised identities at work, in particular, through its

utilisation of a critical approach to identity, and by drawing on the processes and nuances of identification and struggle and their interrelation to practices of disclosure. Lastly, the chapter discussed the contribution that this study makes towards the understanding of resistance. It provides a better understanding of two different acts of resistance in organisations, namely: 'resist to survive' and 'declaring, normalising and championing'. And, it also makes a theoretical contribution for understanding agency and resistance as an act of ethics of care for the self (Foucault, 1986). The final chapter presents the conclusions of this study whilst also evaluating the theoretical and methodological approach taken, and gives consideration to the practical implications of the study, while offering suggestions for future research.

Chapter 9: Conclusions

This final concluding chapter will consolidate the thesis, drawing together the main themes, reflecting on the approach taken, considering the potential limitations, and outlining future research directions. The discussion starts by revisiting the aims of the research, presents a brief summary of the findings and an overview of the three main contributions that the research offers. Following this, the approach taken in the research will be assessed. Given the political orientation of the research and the desire to improve the lives of people with MHCs at work, the chapter also picks up and discusses some of the implications of the research for policy and practice. Finally, the chapter closes, with ideas for developing the research further.

9.1. Identities and mental illness in the workplace

This research aimed at examining the identity construction of individuals with MHCs. It examined how the discourse and subject position of mental illness is understood and experienced in work settings and in relation to employment discourses. More specifically, the study asks a number of interrelated questions: (1) What is the relationship between an individual's notion of self and the discursive resources available to them in constructing their identity? To what extent does their MHC influence this construction? (2) What are the paradoxes and struggles experienced during the attempts to secure employment and a legitimatised identity at work? (3) In what ways do individuals with MHCs take on, resist or challenge the discourse of mental illness in the workplace?

Two main bodies of literature were drawn on in constructing the conceptual framework to the thesis and in developing the research questions: mental health and illness at work, and critical identities studies in organisations. Empirical

materials were collected through repeat interviews with individuals with MHCs as well as from interviews with employers, mental health professionals and charity employees.

The research was inspired by critical poststructuralism, specifically, Foucauldian studies on discourse and the subject, which takes identities as being in a state of flux, discourse bound and comprising of a number of subject positions. Developing these ideas, the research analysed contemporary meanings of mental illness and associated subject positions. This approach to studying the identity construction of people with MHCs in the workplace differs from the dominant approach of studying identities in the context of mental illness at work which, by and large, takes an essentialised understanding to identity (e.g. Muir, 1982; Manning and White, 1995; Rinaldi and Hill, 2000) and which is dominated by the occupational health perspective (e.g. Honey, 2004; Tse, 2004; Leufstadius, Eklund and Erlandsson, 2009). Thus the theoretical approach taken in this study brings a new perspective to the literature by critically examining how identities are constructed, contested and resisted through the prevailing discourses of mental illness.

Following an evaluation of the literature informing the study and an account of the methodological approach taken, the main findings for the study are structured around three themes. Chapter 5 showed how the discourse of mental illness promotes a stigmatised mentally ill subject, someone who is either dangerous or dysfunctional, incapable of performing effectively in work. The analysis illustrated the complex intersections of the mental health discourse with other work discourses, and how the stigmatised subject position clashes with the prevailing meanings surrounding the productive worker. Chapter 6 then showed how individuals respond to workplace discourses. The main theme, that of concealment, drew attention to the complex practices of subterfuge, and how these resulted in struggles to be open with colleagues, and the individualised response in addressing mental health needs brought about through not having access to organisational support. Although workplace disclosure was discussed as

the 'joy of being understood', this was often at the expense of being associated with a highly negative identity as well as practices of self-stigma. The final data chapter explored practices of self-management and resistance. The chapter showed how an empowered and in control identity is constituted from the contrasting mental health subject position of the self-managing person, and how this then serves as a platform for maintaining employment. The chapter also considered radical practices of resistance, illustrating the rewriting of meanings as an attempt to either normalise mental illness in the workplace or to promote mental health.

This research, in studying the identity construction of individuals with MHCs, in their attempts to secure employment, good health and a legitimised sense of self, also has wider implications for how mental health is understood in contemporary work organisations. In this sense the study is particularly timely, given the growing figures of mental illness worldwide and when the condition of depression alone is reported to become the second biggest cause of disability in the world by 2020 (WHO 2003, Sunley, 2008).

The thesis makes the following contributions. First, it contributes to the theorising on identities in the context of mental health and organisational studies. This study highlights the different responses and strategies to acting upon a mental illness subject position, and the different techniques for managing a MHC at work. These insights also contribute to identity regulation literature in the area of health and performance. The study provides a better understanding of the counterproductive nature of the discursive regulation of the ideal worker subject position in the context of mental health. This contribution is particularly timely, given both the popularity of discourses of wellness and the scarcity of studies on health conditions at work.

