

Older workers' experiences of depression in the contemporary workplace

By

Oluwatoyin Aderonke Adewunmi

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**Faculty of Health and Medicine
Lancaster University**

**I declare that this thesis is my own work and has not been submitted for the award of a
higher degree elsewhere**

LIST OF TABLES	IX
LIST OF FIGURES.....	X
LIST OF ABBREVIATIONS	XI
ACKNOWLEDGEMENTS	XII
THESIS ABSTRACT	13
CHAPTER 1	15
BACKGROUND	15
1.1 INTRODUCTION	15
1.2 DEFINITION OF KEY CONCEPTS.....	15
1.2.1 <i>Older Worker</i>	15
1.2.2 <i>Depression</i>	16
1.3 DEMOGRAPHIC CHANGES IN INDUSTRIALISED NATIONS	16
1.4 THE GLOBAL PREVALENCE OF DEPRESSION AMONG WORKERS	18
1.5 THE IMPACT OF DEPRESSION ON WORKERS.....	20
1.6 THE SYSTEMATIC REVIEW: AN OVERVIEW OF WORK FUNCTIONING DURING AND AFTER DEPRESSION.....	22
1.7 THE WORLD HEALTH ORGANIZATION’S RESPONSE TO OVERALL WORKPLACE HEALTH AND WELLBEING.....	24
1.8 THEORETICAL FRAMEWORK	24
1.9 PHILOSOPHICAL UNDERPINNING AND METHODS	25
1.10 THE RATIONALE FOR EXPLORING THE EXPERIENCES OF OLDER WORKERS WHO HAVE HAD DEPRESSION.....	25
1.11 STATEMENT OF PURPOSE AND DESIGN FOR THE EMPIRICAL STUDY	26
1.12 AIM AND OBJECTIVES	27

1.12.1 <i>Research and Sub-research Questions</i>	28
1.13 SUMMARY.....	28
CHAPTER 2.....	29
THEORETICAL AND CONCEPTUAL FRAMEWORKS.....	29
2.1 INTRODUCTION	29
2.2 THEORIES THAT HAVE BEEN PREVIOUSLY UTILISED IN SIMILAR STUDIES.....	30
2.2.1 <i>The person-environment-occupation model</i>	30
2.2.2 <i>Beck’s cognitive model of emotional disorders</i>	31
2.3. CONCEPTUAL FRAMEWORKS	32
2.3.1 <i>The Healthy Workplace Framework and Model</i>	33
2.4 THE IMPORTANCE OF HWFM IN EXPLORING OLDER WORKERS’ EXPERIENCES OF DEPRESSION.....	37
2.5 THE IMPLICATIONS OF HEALTHY WORKPLACES FRAMEWORK AND MODEL	38
2.6 THE APPLICATION OF HWFM IN PREVIOUS STUDIES	39
2.7 LIMITATIONS AND POTENTIAL PITFALLS OF HWFM.....	40
2.8 SUMMARY.....	44
CHAPTER 3.....	45
WORKERS’ EXPERIENCES OF WORK FUNCTIONING DURING AND AFTER DEPRESSION.....	45
3.1 INTRODUCTION	45
3.2. CONSERVATION OF RESOURCE THEORY.....	46
3.3 AIMS, OBJECTIVES AND REVIEW QUESTION	50
3.4 METHODOLOGY AND METHODS	51
3.4.1 <i>Eligibility Criteria</i>	51

3.4.2	<i>Literature Search and Information Sources</i>	55
3.4.3	<i>Study Selection</i>	55
3.4.4	<i>Quality Appraisal</i>	56
3.4.5	<i>Data Extraction</i>	57
3.4.6	<i>Synthesis of findings: Thematic synthesis</i>	57
3.5	FINDINGS AND ANALYSIS	58
3.5.1	<i>Study Selection</i>	58
3.5.2	<i>Reporting of included studies and characteristics</i>	61
3.5.3	<i>Features of the selected studies</i>	74
3.6	SYNTHESIS OF RESULTS	80
3.6.1	<i>Descriptive and analytical themes</i>	80
3.6.2	<i>Themes and Subthemes</i>	82
3.7	DISCUSSION	94
3.7.1	<i>Summary of evidence</i>	94
3.7.2	<i>Strengths and Limitations</i>	97
3.7.3	<i>Current gaps in the literature</i>	97
3.7.4	<i>Suggestions for further research</i>	98
3.7.5	<i>Implications for Practice</i>	98
3.8	CONCLUSIONS	102
	CHAPTER 4.....	104
	METHODOLOGY AND METHODS.....	104
	PHILOSOPHICAL UNDERPINNING, METHODS AND THEMATIC ANALYSIS	104
4.1	INTRODUCTION	104
4.2	RESEARCH PARADIGM.....	105
4.2.1	<i>Ontology</i>	105

4.2.2	<i>Epistemology</i>	106
4.2.3	<i>Methodology</i>	107
4.3	THEMATIC ANALYSIS	109
4.4	AIM AND OBJECTIVES	110
4.5	RESEARCH AND SUB-RESEARCH QUESTIONS.....	111
4.6	METHODS.....	111
4.6.1	<i>Study Setting</i>	111
4.6.2	<i>Population</i>	111
4.6.3	<i>Eligibility Criteria</i>	112
4.6.4	<i>Sampling and Sample Size</i>	113
4.6.5	<i>Participants</i>	114
4.6.6	<i>Recruitment strategy</i>	115
4.6.7	<i>Data collection</i>	116
4.6.8	<i>Reflexivity</i>	116
4.6.9	<i>Approach to Data Analysis</i>	117
4.7	ETHICAL CONSIDERATIONS	120
4.7.1	<i>Ethical Approval</i>	120
4.7.2	<i>Recruitment</i>	120
4.7.3	<i>Consent</i>	121
4.7.4	<i>Safety</i>	121
4.7.5	<i>Anonymity and confidentiality</i>	122
4.7.6	<i>Acquaintance Interview</i>	122
4.7.7	<i>Data management</i>	123
4.7.8	<i>Dissemination</i>	124
4.8	DISSEMINATION PLANS	124
4.9	SUMMARY.....	124

CHAPTER 5.....	126
ANALYSIS AND FINDINGS.....	126
5.1 INTRODUCTION	126
5.2 DESCRIPTIVE CHARACTERISTICS OF THE PILOT STUDY	126
5.3 DESCRIPTIVE CHARACTERISTICS OF THE DATA SET - THE MAIN STUDY.....	127
5.4 FINDINGS.....	131
5.4.1 <i>Characteristics of depression among older workers</i>	131
5.4.2 <i>Participants' interview characteristics</i>	131
5.5 THEMES AND SUBTHEMES FROM THE MAIN STUDY	132
5.5.1 <i>Theme 1 – Disclosure and non-disclosure of depression among older workers.....</i>	135
5.5.2 <i>Theme 2 – OWs' struggles during depression and the factors influencing the uptake of organisational support interventions.....</i>	148
5.5.3 <i>Theme 3 – Future outlook: The importance of work participation during and after depression.....</i>	157
5.6 SUMMARY.....	162
CHAPTER 6.....	164
DISCUSSION AND RECOMMENDATIONS.....	164
6.1 INTRODUCTION	164
6.2 EMPIRICAL CONTRIBUTIONS AND LIMITATIONS	164
6.2.1 <i>Negative perceptions about the combination of age and depression influenced OWs' choices and decisions.....</i>	165
6.2.2 <i>Organisational culture is crucial to disclosure and nondisclosure of depression among OWs</i>	167