Second, the study provides a better understanding on the processes of identifying with an invisible and stigmatised identity. It makes a contribution to literature on invisible and stigmatised identities at work by throwing light on the multifaceted forms of struggle and identification with concealed stigmas. The understanding of identities as fluid and crafted through practice as well as the intensified mental health stigma and, the ebbs and flows characterising the extent to which the mental illness subject position is salient for the overall individual's identity, throw light on how different forms of identification lead to different forms of struggle and possibly, different practices of disclosure. This contribution extends the existing literature on invisible and stigmatised conditions which tends to focus on practices of identity management (Clair et al., 2005) and less on the process of identity construction.

Lastly, the thesis contributes to understandings on studying agency and resistance. The research contributes to understandings of micro-political resistance and how individuals respond to prevailing workplace discourses. The study adds to existing knowledge in this respect, by understanding how resistance is manifested in the context of stigmatised and marginalised identities; how different practices of resistance occur; and what impact they have on normalising discourses. Secondly, the study develops an understanding of resistance as practices of care for the self (Foucault, 1986). This contribution focuses on how the agential act of self-management creates space within constraining discursive regulation and betters organisational life more broadly.

9.2. Limitations

This study utilises a qualitative methodology, deeming most suitable for engaging with the complex nature of the social world as manifested through a range of contexts (Arksey and Knight, 1999). This approach recognises the subjective experiences of participants as well the importance of language for connecting

knowledge, experience and meaning production. This considers the mutual role of study participants and researchers in the process of knowledge production. Interviews provided the tool for data collection, taking the approach that the interview setting provides the space for study participants to express their thoughts and experiences in a way that produces rich data.

Whilst the reflexivity section in the methods chapter (chapter 4 section 4.7) has highlighted the role of the author in the construction of this work (Alvesson and Deetz, 2000), it is appropriate at this juncture to give further reflection to the approach taken in this study and the relationship between the research process, the researcher and the research product. Unlike the clearly defined criteria for evaluating quantitative and positivistic studies, the flexibility in the evaluation criteria of qualitative research (Seale, 1999; Spencer et al., 2003; Johnson et al., 2006) suggests some reflexive scrutiny over the theoretical perspective as well as the methodological approach and how this affects the course of the work. In order to broaden the reflexive account on the decisions taken, Johnson and Duberley's (2003) popular reflexive framework is utilised, addressing hyper/deconstructive reflexivity; epistemic reflexivity; and methodological reflexivity.

9.2.1. Deconstructive/Hyper reflexivity

The critical poststructuralist approach to studying identities in organisations attempted to provide an account on identities and mental illness in a way that sees identity as a micro-political site for struggle and resistance. Separate from being bounded within this approach, the thesis is also bounded within a number of other constrains. Some of which are: the sample used in this study, the data generated, and my own interpretation of the findings as well as a number of academic regulations and rules (e.g. academic writing style, layout and presentation) (Chia, 1999). Furthermore, the research is also bounded within the research communities to which it contributes (Hardy and Clegg, 1997). Its aims and

contributions were constructed in a certain way that matches both the discipline of organisational studies and specifically those which match the critical view point it adopted. Whilst 'organisational studies' is the discipline within which this study is located, there was scope to examine identities in the context of mental health at work from a number of alternative theoretical perspectives, which would, in turn have had an impact on the entire course of this work. For instance, instead of adopting a critical lens, an essentialist examination of identity in the context of mental illness and employment could have evaluated the correlations between different types of mental illness, how these impact on individuals' identifications with work organisations, and provided conclusions in terms of rehabilitation and recovery and recommendations on how to improve their participation.

However, taking an essentialist stance to studying identities and mental illness would have limited the potential contribution of this study and its aims. Studying identities critically draw attention to the multiplicities and nuances of meanings in a way that illuminates the range of responses and practices of struggle, agency and resistance. This in turn makes a significant contribution to understanding societal processes and micro-political tensions which would not have been possible to explore fully if an essentialist stance towards identities had been adopted.

9.2.2. Epistemic reflexivity

Whilst the discussion on disciplinary reflexivity underpinning this study is reflected through the choices made in terms of studying identities from a critical perspective, the epistemological reflection examines the positioning of the researcher and the actors within the research process (Johnson and Duberley, 2003), predominantly focusing on the 'interpretation of the interpretation' (Alvesson and Sköldbberg, 2000) and the process of knowledge production (Thomas et al., 2009). A number of interrelated issues are thus concerned with the reflexive account of this study which is linked to my own position within this work, the

power relations embedded within the research process and the writing up of the thesis.

As discussed earlier (see method chapter 4, section 4.7), my background not only led me to look at this topic, but also remains dominant throughout the research process. Clearly, other scholars carry with them other ‘baggage’ which would have impacted on the research inquiry, as well as the processes by which it is produced. Additionally, at its epistemic level the power relations between the researcher and the researched require reflection on the process of knowledge production (e.g. Thomas et al., 2009). Whilst being constrained within the authoritative power of my role as the researcher, at its epistemic level this study aims to explore the experiences of an understudied population as they are being constructed through their own reflections and the variety of meanings that are important to them. This issue has been discussed in detail during the methods chapter (chapter 4). However, it is worth making a further comment that, whilst being the only author of this work, it was my awareness of the understudied struggle of those who cope with prolonged and enduring MHCs in their attempts to gain and maintain employment that has led me to conduct this study. And this awareness has guided me during the research process, the analysis of the findings and the writing up of this thesis.

Reflections on the interview situations and the asymmetrical power relations within the process of knowledge production have also been extensively discussed in chapter 4 (over three sections number 4.3, 4.5, and 4.7). Whilst being aware of my controlling position within the researched-researcher relationship, the reflection which took place during the interviews and the process of knowledge production provided an opportunity for the interviewees to present an account of experiences of a significant part of their lives. This, together with my own positioning within the study and my approach to the interviewees as experts of their own reflections, was then brought into the interview setting. The interview setting was thus an opportunity for ‘shaking’ the imbalanced power relationship

between the author and the researched (Johnson and Duberley, 2003) and provided an opportunity for the study participants to 'have their say', gain the recognition for their experiences and become empowered. Consequently, the writing up process aimed to challenge social settings and existing power dynamics and to promote change (Grundy, 1987).

9.2.3. Methodological reflection

While the methods chapter provided an account of the way in which I have attempted to be reflexive over the choice of methodology and the process by which the method was used (see chapter 4, section 4.7), this discussion provides an opportunity to reflect on some of the limitations embedded within the choice of the method adopted. Although the approach adopted is based on repeated interviews with people from a wide range of sectors, organisations, and hierarchical mix, the informants who participated in this study had one of four MHCs: depression, bi-polar, anxiety disorder (OCD), or schizophrenia. Even though the sample was chosen under the practical constraints of identifying individuals who were willing to participate in the interview and were in employment, the study could have benefited from a larger sample of working individuals with a wider range of MHCs. This would possibly have allowed for greater insights within various forms of MHCs and also in terms of the intersection with profession, seniority and sector. This might have teased out further the different meanings attached to different forms of mental illness in relation to their constitution in workplace settings and the factors facilitating resistance.

At the same time, however, the sample consulted in this study was broad and represented the main MHCs of people in employment, who are mostly reported to have anxiety disorders and depression (Mental Health Foundation, 2007). Additionally, while the study sample was heterogeneous in terms of a professional and hierarchical mix, and although a wider sample could have allowed for more

detailed insights between different conditions, the purpose of this study was to understand the individual experience and reflections rather than to compare and contrast between sectors and populations. In this sense the sample adopted was adequate to serve the aims of the study.

Another methodological concern relates to the limitations of generalising from findings which utilises qualitative enquiry (e.g. Deetz, 1996). One concern which relates to the sample and requires recognition is the fact that most of the interviewees participating in this study were recruited through a peer-to-peer support group and this in turn may suggest that the interviewees' actively acknowledge and related to their MHCs (see also discussion in methods chapter section 4.5). The way in which they relate to their condition could in turn have an impact upon their identity construction. This may suggest that the interviewees experienced their MHCs as something that had certain significance and meaning in their lives, but also that they were comfortable talking about these experiences with a stranger.

This reflexive account highlights the limitations of this study but, equally, it also provides details of the strength of this work within the boundaries of its limits. In this vein, the study offers a number of practical implications which are discussed next.

9.3. Mental health in the workplace: practical implications

This study offers a number of contributions to policy makers and practitioners. Government legislation often manifests as 'empty promises' for improving the working lives of those with health conditions (Clair et al., 2005). Although the argument that diversity in organisations has become the new norm (Beck, 2007), a number of studies (e.g. Beatty and Kirby, 2006; Beatty, 2011), including this one,

illustrate how individuals with health conditions still struggle to secure employment and legitimacy in the workplace. There is a pressing need for increased awareness of MHCs and the improvement of the experiences of those with invisible impairments.

This study offers two main practical contributions for tackling mental health stigma in the workplace and for the management of invisible conditions at work. These are the non-formal disclosure of employees in senior positions and mental health awareness. The findings chapters illustrated how non-formal disclosure can be a useful method of legitimising the discourse on mental health at work. Bruce provided an account of the managerial initiative of creating ‘mental health champions’ which offered employees a route to confidential and non-formal disclosure to specially designated senior people in the organisation. Likewise, Cliff’s account illuminates how ‘Listeners’, role models in the firm who are senior employees willing to disclose their MHCs and to support others in their disclosure, can help in recrafting the pejorative meanings associated to mental health at work (see chapter 7 section, 7.3.2).

Building on these findings, encouraging senior employees with MHCs who are willing to provide mental health support and guidance for other colleagues could prove to be a practical initiative for the management of invisible diversity at work. This could then help in challenging the stigmatised discourse on mental illness at work through normalising the illness. Linked with this awareness raising to mental health in the workplace, in terms of better management, and the opening up of the discussion of mental health at work at both personal and managerial levels, also serves to challenge the othering of people with MHCs. For instance, the notion of mental health training, as presented in the account of Kerry (chapter 7, section 7.3.2), might be an effective method of raising mental health awareness in the workplace. In this sense mental health training and education for both managers and employees could be practical methods to embrace change.