6.2.3	<i>The effect of depression on OWs' work functioning, work environment and work participation</i>	169
6.2.4	<i>Line managers' support to OWs during a depression</i>	173
6.2.5	<i>Determinants of usefulness and accessibility to workplace support in the light of depression-related struggles among older workers.....</i>	175
6.3	THEORETICAL CONTRIBUTION AND LIMITATIONS	178
6.3.1	<i>The differences between OWs' experiences of depression compared with similar studies conducted across the full working-age range</i>	178
6.3.2	<i>Reconfiguring the framework and model of the healthy workplace</i>	178
6.3.3	<i>A new conceptualisation of depression among OWs: Replacing the cycle of heightened shame, vulnerability and stigma with dignity.....</i>	182
6.4	METHODOLOGICAL CONTRIBUTIONS AND LIMITATIONS	184
6.4.1	<i>Strength and Limitations</i>	184
6.5	IMPLICATIONS FOR POLICY AND PRACTICE	186
6.6	CONCLUSION OF THE EMPIRICAL FINDINGS.....	188
6.7	SUMMARY AND CONCLUSION OF THE THESIS.....	189
	REFERENCES.....	191
	APPENDICES.....	214
	APPENDIX 3.1 SYSTEMATIC REVIEW - SEARCH TERMS.....	214
	APPENDIX 3.2 ASSESSMENT OF METHODOLOGICAL QUALITY - CASP W54 (2018) FOR QUALITATIVE STUDIES.....	215
	APPENDIX 3.3 DATA EXTRACTION INSTRUMENT.....	217
	APPENDIX 3.4 LIST OF EXCLUDED STUDIES AND REASONS FOR EXCLUSION	220
	APPENDIX 3.5 A TABLE OF ARTICLES REPRESENTED IN THE THEMES	222
	APPENDIX 4.1 ETHICS APPLICATION FORM.....	228

APPENDIX 4.2A THE FIRST ETHICS APPROVAL.....	249
APPENDIX 4.2B THE SECOND ETHICS APPROVAL	250
APPENDIX 4.3 INTRODUCTORY OR COVERING LETTER	251
APPENDIX 4.4 EXPRESSION OF INTEREST FORM.....	252
APPENDIX 4.5 PARTICIPANT INFORMATION SHEET	253
APPENDIX 4.6 DEMOGRAPHIC DETAILS FORM.....	258
APPENDIX 4.7 CONSENT FORM.....	259
APPENDIX 4.8 PROJECT FLYER	261
APPENDIX 4.9 INDICATIVE INTERVIEW SCHEDULE.....	262
APPENDIX 5.1 DESCRIPTIVE THEMES FROM THE PILOT STUDY	265
APPENDIX 5.2 EXAMPLE OF NVIVO CODING	266
APPENDIX 5.3 EXAMPLE OF THE CODING PROCESS	268
APPENDIX 6.1 A 15-POINT CHECKLIST OF CRITERIA FOR GOOD THEMATIC ANALYSIS. BRAUN AND CLARKE (2006).....	272
APPENDIX 6.2 AN EXTRACT OF MY REFLEXIVE JOURNAL.....	273

LIST OF TABLES

Table 2.1	Healthy Workplaces Framework and Model individual experiences	43
Table 3.1	Conservation of Resource Theory.....	48
Table 3.2	The SPICE framework.....	52
Table 3.3	Inclusion and exclusion Criteria.....	53
Table 3.4	Study characteristics	62
Table 3.5	The findings of individual studies.....	75
Table 4.1	Eligibility criteria	112
Table 4.2	Stages of thematic synthesis.....	118
Table 5.1	Participants' characteristics.....	128
Table 5.2	Themes and Subthemes.....	132
Table 6.1	Reconceptualising Healthy Workplaces Framework and Model	181

LIST OF FIGURES

Figure 2.1	WHO Healthy Workplaces Model	35
Figure 2.2	Conceptual framework on older workers experiences of depression	42
Figure 3.1	PRISMA flow diagram illustrating search results and selection process.....	60
Figure 3.2	Themes and Subthemes from Depression-related Work functioning.....	81
Figure 3.3	Schematic representation of themes and relationships.....	83
Figure 5.1	Relationship between themes.....	134
Figure 6.1	Replacing the cycle of heightened shame, stigma and vulnerability with dignity.....	183

LIST OF ABBREVIATIONS

CASP w54	Critical Appraisal Skills Programme
CINAHL	Cumulative Index to Nursing and Allied Health
CMD	Common Mental Health Disorders
CRD	Centre for Reviews and Dissemination
DOH	Department of Health
DSM	The Diagnostic and Statistical Manual of Mental Disorders
EAP	Employee Assistance Programme
ENTREQ	Enhancing Transparency in Reporting the Synthesis of Qualitative Research
EPPI CENTRE	Evidence for Policy and Practice Information and Coordinating Centre
IAPT	Improving Access to Psychological Therapy
IPA	Interpretative Phenomenological Analysis
OECD	Organisation for Economic Cooperation and Development
OWs	Older Workers
PHE	Public Health England
PsycINFO	The American Psychological Association's resource for abstracts of scholarly journal articles, book chapters, books, and dissertations
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
PubMed	The National Library of Medicine's free search
WF	Work Functioning
WHO	World Health Organization

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THESIS ABSTRACT

The past two decades have witnessed an increase in research on the ageing workforce (Boot et al., 2016; Siegrist et al., 2012) due to demographic changes in industrialised nations and increasing numbers of older workers (OWs) (Statistical Office of the European Union (EU) (Eurostat) 2015; Coduti, 2015). An increasing prevalence of depression across the entire working population (World Health Organization [WHO], 2009; Tan et al., 2014), along with its impact on workers and OWs, are causes for concern for individuals, organisations and society (Stynen et al., 2015). This thesis presents a qualitative systematic review, which is concerned with workers' experiences of work functioning (WF) during and after depression, and an empirical study, which explored OWs' experiences of depression.

For the systematic review, a systematic search of international literature was conducted across five databases. Eleven peer-reviewed qualitative studies, published from 2004 to 2019, that explored experiences of WF among workers during and after depression or common mental disorders were included in the thematic synthesis. Following the quality appraisal, data were extracted and synthesised. The following four overarching themes emerged from the synthesis: *Obstacles to work functioning*; *Challenges of impaired work functioning*; *Consequences of impaired work functioning*; and *Promoters of work functioning*. The analysis highlights the importance of understanding workers' experiences of work functioning in relation to depression and the coping mechanisms utilised to mask their limitations. The empirical study for this thesis focuses on older workers because of the findings of this thesis' systematic review and OWs' vulnerability to involuntary job exclusion (Boot et al., 2016; WHO, 2010). Underpinned by the Healthy Workplaces Model and Framework, this qualitative study aimed to explore OWs' experiences of depression. An interpretive approach was useful in understanding participants'

meanings of depression in the contemporary workplace. Following a pilot study, 21 participants who experienced depression at age ≥ 50 years were recruited through snowballing and purposive sampling from across the UK. A semi-structured in-depth interview was conducted either over Skype, telephone or face-to-face.