Overall, embracing the above practices as methods to manage invisible diversity at work and for mental health awareness also contributes to effective management, through better people management. Other studies have illustrated how workplace disclosure of invisible diversity at work is associated with increased engagement and commitment to the organisation (Croteau, 1996; Driscoll, Kelley and Fassinger, 1996; Day and Schoenrade, 1997). This issue is particularly relevant given the growing figures of mental illness worldwide (WHO, 2003) and the billions of days of work lost every year, due to mental ill health (including depression, anxiety and stress related concerns) (The Sainsbury Centre for Mental Health, 2007).

Nevertheless, and following the critical nature of the thesis, it is important to recognize the limitations of the business case for the increased awareness to mental health in the workplace. One of the reasons for the increased popularity of the notion of difference (whether it mental health related or other) for both business (Jones et al., 2000; Edelman et al., 2001; Boxenbaum, 2006; Süß and Kleiner, 2008; Zanoni and Janssens, 2008) and researchers (Milliken and Martins, 1996; Williams and O'Reilly, 1998; Van Knippenberg and Schippers, 2007) may have been its potential for maintaining competitive advantage in the workplace (Robinson and Dechant, 1997; Kelly and Dobbin, 1998; Boxenbaum, 2006). This approach however has been criticised for its attempt to measure individual difference from what is considered the norm (Zanoni et al., 2010). The approach has also been considered problematic because it neglects broader contexts, power inequality (Thomas and Alderfer, 1989; Ely, 1995; Kanter, 1977; Prasad et al., 2006; Siebers, 2009) and the role of the organization in constructing otherness within a diversified workplace (Janssens and Zanoni, 2005; Prasad et al., 2006; Joshi and Roh, 2009; Siebers, 2009).

Taking the criticism of the business case into the setting of mental health, it could be argued that there are broader workplace diversity issues such as the recognition of otherness at work, which need to be considered in addition to the benefits of good mental health management in work organisations. Thus addressing difference

in order to enhance the managerial concern over performance per se, Zanoni and Janssens (2004) draw attention to the danger that organizations may attempt to 'fix' or 'correct' individuals in order for them to live up to the idealised or productive worker subject position. Hence, rather than drawing attention to 'difference in its own right' (Deleuze, 1994; Overboe, 1999; Roberts, 2005), there is that danger that good mental health management would lead to further reinforcement of the norm over the account of a diversified workplace and a managerial strategy which values the essence of 'being other'.

9.3.1. Policy implications: Challenges to mental health patients and stigmatised identities

The discussion in Chapter 3, on the empowering subject position, gave an optimistic view of patients leading their own treatment. This process also drew attention to greater equality between medical knowledge and patients taking the lead over their own treatment. However, one could question the extent to which these issues indeed manifest themselves in daily lives and through policy. Although health services today do recognize how people with health conditions have their own sets of expertise for managing their health, the way by which these are embedded in policy and practice is limited. This is especially the case given that the most popular forms of treatments still reflect the basic essence of the medical model namely: medical professionals leading the course of patients' treatments. Either through popular practices such as counselling and psychiatric drugs (NHS, 2013a) but even further than that, contemporary information on self-management given through the health services still illuminates the dominancy of medical knowledge in conventional practices such as medication and talk therapy (e.g. NHS 2013b).

The findings presented in this study go beyond what was currently looked at within the medical model/health policies and practices. Chapter 7 demonstrated the

range of self-management practices utilised by people with MHCs in the workplace. It was illustrated in the chapter how those practices go beyond traditional forms of treatment for mental health and in a way that challenges the medical model. For example in page 180, we could see from the text of James, how through his engagement with his own reflexive account for managing his mental health, he was able to improve his own circumstances in a way that conventional treatment did not. By drawing on a set of reflexive practices for managing mental health, this thesis then goes another step further in challenging the conventional modes of treatment and the traditional power relations which are embedded within it (Foucault, 1971).

The significance of self-management for the working lives of the participants demonstrates how the shift towards a more empowered subject position draws attention to the limitations of medical knowledge in more than one way. First, this provides empirical support to the Foucauldian criticism on the discursive construction of the mentally ill subject position (Foucault, 1971). Second, this also draws on a set of practical implications for policy makers in a way that brings to being a more empowered position at the individual level as well as greater credibility to the reflexive engagement of the individual in the self-management of their own conditions. Furthermore, the importance of the reflexive engagement with self-management for the working lives of people with MHCs then suggest that policymakers need to give more attention to the importance of self-management at work and to the critical role that these reflexive practices can have for the working lives of people with mental health at work. These practical implications could have significance for future research and it is to the discussion of that possibility that we now turn.

9.4. Future research

As this research explores an understudied concern within the context of organisational research and critical identity studies, it provides scope for future research in a number of areas. First, building on the practical implications suggested above, it would be interesting to examine and evaluate the impact of mental health promotion and education at work on prevailing discourses and identities. In this respect, more research exploring the experiences of employees with MHCs who have disclosed their health condition at the organisational level and are presenting themselves as the mental health ‘experts’/‘champions’ is recommended.

Second, given the significance of self-management for the working lives of the interviewees, more research is needed on how these practices play out in different work contexts. Whilst this study provided an illuminating example of the way in which self-management is understood in terms of the space it allows for resistance and for participation in work, further research may allow for an understanding of how self-management can be understood as a practice of inclusivity in employment, whilst offering a wide range of tools for others with MHCs in their attempts to secure material conditions, wellness and a legitimised sense of self at work. Additionally this might also provide managers with insights into the support that could be provided for employees in order for them to perform to their full potential. In this sense broadening the notion of self-management may have the potential usefulness for preventing late diagnosis, insufficient support, non-therapeutic effects and delayed treatments which currently characterise many of the experiences of people with MHCs in the workplace (Honey, 2003; Gelb and Corrigan, 2008).

Lastly, conducting a longitudinal study over a longer period of time could provide greater insights into processes of identity construction in different contexts and mediated by the ebb and flow of the MHC. Additionally, this would permit

generating wider insights into the meanings embedded within mental health discourses and the way in which these change.

9.5. Concluding comments

The critical approach adopted by this study revealed the practices by which individuals with MHCs are affected by and affect the constraining discourses of mental illness in work organisations. The study illustrated the importance of moving forward: from illness to mental health management; from concealment to disclosure; from invisibility to visibility; from stigma to legitimacy. It also showed how the meanings constructed in discourse and through the experiences and reflections of those involved, has discursive and material consequences that influence organisational life on a number of levels. Some of which are: performance and commitment to work, a sense of being at work, relationships with colleagues and managers, as well as issues of openness and change.

This work illuminated the courageous acts and calls for change by those who have participated in this study. As Chris notes: *'the best way myself I can tackle stigma is to be as well as I can. And then when I am ready to talk to someone to say: "Actually, I have got bi-polar disorder". And for them to say "Wow! I never would have known".'* While a minority of the working population puts their best efforts to live up to employment discourses and manage their health, the concerns dealt with in this study are not a problem of a marginal population. Rather, the discourse of mental illness has broad societal implications and the growing figures of mental health issues worldwide only intensify these concerns. This study suggests that denying or denigrating mental health issues at work have detrimental consequences not only for workers and organisations but also for communities and society at large. It is time that mental health 'came in from the cold', not only to remove stigma at work but more, to ensure that through this people with skills, experience and ability are able to participate fully in organisations.

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Appendix 1: Research outline



Work, Mental Health and Illness:

Exploring Mental Health Concerns in the workplace

[Funded by Economic and Social Research Council (ESRC) in collaboration with Cardiff University]

Introduction

Increasingly, it is recognised that the required support and necessary adjustments that individuals with mental health conditions need to make to attend and thrive in paid employment is complex and unclear. Despite this, there is a surprising lack of in-depth research that investigates the lived experiences of those with mental health conditions returning to work and maintaining their employment. This current study focuses on the day-to-day experiences of employees and job seekers with mental health conditions. In addition, the perceptions and understandings of employers and organisations regarding mental health and illness will also be explored.

The proposed study will involve interviews with employees, employers and job seekers with mental health conditions. This academic study is being conducted to provide a greater understanding of the experiences that individuals have in gaining employment and working. Participation in the study will be voluntary with the possibility to freely withdraw from the study at any time without giving a reason.

Interviews will take place over a period of up to eighteen months. Naturally, all information will be treated anonymously, securely and confidently. Data will be gathered, stored, coded and analysed anonymously immediately after the interview, and will be retained for up to one year before it will be deleted/destroyed.

Research Aims:

1. To explore the experiences of individuals with mental health conditions in the workplace
2. To explore employers' understandings of mental health conditions in the workplace
3. To make recommendations for policy and practice

Your Commitment

In agreeing to participate in this important and influential piece of research, you will be interviewed once or twice over the next year. Each interview will last for around one hour. You can withdraw your participation in the study at any time.

Thank You for participating in this vital study

Your support is much appreciated

Hadar Elraz ElrazH@Cardiff.ac.uk

Cardiff Business School, Colum Drive, Cardiff CF10 3EU

Appendix 2: information about the MHCs experienced by study participants

OCD: Obsessive Compulsive Disorder

Anxiety disorder characterised by obsession and compulsion and has an impact upon ones' thinking, feeling (obsession) and acting (compulsions) (Kelly, 2011). About 1 in 50 individuals suffer from OCD at some point in their lives compounding a total of 1 million suffered in Britain. The experiences of OCD thoughts can be manifested as unpleasant worries and dangers; self-doubt and other troubling thoughts and vision. OCD is also linked to a variety of emotions such as feeling tense, anxious, fearfulness, guilt, and depression. In terms of behaviour, OCD can also be linked with repetitive behaviours such as reassurance, hoarding, avoiding anything that may remind of the obsessive thoughts; checking and rituals (RCPSYCH, 2013).