Thematic analysis was chosen to analyse and interpret the patterns of meaning within the dataset. Data analysis led to the development of three superordinate themes and seven subthemes. The overarching themes are Theme 1 – *Disclosure and nondisclosure of depression among OWs*; Theme 2 – *OWs' struggles during their depression and organisational support interventions*; Theme 3 – *Future outlook: The importance of work participation during and after depression*. This empirical study's significant contribution highlights OWs' meanings of being diagnosed with depression at age 50 or above and how these meanings influenced their decision about disclosure, nondisclosure, accessing workplace support and future work participation. Organisational culture is a crucial factor for disclosure or nondisclosure among OWs. A salient theme throughout the study was the participants' desire for work participation and functioning. Further research on organisational and OWs' experiences of depression is recommended.

Chapter 1

BACKGROUND

1.1 Introduction

The past two decades have witnessed an increase in research on the ageing workforce (Boot et al., 2016; Siegrist et al., 2012) due to demographic changes in industrialised nations and increasing numbers of older workers (OWs) (Coduti, 2015; Statistical Office of the European Union [Eurostat], 2015). An increasing prevalence of depression across the entire working population (Tan et al., 2014; World Health Organization [WHO], 2009), along with its impact on workers and OWs are causes for concern for individuals, organisations and society (Stynen et al., 2015). This thesis presents a literature review, which is concerned with workers' experiences of work functioning (WF) during and after depression, and an empirical study, which explored OWs' experiences of depression.

This chapter defines the key concepts in Section 1.2. Sections 1.3 to 1.6 provide an overview and context for this thesis. Section 1.7 details the WHO's response to overall workplace health and wellbeing. Sections 1.8 and 1.9 highlight the conceptual and theoretical frameworks, as well as the philosophical assumptions underpinning this study. Section 1.10 and 1.11 provide a statement of purpose and design as well as the rationale for this study. Section 1.12 details the aim, objectives, the research question and the sub-research questions for the empirical study. Section 1.13 summarises the entire chapter.

1.2 Definition of key concepts

1.2.1 Older Worker

Internationally, an OW is defined in various ways. For instance, the WHO (2010a) defined an OW as an individual who is aged ≥ 45 years; in the United States of America, this is ≥ 55

years (Poscia et al., 2016); and in the United Kingdom (UK), this is defined as 50 years and above (Office of National Statistics (ONS), 2013). Given that this current study is based in the UK, the UK definition of an OW has been adopted.

1.2.2 Depression

Depression would be indicated if an “individual experiences depressed mood or the loss of interest/pleasure in nearly all activities” for two weeks (Diagnostic and Statistical Manual of Mental Disorders-DSM-5; American Psychiatric Association, 2018). To meet the full criteria for an episode of major depression, individuals must also concurrently experience at least five out of a list of seven groups¹ of symptoms lasting two weeks or more. Depression is classified in various ways, which Beck and Alford (2009) argued can be controversial, with many in disagreement. Therefore, in this study, depression has not been classed or categorised with one specific definition. The empirical work in this thesis also included those diagnosed by a clinician and those who self-diagnosed if they met the inclusion criteria.

1.3 Demographic changes in industrialised nations

In many industrialised nations, population demographic changes, such as an increase in the older population and a decrease in the number of younger people, are being recorded (Eurostat, 2015; WHO, 2010). According to Crawford et al. (2010), these changes are attributed to increasing life expectancy, declining fertility and low birth rates. The WHO (2010a) and (Eurostat, 2015) estimated that this affects 57 industrialised countries, including the EU’s 27 nations and the UK. For instance, statistics have shown that the UK population numbers around 66 million and has an average life expectancy of 80.96 years (ONS, 2018; The World

¹ 1) changes in weight or appetite; 2) changes in sleep, 3) changes in psychomotor activities, 4) decreased energy, 5) feelings of worthlessness or guilt, 6) difficulty thinking, concentrating and making decisions, 7) recurring thought of death or suicidal ideation, plans or attempts. Furthermore, the symptoms must not be solely the psychological effects of substance use, i.e. drugs, alcohol, medication or of a medical condition. Also, these symptoms must be severe, meaning they are associated with clinically significant distress and with impairment in social, occupational, or other types of functioning (American Psychiatric Association, 2018).

Bank, 2016). The UK population is generally living longer than before, as the life expectancy of baby boomers (those born between 1946 -1964) at age 65 is approximately an additional 20.9 years (Baby Boomer Hotspots Report, 2019).

There are also concerns that as baby boomers are now reaching their retirement age with fewer younger workers entering the labour force, there might be recruitment challenges (Eurostat, 2015). Thus, this new development is crucial for organisations as they might have to rely on OWs to meet their business needs. Thus, the international responses to the demographic changes highlighted above include initiatives to retain OWs for longer, such as adopting the EU legislation on age discrimination – the Employment Equality (Age) Regulation 2006 (Ross, 2010). Official statistics have confirmed the consequence of these international responses to include a growing number of OWs (ONS, 2018; Statistics Canada, 2018). In 2011, the UK Government undertook several reforms, such as abolishing the retirement age, which targeted preventing future employment challenges among OWs (Barrett & Sargeant, 2015). Given the likely implications of the demographic changes on the UK's economy, the UK Government's Industrial Strategy has identified that meeting the needs of an ageing society is one of its four 'Grand Challenges' with a call to support industry to adapt to an ageing workforce (House of Commons, 2018).

Ng and Feldman (2013) argued that many baby boomers remain in employment into older age. For instance, findings of international studies indicate that OWs have been highlighted to be among the fastest-growing groups in today's workforce, with further predictions that, in the next 5-10 years, one-third of workers would be over the age of 50 (Knebelmann & Prinz, 2016; Toossi, 2007). According to the Ageing Workforce Report (2017), the US Bureau of Labor Statistics revealed that the proportion of people aged 55 and above in employment would increase from 35.7 million in 2016 to 42.1 million in 2026. According to Statistics Canada (2018), between 1996 and 2018, and compared with workers aged 25 to 34, the number of workers aged 55 years and above has increased and now almost tripled. Recent statistics have shown that the UK's workforce now includes more than ten million OWs (ONS, 2018). For instance, a commissioned nationwide study by Dunstan Thomas (2017) revealed that "one

in five (19%) 66-71-year olds in the UK are still working full- or part-time today to supplement their retirement incomes” (p.1). According to ONS (2018), older peoples’ work activity has increased in the past two decades due to lack of readiness to stop working, afford the essential payment, or boost pension pots. Nevertheless, the effect of the abolition of the retirement age cannot be underestimated.