Depression

Depression is a mood disorder which can impede significant aspects of daily life during work social activities. Between 8 to 12% of the population in Britain experiences depression, making mixed depression and anxiety the most popular mental disorder in Britain (Mental Health Foundation, 2013). Depression is defined by on-going "low" mood, a sense of worthlessness, guilt, fatigue, reduced energy and loss of interest in daily routine activities (for period of at least two weeks). Depression is also associated with significant changes in weight, unstable sleeping routine, anxiety and delayed cognitive responses, reduced ability to concentrate, un-clarity as well as thought of death (DSM-IV, 2008).

Bipolar Disorder

Bi-polar disorder (also known as manic depression) is a health condition that normally affects one in 100 individuals and is characterised by episodes of extreme mood swings of depression (low mood and exhaustion) and mania (high mood and full of energy) which last at least a few weeks. There is no unified pattern for the

way in which these episodes of the condition are manifested in individual cases. Whilst some individuals will only experience one or two episodes of the condition and stay balanced in the remaining time, others may experience recurrent episodes during their lives.

Depressive episode normally experienced before (weeks, month or years) the manic episodes and are diagnosed by vast sense of worthlessness and sometimes thoughts of death. A manic phase on the contrary, is characterised by increased levels of energy, excessive spending, getting easily annoyed, not having enough sleep, reduced appetite and overall sense of creativity and happy feelings. Manic state may also be characterised by delusions and reduced ability for reality testing (NHS, 2012b).

Schizophrenia

Schizophrenia is a health condition that normally affects one in 100 individuals' and has an impact on ways of thinking, feeling and behaving. The condition is characterised by a number of symptoms including changes in behaviours, muddled thoughts, delusions (unusual strong beliefs /ideas that contradict evidence /seeing special meanings in ordinary daily events) and hallucinations (hearing pleasant, rude, critical, abusive and irritating voices, smelling, feeling or having visions of things that are created by the mind and do not exist in the external environment) (NHS, 2012c). More symptoms include intense, troubling and distressing experiences, thoughts disorder with difficulty to concentrate, discontinuity in thinking, loss of own ordinary thoughts and a sense of being controlled. Other symptoms' include loss of interest in life, lack of motivation and energy, difficulty to socialize and constant feeling that others are 'wrong'. Schizophrenia is also linked with depression when 1 in 7 individuals who experience continuing symptoms also become depressed (RCPSYCH, 2011).

Appendix 3: List of themes

1. Identity change
2. Subject positions
3. Getting a job and identity construction
4. Public/ Private/
5. Invisibility/Visibility/Honesty
6. Intersection Visibility and: 1. Employment 2.Medicine
7. Struggle (overt and covert)
8. Identification/Dis -identification
9. Victimhood/ Coming out
10. Reinforcing discourses
11. Discourse of Change
12. Matters of Agency
13. Overlapping /Intersecting discourses
14. Typology of MHCs
15. Health and Symptoms of Illness
16. Identity and Stigma
17. Discourse of Friendship
18. Self-regulation
19. Role models, Friends and Acquaintance
20. Other

Appendix 4: Portraits of the participants whose quotes are used in chapters 5, 6, 7

Names are presented by the order in which they appear in chapters 5, 6, 7:

Name	Age	Condition	Severity	Occupation
Fred	Mid thirties	bipolar	severe	Art technician
Melanie	Late forties	bipolar	severe	Lecturer
Beth	Early thirties	Schizophrenia	severe	Runs a peer to peer support group
Roger	Early forties	bipolar	Moderated	Home-insurance consultant
Patrick	Early forties	OCD	Mild	Lecturer
Jack	mid forties	OCD	Mild	Manages a small charity
James	Mid thirties	OCD	Severe	Architecture professional
Bret	Mid forties	Bipolar	Moderated	Radio engineer
Chris:	Mid thirties	Bipolar	Severe	IT consultant
Tony:	Early fifties	Bi Polar	Severe	Runs a peer to peer support group and works as support staff in the hospital
Brain	Mid forties	Bipolar	Mild	Has his own business for diversity education in schools

Jo	Mid thirties	Depression	Severe	Social work
Carol:	Early fifties	N.A.	N.A.	Occupational health doctor
Kevin:	Mid fifties	N.A.	N.A.	Occupational health doctor
Martin	Early fifties	Bipolar	Moderate	Managerial role in a Bank (Agency worker)
Albert	Early forties	Schizophrenia	Moderate	Mental health charity worker
Kim	Early forties	Depression and Anxiety	Moderate	Retail
Sam	Mid thirties	Schizophrenia	Severe	Volunteers in a mental health organization
Clair	Mid thirties	Schizophrenia	Severe	Runs a peer to peer support group
Cliff	Early fifties	Bipolar	Moderate	Founder of a mental health charity
Grace	Late thirties	Bipolar	Mild	Works in a cafe
Glen	Late thirties	Schizophrenia	Severe	Gardener
Bruce	Late forties	One episode of depression	Mild	A partner in an accountancy firm
Kerry	Mid forties	N.A.	N.A.	Project leader on mental health awareness at work