While it is understandable that an increasing number of OWs might be beneficial to individuals, organisations and society in general, this might also present additional workplace challenges. Crawford et al. (2010) have highlighted the health, safety and welfare issues that are likely to be associated with this change. Given the increasing proportion of OWs, Koh and Koh (2006) argued the need for a paradigm change and further research into an ageing workforce's occupational health (OH) problems. For instance, Tan et al. (2014) and the WHO (2010b) highlighted that significant health and wellbeing challenges confronting the contemporary workforce are common mental health disorders (CMD) or issues, with depression being at the forefront. The prevalence of depression is presented below.

1.4 The global prevalence of depression among workers

In 2015, the WHO estimates were that over 300 million people experience depression globally, which is equivalent to 4.4% of the world population (WHO, 2017). This same document indicates that the “prevalence rates vary by age, peaking in older adulthood (above 7.5% among females aged 55-74 years, and above 5.5% among males)” (p.8). Gao et al. (2020) argued that older people are more vulnerable to mental health issues such as depression. Depression is classed as a complex health condition contributing significantly to the global burden of disease in terms of disability and costs (Kessler et al., 2009), especially in a rapidly ageing population (Knebelman & Prinz, 2016; Siegrist et al., 2012). Depression is ranked as the leading cause of disability measured by years lived with disability, and the fourth leading cause of global burden of disease by the WHO (cited in Reddy, 2010). Furthermore, various studies have highlighted the challenge of under-reporting, under-detection and

inadequate treatment of depression among the older population (Colman & Ataulahjan, 2010; Oliffe, 2013; Padayachey et al., 2017). If left untreated or unaddressed, this might impact on organisations.

Organisationally, there is a growing concern about the high prevalence of CMD, such as depression, across the working-age population (Andrea et al., 2009; Gallo et al., 2006). A Labour Force Survey of self-reported cases of work-related stress, depression and anxiety between 2017/19 and 2019/20 revealed that, overall, women had statistically significantly higher rates of work-related stress, depression or anxiety (Health and Safety Executive [HSE], 2019). Compared with all workers, male workers in the age groups of 16-24 and 55 years plus had significantly lower rates of work-related stress, depression or anxiety for the same year. However, females in age groups 25 to 34, and 35 to 44 had significantly higher work-related stress, depression or anxiety. Based on these statistics, the prevalence of depression seems to reduce as people age, which could be attributed to under-reporting among OWs given the WHO estimate mentioned above. A review of the literature for this thesis shows that statistics on OWs and depression are scarce.

The prevalence of depression across the full working-age population and its accurate estimation have been highlighted as a challenge for various reasons (Tan et al., 2014; WHO, 2009), such as its variability with age, gender, and education (OECD, 2011). Furthermore, Kessler and Bromet (2013) highlighted that the recurring nature of depression over an individual's life course further compounds the problem as it could persist to old age. Thus, Ng and Feldman (2013) argued that "understanding the relationship of age to employee health has both theoretical and practical importance, yet there have been no attempts to address that relationship" (p.337) comprehensively. However, despite the increasing number of OWs and statistics highlighting that 8% of the global burden of disease from depression is attributed to occupational factors (Prüss-Ustün, 2006; Siegrist, 2012), there is a paucity of studies on this crucial topic. Moreover, Gao et al. (2020) argued that OWs with higher work pressure are more likely to experience depression than older ones with low or no work pressure. A cross-sectional and longitudinal study conducted in three continents found that effort-reward imbalance and

low job control are high-risk factors for depression among OWs (Siegriest et al., 2012). Therefore, an in-depth understanding of this phenomenon's multifaceted challenges among OWs is essential in addressing the issues it presents. Unless these issues are addressed, the impact of these combined problems could result in individual, organisational and societal resource losses.

A Labour Force Survey by the HSE (2019) revealed that the total number of cases of work-related stress, depression or anxiety in the UK in 2018/19 was 602,000. This figure equated to a prevalence rate of 1,800 per 100,000 workers with a total number of working days lost for the same year documented as 12.8 million days. This finding equated to an average of 21.2 days lost per case. In 2018/19, the same survey reported that depression or anxiety accounted for 44% of all work-related ill health cases and 54% of all working days lost due to ill health. Consequently, the organisational and national impact of depression remains significant.

1.5 The impact of depression on workers

A central issue with depression is its multifaceted impacts on workers, OWs, organisations and society. For instance, Knebelmann and Prinz (2016) and Sobocki et al. (2006) estimated the financial impact of depression as approximately 118 billion Euro, 1% of EU GDP. Cornelius et al. (2011), Harper and Marcus (2006), Ivandic et al. (2017) and the WHO (2018) have highlighted the burden of sickness absence and productivity losses on organisations due to depression. Additionally, several studies have highlighted the dual challenge of age and depression on OWs' sustainable employability, which may be due to disability, impaired WF, organisational stereotypes, and work exit (Cornelius et al., 2011; Doshi et al., 2008; Knebelman & Prinz, 2016; Ng & Feldman, 2013; Stynen et al., 2015). Longitudinal studies have shown that OWs with depression reported consistently lower functioning levels, lower job control, and increased emotional job demands than other working age groups (Cornelius et al., 2011; Stynen et al., 2015). In their prospective cohort study, Stynen et al. (2015) found

that OWs with depression were vulnerable to functional losses with varying impacts, based on individual working conditions.

Knebelmann and Prinz (2016) argued that depression-related stigma and discrimination have a more significant impact on the employability of OWs than for the younger working population since they are already vulnerable to depression due to their age. These authors maintained that, apart from age, the onset of new episodes of depression among OWs appears to be an additional discriminatory factor that could cause a “double barrier” to employment, making the impact of depression on their career trajectory stronger than for younger workers. The recurrent nature of depression could mean inconsistent work participation (Knebelmann & Prinz, 2016). Of particular challenge is the dual impact of depression on OWs because of their age and the demand to remain in employment beyond the conventional age (Knebelmann & Prinz, 2016). Furthermore, a mixed-methods study on ageing workers and their work environment as a factor in employee mental health found that those aged 50-59 had a longer sickness absence duration than workers aged 40-49 (Coduti et al., 2015). The study also found that depression and anxiety were the most common reasons for mental health short-term disability claims.

The impacts of depression include impaired WF, work attendance and work participation issues among OWs (Knebelmann & Prinz, 2010; Lagerveld et al., 2010); being a precursor to work exit (Stynen et al., 2015); as well as productivity and financial losses within organisations and globally (Ivandic et al., 2017). Thus, these impacts could be financially significant both for organisations and society.

Given the high prevalence of depression and its impact on organisations as revealed from the literature review, this thesis's empirical study is concerned with understanding the experiences of depression among OWs. The literature review for this thesis concerns itself with understanding workers' experiences of WF during and after depression.

1.6 The Systematic review: An overview of work functioning during and after depression

The review for this thesis initially aimed to synthesise qualitative studies on OWs' functioning (workers aged ≥ 50 years) during and after depression due to the ageing workforce phenomenon. However, a scoping search of existing literature yielded limited studies. Therefore, the review was conducted across the full working-age group. This new conceptualisation of the systematic review scope to include the full working-age group is argued to provide a broad understanding important for developing the empirical study.

The growing interest in and continuing concern about the high prevalence of depression and its adverse effects on employees' WF have stimulated this review (Boot et al., 2016; Ivandic et al., 2017; Kessler et al., 2008; Stynen et al., 2015). Several studies have highlighted the significant impact of depression-related impaired WF at individual, organisational and societal levels (Ivandic et al., 2017; Kessler et al., 2008). However, a comprehensive overview of the literature to understand depression-related WF among workers remains underdeveloped. With the aim of understanding workers' experiences of WF during and after depression, this review sets out to synthesise qualitative studies that focused on this phenomenon.

Optimum WF is vital to every organisation's success, which ultimately supports the global economy's sustenance. Organisational focus on depression-related impaired WF has increased as policymakers have become more aware of the associated heightened financial and societal burden (de Graaf et al., 2012). According to de Vries et al. (2015), WF is defined as "the capacity of an individual employee to adequately meet work responsibilities" (p.181). As a multidimensional construct, WF includes workers' experiences in fulfilling their roles, the dynamic relationship between individual health resources, work expectations, and the work environment's structural conditions (Ivandic et al., 2017; Lagerveld et al., 2010; Stynen et al., 2015). However, according to de Vries et al. (2015), impaired WF is defined as work limitations experienced by an individual worker. Individual limitations might be associated with their

symptoms, medication side effects, lack of effective treatment, skills, or workplace support level.

Depression-related impaired WF has been highlighted as a central organisational issue due to disability, productivity losses, sickness absence and work exit (de Vries et al. 2015; Knebelmann & Prinz, 2016). For instance, a systematic review of quantitative studies conducted by Lagerveld et al. (2010) focused on factors associated with work participation and WF in depressed workers. The review found that severe depressive symptoms were associated with work limitations and clinical improvement was related to improved work productivity. Dewa and Lin (2000) also found that workers with depression might only achieve normal productivity with increased physiological and psychological effort. However, Adler et al. (2006), Ivandic et al. (2017) and Vos et al. (2016) highlighted that impaired WF might persist even after the symptoms of depression have improved, causing productivity losses, and eventual work exit, which might be attributable to the fluctuating nature of depression.

Given that the benefits of optimum WF include psychological and physical health advantages, it has been argued that underperformance frequently exerts negative consequences on the individual (de Graaf et al., 2012; Knebelmann & Prinze, 2016; Plaisier et al., 2010). Despite these findings, an in-depth understanding of workers' experiences of inherent challenges encountered due to depression-related impaired WF remains unclear. The rationale for the systematic review for this study is discussed in Chapter 3.

Having established the challenges presented by the prevalence and impact of depression across the full working-age population, OWs, organisations and society, it is prudent to understand the WHO's position in enabling organisations to manage workplace health and wellbeing issues effectively.

1.7 The World Health Organization's response to overall workplace health and wellbeing

According to Burton (2010) “addressing a huge burden of disease, its economic costs and long-term loss of human resources (HR) from unhealthy workplaces is a formidable challenge for national governments, workplaces, economic sectors, health policymakers and practitioners” (p.1). In its quest to support organisations' health and wellbeing and based upon the 1996 World Health Assembly Global Strategy for Occupational Health (OH) for all, the Workers' Health: Global Plan of Action (GPA) (2008-2017) was developed by motivating member states to devise a strategy (WHO, 2007). The GPA includes five objectives:

1) develop and implement policy instruments on workers' health; 2) incorporate workers' health into other policies; 3) provide and communicate evidence for action and practice; 4) improve the performance and access to OH services; 5) protect and promote health at work. (Global Country Survey, 2008/2009, p.8., WHO, 2013).

As an ongoing workplace health and wellbeing strategy and to facilitate a framework for implementing the GPA, the WHO healthy workplace model highlights a comprehensive way of thinking and acting. The model aims to create a workplace environment that does not cause re-injury or reoccurrence of an illness when someone returns to work after being away with an injury or illness, such as depression, whether work-related or not. Ultimately, the model is “targeted at providing a supportive, inclusive and accommodating work environment for OWs or those with chronic diseases or disabilities” (Burton, 2010, p. 82).

1.8 Theoretical framework

The Healthy Workplace Framework and Model will guide the empirical study (HWFM) (Burton, 2010). Developed by the WHO, the HWFM is a framework that allows the exploration of this topic within organisational institutions (Burton, 2010). The conservation of resources (COR) theory (Hobfoll et al., 2018) will help unravel the complexities of depression and impaired WF among workers during this study's systematic review.

1.9 Philosophical Underpinning and Methods

Having underscored the complexities of depression among workers, OWs, and its likely impacts, it is imperative to understand the experiences and meaning OWs associate with their experiences. Thus, the ontological underpinning for this thesis (relativism) assumes that reality exists within human minds and no one true reality exists (Moon & Blackman, 2017). Ontology is the study of being or the nature of reality, which this study views as subjective and changing; there is no one ultimate truth (Bunniss & Kelly, 2010). Epistemology refers to the nature of knowledge (Bunniss & Kelly, 2010). This study's epistemological assumption is based on interpretivism, a philosophical approach usually associated with qualitative methodology and grounded on the assumption that knowledge is subjective (Bryman, 2012). The philosophical underpinnings are justified in Chapter 4.

1.10 The rationale for exploring the experiences of older workers who have had depression

Given the prevalence and impact of depression across the entire working population, OWs, organisations and society, this study is needed. Depression among OWs progressively contributes to disability and eventual work exclusion (Cornelius et al., 2011; Knebelmann & Prinz, 2016). Also, a UK government report highlights that despite the enactment of the Equality Act (2010) which has age discrimination as one of its eight protected characteristics, the challenges confronting older people and employment remains unresolved (House of Commons, 2018). For instance, a longitudinal study conducted by Knebelmann and Prinz (2016) across Europe revealed that “for persons aged 50-64, depression symptoms lead to a decrease in the probability of being employed or self-employed between 22 and 51 percentage points” (p. 19). Additionally, the study revealed that depression symptoms also play a leading role in early exits from the labour force among the 50-59 age group. This study also highlighted that OWs aged between 50 to 54 and with stronger symptoms are more than twice as likely to exit employment before reaching retirement age compared with their peers without depression

symptoms. Arguably, if organisations continue to rely on OWs to sustain the economy, then the issue of depression must be addressed.

Knebelmann and Prinz (2016) also found that, on average and irrespective of the symptoms' intensity, depression symptoms increase the annual number of sickness-leave days of workers aged 50-64 by 7.2 days. These statistics suggest challenges such as productivity losses, reduced human capital with prolonged or recurrent sickness absence, and eventual work exit (Knebelmann & Prinz, 2016). Those who remain at work might continue to struggle without much support. Crawford et al. (2010) have highlighted the associated health, safety and work capacity challenges of increasing OWs in the contemporary workplace. An increasing need for OWs' work participation in developed countries, such as Europe, presents a significant challenge.