Appendix 5: Approved ethic form

CARDIFF BUSINESS SCHOOL ETHICAL APPROVAL FORM: PHD THESIS RESEARCH	
(For guidance on how to complete this form, please see http://www.cf.ac.uk/carbs/research/ethics.html)	
For Office Use: Ref	Meeting
Does your research involve human participants? Yes	
Does your research have any involvement with the NHS? No	
Name of Student:	Hadar Elraz
Student Number:	0955071
Section:	HRM
Email:	ElrazH@cardiff.ac.uk
Names of Supervisors: Professor Robyn Thomas; Dr Andrea Whittle; Professor Rick Delbridge	
Supervisors' Email Addresses: ThomasR4@cardiff.ac.uk ; WhittleA@cardiff.ac.uk ; DelbridgeR@cf.ac.uk	
Title of Thesis: Work and Identity: a critical study on identities, mental health and employment	
Start and Estimated End Date of Research: October 2010-September 2013	
Please indicate any sources of funding for this research: ESRC	
1. Describe the Methodology to be applied in the research	
A qualitative, inductive, multi-method methodology will be adopted in the study. A discursive approach will be used to carry out a discourse analysis of texts and interviews. As the main focus of this research is the subjective experiences of individuals with mental health conditions (MHCs) within an employment context, the methodological assumptions of the research aim to produce context-bound research findings (Thomas and Linstead, 2002). Consequently, the intention of this research is to analyse the processes of identity construction within specific texts of individuals with MHCs and not to produce generalised theories.	
2. Describe the participant sample who will be contacted for this Research Project. You need to consider the number of participants, their age, gender, recruitment methods and exclusion/inclusion criteria	
This research project focuses on the work experiences of people with MHCs. The study will include the participation of a range of individuals with MHCs, in terms of age, gender, race, as well as occupational, professional and hierarchical mix. Research participants will be both males and females and will have occupational backgrounds from both private and public	

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sector organisations.

Participants will be recruited via the Mind Organisation¹ in Cardiff where information about the research will be spread throughout the organisation and to other organisations who support individuals with MHCs. Individuals with MHCs, who will be interested in participating in the research and will either be seeking work or in employment, will be interviewed. In addition employers, HR and mental health professionals who will be interested in participating in this study will be interviewed. On the whole the number of participants in this study is estimated to be fifty or sixty individuals comprising of employees, employers, and mental health professionals who are happy to discuss mental health and illness related issues. Interviews will take place at Mind's premises, in Cardiff University and in any other suggested location that is convenient for the interviewees and is suitable to conduct the interview. Semi-structured interviews, which are estimated to last for approximately one and a half hours per interview will be conducted, recorded and transcribed by the researcher.

3. *Describe the consent and participant information arrangements you will make, as well as the methods of debriefing. If you are conducting interviews, you must attach a copy of the consent form you will be using.*

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Consent Form

The project conducted to provide a greater understanding of the experiences individuals have in gaining employment and working. I understand that my participation in this project will involve a semi-structured interview, about my experiences of looking for employment/experiences of work, which will take approximately 1 hour of my time.

I understand that participation in this study is entirely voluntary and that I can freely withdraw from the study at any time without giving a reason.

I understand that I am free to ask any questions at any time. If for any reason I experience discomfort during participation in this project, I am free to withdraw or discuss my concerns with Professor Robyn Thomas (Thomasr4@Cardiff.ac.uk) or with Ms Hadar Elraz (ElrazH@Cardiff.ac.uk).

I understand that the information provided by me will be held totally anonymously, securely and confidentially. I understand that, in accordance with the Data Protection Act 1998, I can have access to the information and can ask for the information to be deleted/ destroyed at any time. The information will be coded anomalously immediately after the interview, and will be retained for up to 1 year before it will be deleted/destroyed.

I also understand that at the end of the study I may require some additional information and

¹ Mind Organisation is a leading mental health charity for England and Wales. The organisation promotes campaigns to create a society where people with experience of mental distress are treated fairly, positively and with respect (<http://www.mind.org.uk/about>)

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feedback about the purpose and insights of the study by applying to Hadar Elraz (Elrazh@Cardiff.ac.uk).

I, _____ consent to participate in the study conducted by Hadar Elraz of Cardiff Business School, Cardiff University with the supervision of Professor Robyn Thomas.

Signed:

Date:

4. Please make a clear and concise statement of the ethical considerations raised by the research and how you intend to deal with them throughout the duration of the project

Ethical issues will be carefully considered throughout the entire process of gaining access, conducting, transcribing and analysing the interviews. This is especially relevant given the sensitive nature of the topic and the need to respect and care for the emotional engagement involved. Personal information will be removed from the data while confidentiality and anonymity will be kept and ethical guidelines will be followed throughout the research, as recommended by the ESRC and Cardiff Business School.