1.11 Statement of purpose and design for the empirical study

The empirical study for this thesis explores OWs' experiences of depression in the contemporary workplace and makes sense of the meaning they gave to their experiences. My work experience as an OH specialist manager at a UK university stimulated my interest in this phenomenon. OWs with depression and anxiety were frequently referred to my department for assessment. Consequently, I was tasked with writing a workplace wellbeing strategy for the university, which precipitated a review of the staff demography. It emerged that the University had a workforce demography of over 50% OWs, along with a high level of mental health conditions, such as depression. Furthermore, the empirical study for this thesis builds upon the outcome of the systematic review conducted as part of this PhD thesis. The review revealed several gaps on the topic. For instance, the literature review was initially aimed at synthesising qualitative studies on OWs' experiences of depression and WF. However, it was found that only a few qualitative studies have explored the experiences of OWs with depression or other CMDs. Thus, this study addresses the methodological imbalance on this phenomenon. To the author's knowledge, no UK-based study has focused on OWs'

experiences of depression. Despite the prevalence and impact of depression on OWs, this phenomenon remains under-explored.

Additionally, most workplace-based qualitative studies on depression were focused on the full working-age population (Bertilsson et al., 2012; Sallis & Birkin, 2014). Other authors have highlighted that qualitative studies on this issue are principally based on organisational or managers' perspectives while OWs, the experiential experts, are neglected (Hung et al., 2010). On the one hand, a lack of empirical studies on OWs with depression may be attributable to the significant challenge of recruiting people with depression into research studies (Brown et al., 2019). On the other hand, quantitative studies' inherent nature is not to explore individuals' subjective experiences. Rather, such studies aim to understand the causality, correlates, prevalence and outcomes of depression explored through the life course lens (Colman & Ataulahjan, 2010). Colman and Ataulahjan (2010) posited that the life course approach, although currently underutilised, is useful in understanding the causality, prevalence and outcomes of depression because it influences the trajectories of depression through the life course. The life course approach is an epidemiological method that seeks to understand how health and disease determinants interact across a human life span. It has been used to conceptualise factors such as nearing retirement and concurrent comorbidity among OWs with depression. Thus, it is hoped the subjective approach of this study will contribute meaningfully to the experiences of OWs and the inclusion of their needs when organisations are planning workplace support for mental health issues.

1.12 Aim and Objectives

The empirical study for this thesis aims to explore, through thematic analysis (Braun & Clarke, 2006), the experiences of OWs who have had depression and how they make sense of their experiences. The objectives of this empirical study are as follows:

- To explore the impact of depression on OWs' work attendance, functioning and participation from individual perspectives;

- To understand the workplace issues that were related to OWs' experiences;
- To explore the meaning that OWs gave to their experiences of depression;
- To explore the participants' experiences about workplace support provisions.

1.12.1 Research and Sub-research Questions

The research question for this study is, "What are the experiences of OWs who had depression in the contemporary workplace?". The following sub-research questions will be explored during individual interviews:

- How does depression affect OWs' WF, work participation and work environment?
- How supportive are line managers and supervisors to OWs with depression?
- How useful and easily accessible is workplace support to the OWs with depression?

1.13 Summary

This chapter focused on introducing the systematic review and empirical study for this thesis. It has demonstrated that due to the demographic changes in industrialised nations, there is an increasing reliance on OWs to fill employment gaps. The prevalence and impact of depression across the entire working population seem significant as the entire working population includes OWs. The double impact of depression and age on work participation could be very significant for individuals, organisations and society. Also, the heightened level of mental health issues across the full working-age population, particularly depression, and the research gaps in this area call for further exploration. In Chapter 2, the conceptual framework and theories underpinning this study will be discussed. The empirical study aims to respond to the literature review gaps with further elaboration in Chapter 3. Chapter 4 discusses the philosophical underpinnings, methods and the ethical considerations for this study. Chapter 5 is concerned with the analysis and findings of this study, and Chapter 6 is concerned with the discussion, recommendations, study limitations and summary.

Chapter 2

THEORETICAL AND CONCEPTUAL FRAMEWORKS

2.1 Introduction

This chapter discusses the theoretical and conceptual frameworks that guide the empirical study. These frameworks are pathways that direct and shape research to embed it in theoretical concepts, thereby extending knowledge and producing meaningful findings (Adom et al., 2018). Both types of frameworks work in a complementary manner within a research study, but each has its characteristics and differences (Adom et al., 2018). For instance, a theoretical framework is vital for theory-driven thinking, useful in selecting a topic, developing research questions, conceptualising a literature review, the design approach, and the analysis plan for a study (Grant & Osanloo, 2014). However, a conceptual framework is a template for exploring the research problem and provides direction and the relationship between the key concepts in a study (Grant & Osanloo, 2014). According to Adom et al. (2018) and Grant and Osanloo (2014), a conceptual framework offers multifaceted benefits to research. These include the following: the identification and construction of the researcher's worldviews; simplification of the presentation of solutions to the research problem; accentuation of why a topic is worth studying; and the conceptualisation and grounding of the research approach. Adom et al. (2018) explained that while both frameworks could be utilised in guiding a research study, a conceptual framework could be chosen over a theoretical one where there is no unified theory for the research study. In this study, a combination of theoretical and conceptual frameworks was utilised in extending knowledge. This choice is justified, given the complexity of the research problem. Therefore, this chapter is crucial to the formation and the implementation of this current research.

The utilisation of conservation of resources (COR) theory (Hobfoll et al., 2018) was useful in conducting the systematic review and explaining the outcome of the empirical study. The

principles and corollaries of COR theory, the justification of its choice and its application in previous studies are addressed in Chapter 3. The conceptual framework upon which this empirical research is anchored is the Healthy Workplaces Framework and Model ([HWFM], Burton, 2010). The adapted framework is based on the research question for this study, “What are the experiences of older workers (OWs) who had depression in the contemporary workplace?”. The use of the HWFM is justified, given that this study is organisational research.

In this chapter, Section 2.2 summarises the previous theories that have been utilised in similar studies. Section 2.3 explores the multifaceted aspects of the HWFM (Burton, 2010) as it applies to this current empirical study. Sections 2.4 and 2.5 explain the importance and implications of the HWFM in explaining the experiences of OWs with depression. Sections 2.6 and 2.7 detail the application of the HWFM in previous studies as well as highlight some of its limitations. Section 2.8 provides an adaptation of the HWFM.

2.2 Theories that have been previously utilised in similar studies

A review of the literature revealed that various theoretical frameworks had guided previous experiential studies relating to depression among workers. These include theories such as the person-environment-occupation model (Law et al., 1996) and Beck’s cognitive model of emotional disorders (Clark & Beck, 2010). Their utilisation in past experiential studies and why they are considered unsuitable for this current study are detailed below. Although the COR theory has also been utilised in previous studies, it will be discussed in Chapter 3 because of its relevance to the systematic review for this thesis.

2.2.1 The person-environment-occupation model

Based on environment-behaviour theories (Baker & Intagliata, 1982), the person-environment-occupation (PEO) Model (Law et al., 1996) was first proposed as a tool to examine complex occupational performance issues. The PEO model is an approach to assessing occupational performance and functioning experiences as well as planning

interventions in the environment in which individuals live, work and play (Strong et al., 1999). The model highlights three variables: the person; their environment; and their occupation, and holds that the more closely knitted a person, their environment and occupation are, the better the quality of performance (Strong et al., 1999). An unsatisfactory PEO fit would suggest that engagement with work or at work would be negatively impacted. The PEO model has been utilised in various contexts such as hospitals, communities, academic and research settings.

In their grounded theory, exploring work instability experiences in workers with CMD, Danielsson et al. (2017a) drew on the PEO model as a pre-understanding for their study. Various authors acknowledged that the complexity of functioning at work demands the use of frameworks that recognise the interconnectedness between the worker, the work tasks and their work environment, as well as between their working and private lives (Danielsson et al., 2017a; Law et al., 1996; Ekbladh & Sandqvist, 2015). Thus, it is clear that the PEO model is adaptable to workplace settings and could help explore specific workplace challenges, such as work performance. However, the PEO model appears only to capture a narrow aspect of working life, performance. As this current study aims to explore the experiences of OWs who had depression in the contemporary workplace, the PEO model will not be utilised because it is unlikely to fully capture the reality of other workplace factors that might be associated with this study.

2.2.2 Beck's cognitive model of emotional disorders

Beck's cognitive model of emotional disorders describes people's descriptive and developmental levels of cognition responsible for the persistence of depression (Clark & Beck, 2010). This theory's descriptive level describes schemata's power, which directs data understanding (Clark & Beck, 2010). Schemata are deeply seated rigid structures learned through previous human experience as they guide the "identification, interpretation, categorisation and evaluation of experience" (p. 419). Schemata are assumptions inferred from persistent, repetitive themes in thoughts, images and recurrent patterns of biased

information processing, which might cause individuals to selectively process negative self-referential information about social rejection, as an example (Clark & Beck, 2010). Negative attitude and beliefs reinforce negative beliefs about the self and the world (Clark & Beck, 2010). These schemata are “structurally inflexible, impermeable and absolute, and their content is a biased representation of the experience that is readily activated by a range of stimuli” (p. 419). Once accessed, they dominate the information processing system (Clark & Beck, 2010).

The developmental level highlights the role of cognitive structures and thinking style in the cause of emotional disorders (Clark & Beck, 2010). It posits that the formation of dysfunctional schemata about the self is due to early adverse childhood events such as parental loss, rejection or neglect that sensitises the individual to later losses in adolescence and adulthood (Beck, 2008; Clark & Beck, 2010).

This model has been used in workplace studies to illuminate the problem of depression through the life course. However, as this model only focuses on explaining individual cognitive experiences, it might not fully highlight issues from various aspects of the work environment. Although depression among OWs might not have originated from the workplace, it could significantly impact individuals' work, work environment, and vice versa. Consequently, Beck's model will not be utilised in this study as it does not provide a broad concept from which the study aim could be explored.

2.3. Conceptual Frameworks

This section provides detailed information about the HWFM (Burton, 2010) and the various elements that make up the framework. It also highlights its importance in explaining the experiences of depression among OWs and its use in previous studies. This section also provides the limitations of the HWFM and detailed information about its adaptation in exploring depression-related experiences among OWs within workplace settings.

2.3.1 The Healthy Workplace Framework and Model

As highlighted above, the multifaceted nature of depression within work contexts requires a broad conceptual framework in exploring OWs' experiences. Combining health protection and health promotion, the HWFM was developed out of a systematic review of the literature. In October 2009, (the World Health Assembly Worker's health: Global plan of action 2008 – 2017), a WHO workshop, that included 56 experts, international workers, employer representatives and leading Occupational health (OH) experts from 22 countries developed the HWFM. The HWFM is a model for action for employers, workers, policymakers and practitioners (WHO, 2010) that provides a framework for developing healthy workplace initiatives adaptable to diverse countries, workplaces and cultures. Burton (2010) defines a healthy workplace as “one in which workers and managers collaborate to use a continual improvement process to protect and promote the health, safety and wellbeing of all workers and the sustainability of the workplace based on identified needs” (p.82). A healthy workplace includes considering the health, safety and wellbeing concerns in the physical and psychosocial work environment; “personal health resources in the workplace; and providing ways of participating in the community to improve the health of workers, their families and other members of the community” (Burton, 2010, p.82).

Historically, the moral and ethical principles expected from businesses/organisations have been blurry until recent times (Burton, 2010). The HWFM highlights the ethical, moral and legal issues that are likely to arise from business processes, thereby negatively impacting employees and communities. It argued the need for organisations to build business relationships with their employees based on moral and ethical principles, such as nonmaleficence, that is, do no harm (Beauchamp & Childress, 2013). It argued the need for organisations to ensure the creation of a work environment that does not cause harm.

From a legal standpoint, the Seoul Declaration on Safety and Health at Work at the XVIII World Congress held in Seoul, Korea, in 2008 details the fundamental human right of every worker to a safe and healthy work environment regardless of their age, gender or organisation.

In the UK, Section 2 of the Health and Safety at Work Act (1974) places a duty of care on employers to ensure the health, safety and welfare of their employees. Furthermore, the Equality Act (2010) has eight protected characteristics, including age and disability. Within this legal framework, organisations have a legal duty to consider reasonable adjustments for workers with disability. Thus, in the context of this current study, OWs who had depression or other mental health issues are fundamentally entitled to a safe and healthy work environment that does not discriminate based on gender, age, disability or cause re-injury.

The HWFM encompasses three levels: avenue of influence; process; and core principles. Thus, it highlights a comprehensive way of thinking and acting that addresses three key areas: 1) work-related physical and psychosocial risks; 2) promotion and support of healthy behaviours; 3) broader social and environmental determinants ([Fig 2.1](#)). This framework is vital to this current study because it reflects how an understanding of employee health and wellbeing has evolved from an almost exclusive focus on the physical work environment to the inclusion of psychosocial and personal health practice factors. It also conceptualises the increased importance of utilising the workplace as a setting for health promotion and preventive health activities to prevent occupational injury and assess and improve people's overall health. The HWFM increasingly emphasises workplaces that are supportive, inclusive, and accommodating OWs and people with chronic diseases or depression (Burton 2010), thus aligning the study to this model. Additionally, the model encourages creating a work environment that does not cause re-injury or reoccurrence of an illness when employees return to work following injury or illness-related sickness absence, such as depression, whether it is work-related or not. These explanations resonate with the phenomenon of this study.