Ethical considerations begin immediately with the construction of the researched phenomena, and will continue throughout the research process (Saunders et al. 2003; Zikmund, 1997; Ghauri and Grønhaug, 2002). The ethical decision regarding the methods used in the study is also considered. As the topic of this study involves a vulnerable population, semi-structured interviews deem most appropriate method. Among other reasons, this method allows for sharing information between the interviewee and the interviewer only, unlike other qualitative methods (such as focus groups), where information is shared with wider audiences.

A trustworthy relationship between the researcher and the research participants (Ghauri and Grønhaug, 2002) is vital given the sensitive nature of social research (Benton and Craib, 2001) and of this study's topic in particular. As part of this relationship, all participants will be asked to give their consent to participate in this research, while being fully aware of the research concerns (Saunders et al. 2003). Participants will also be reassured regarding the confidentiality and anonymity of the data, including methods of keeping the empirical material as well as using it and presenting it. In addition, the use of simple non-jargonised language when communicating with interviewees will be considered throughout the entire process (Ghauri and Grønhaug, 2002) and direct questions, which may cause the interviewees mental distress, will not be asked (Churchill, 1999). Interviewees will be informed at the beginning of the interview that they could refuse to answer any of the interview questions or stop the interview at any stage if they feel uneasy (Ghauri and Grønhaug, 2002). The study considers the moral responsibility to gather the data and to explain the researched phenomena in an honest and accurate manner (Ghauri and Grønhaug, 2002). Its aim—to present the research in a reflexive and transparent form (e.g. Thomas et al., 2009)—will be another indicator of the ethical considerations undertaken throughout this research.

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Interview Guide:

Interview guide for individuals with MHCs

A. Introduction – some questions about your background

1. Tell me a little about your self—your background—your employment background in light of your condition
2. What your ambitious are for the future?

B. The recruitment process

3. Tell me about your experiences of job seeking?
4. Can you reflect on your experiences of the recruitment process?
5. Do you normally disclose your health condition?
6. What made you apply for this particular employment?

C. Your day-to-day experiences

7. Tell me about your day-to-day experiences? The management of your routine?
8. How do you get on in this organisation?
9. Where do you go from here?
10. What are your employment ambitions for the future?

D. Finally, I would like to ask some wider questions about work

11. Tell me what work means to you?
12. How important is work to you?
13. Can you reflect on times when you were not in employment?
14. In the light of your experiences what could employers do to improve the daily experiences / routine of employees or people looking for work?
15. Any other questions/Comments?

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Interview guide for employers /mental health professionals

A. Introduction – some questions about the organisation and mental health management

1. Tell me a little about the organisation
2. How do you perceive mental health matters in the organisation?

B. The management of ill mental health

3. What are images of ill mental health for you?
4. Do you have any experiences of coping with mental ill health in a working environment?
5. Do you have any policies towards management of mental ill health in your organisation?

C. Recruitment and employment of individuals with mental health conditions

6. Getting employers perception regarding recruitment and employment of individuals with mental health conditions
7. How do you perceive the dominant approach organisations have towards mental health and illness at work?
8. What sort of challenges do you think that individuals with mental ill health are facing when seeking or maintaining employment or developing a career?
9. What sort of challenges do you think that employers face when recruiting individuals with mental health conditions?
10. Any ambitions that your organisation has in regards to the management of mental health and illness of employees?
11. Anything else that you wanted to add?

PLEASE NOTE that you should include a copy of your questionnaire

NB: Copies of your signed and approved Research Ethics Application Form together with accompanying documentation must be bound into your Dissertation or Thesis.

Please complete the following in relation to your research:

		Yes	No	n/a
(a)	Will you describe the main details of the research process to participants in advance, so that they are informed about what to expect?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b)	Will you tell participants that their participation is voluntary?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c)	Will you obtain written consent for participation?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d)	Will you tell participants that they may withdraw from the research at any time and for any reason?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e)	If you are using a questionnaire, will you give participants the option of omitting questions they do not want to answer?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
(f)	Will you tell participants that their data will be treated with full confidentiality and that, if published, it will not be identifiable as theirs?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(g)	Will you offer to send participants findings from the research (e.g. copies of publications arising from the research)?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PLEASE NOTE:

If you have ticked No to any of 5(a) to 5(g), please give an explanation on a separate sheet.
(Note: N/A = not applicable). There is an obligation on the lead researcher to bring to the attention of Cardiff Business School Ethics Committee any issues with ethical implications not clearly covered by the above checklist.

Two copies of this form (and attachments) should be submitted to Ms Lainey Clayton, Room F09, Cardiff Business School.

Signed

Print Name: Hadar Elraz

Date: 21/10/2010

SUPERVISOR'S DECLARATION

As the supervisor for this research I confirm that I believe that all research ethical issues have been dealt with in accordance with University policy and the research ethics guidelines of the relevant professional organisation.

Signed

Print Name: Professor Robyn Thomas

(Primary supervisor)

Date: 21/10/2010

STATEMENT OF ETHICAL APPROVAL

This project has been considered using agreed School procedures and is now approved.

Signed

Print Name:

Date: 21/10/2010

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(Chair, School Research Ethics Committee)