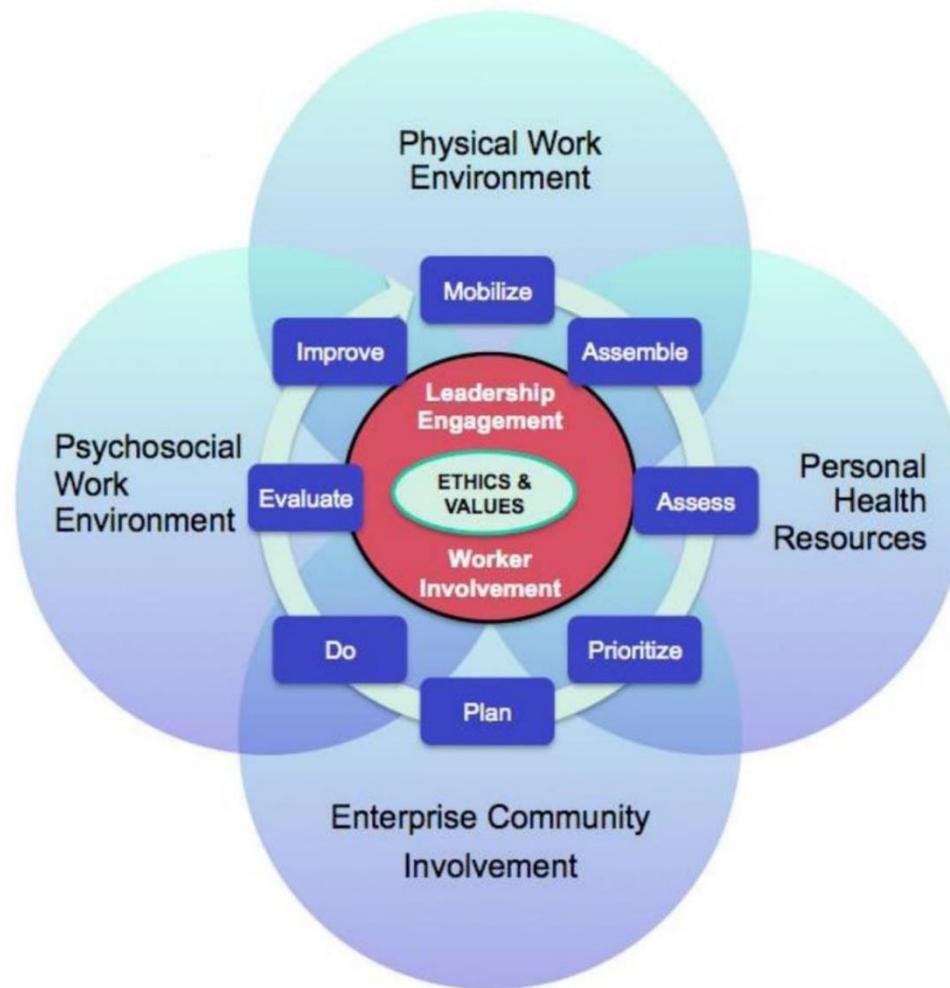


Fig. 2.1 WHO Healthy Workplaces Model: Avenues of Influence, Process and Core Principles (Burton, 2010).

The avenues of influence encompass four interrelated and vital concepts essential to a healthy workplace. The first key element is the *physical work environment*. Burton (2010) explains this as the detectable part of the workplace facility by human or electronic senses. It includes the physical materials in the workplace such as structure, air, machines, and processes that could potentially impact workers' physical or mental safety, health, and well-being (Burton, 2010). This includes outdoor or in-vehicle tasks performed by workers. The hazards presented in the physical work environment could potentially impact on mental wellbeing. The second key concept is the *psychosocial work environment*, and this includes, the organisation of work and the organisational culture; the attitudes, values, beliefs and practices that are demonstrated daily in the enterprise /organisation, and which affect the mental and physical wellbeing of employees. These are sometimes generally referred to as workplace stressors, which may cause emotional or mental stress to workers (Burton 2010, p.85). For example, the psychosocial work environment, such as organisational culture, support and work-life balance issues, could harm an OW or exacerbate their depression. Or in some cases, it might be the origin of mental health issues. For example, in their cross-sectional and multivariate regression analysis of data of four cohort studies with OWs, Siegrist et al. (2012) found that psychosocial stress at work is a likely relevant risk factor for depression among OWs. This study highlights the importance of the psychosocial work environment in OWs' depression symptoms.

The third key concept is *personal health resources in the workplace*. This resource includes workplace support to motivate workers to improve or maintain healthy personal lifestyle practices. These are exemplified as the provision of health services, information, resources, opportunities and flexibility to monitor and support workers' ongoing physical and mental health (Burton, 2010). This explanation suggests that employee health issues are not the sole responsibility of an individual; organisations also have an obligation. Nevertheless, this also includes individuals' coping resources and the prevailing social situation. The fourth essential concept of HWFM is *enterprise community involvement*. It includes activities, expertise, and other resources an enterprise provides to the social and physical communities where it

operates. These are activities, which might affect the physical, mental health, safety and wellbeing of workers and their families (Burton, 2010). An exemplification of this fourth concept could be night work. See [Fig 2.1](#) for the schematic representation of the four avenues of influence. It shows the relationship between the four elements; an impact on one area affects all the work environment areas.

The second layer of the model, process, is the intervention level, and it includes the following elements: *Mobilise, Assemble, Assess, Prioritise, Plan, Do, Evaluate and Improve*. It involves the process for implementing a sustainable, effective and suitable healthy workplace programme that is fit-for-purpose within an organisation (see [Fig 2.1](#)). The process has been adapted for this study, as will be discussed in Section 2.8. The last layer in the model, core principles, includes *ethics and values*, which unify *leadership engagement, and worker involvement*. This segment of the HWFM highlights leaders and workers as key in creating a healthy work environment (see [Fig 2.1](#) for the HWFM). Therefore, this model is essential in forming a conceptual framework for this current study because it seems robust and comprehensive, and it promises flexibility and user-friendliness.

2.4 The importance of HWFM in exploring older workers' experiences of depression

As discussed above, the HWFM is essential to exploring the research question for this study because of its multifaceted workplace variables. It was chosen over the other theories mentioned above because of its focus on the workplace. It was also chosen because of its potential for easy applicability. Its application facilitates the exploration of the broader experiences of depression among OWs regardless of its causality. The HWFM provides a platform upon which the conceptual framework for this study could be adapted. According to Grant and Osanloo (2014), a conceptual framework helps identify, construct a researcher's worldview, depict and analyse data. For instance, the concepts highlighted in the HWFM, such as the physical and psychosocial work environments, were useful in forming the different

aspects of the research, such as the research question and the questions in the interview schedule.

This framework is also vital because the HWFM drew on several existing models that describe the linkages between an organisation, health (depression), and employees (OWs). Thus, it can provide a rich bedrock upon which a more relevant framework could be built. The HWFM also anchored my assumptions, and it was useful in asserting the solutions to this research problem. The experiences of depression vary between individuals and some of the theories that have been used to understand it is inherently different. For instance, Beck's theory attributes the causality of depression to negative thought patterns (Clark & Beck, 2010). Because each model is specific in their way, therefore, it is believed that this study would benefit from adapting the HWFM (Burton, 2010) to explore OWs' experiences within the work context. As stated above, the HWFM has been supplemented with [COR theory](#).

Thus, in this study, a conceptual framework, the HWFM, has been chosen over the previously discussed models because it is a workplace-based model. Although the HWFM has many similarities with the PEO model because it comprises the physical, psychosocial, and cultural environments as well as occupation, the latter is narrowly focused on individuals' function. The PEO model is also based on the principle that occupational performance is shaped by the dynamic interdependence of persons, occupations and environments, which, although developed for occupational therapists working outside the organisational context, could have been adapted to work settings. However, it is dissimilar to HWFM because it only focuses on performance and emphasises disability rather than health. Therefore, the HWFM is considered more robust than the PEO model in exploring the experiences of OWs who have had depression.

2.5 The Implications of heathy workplaces framework and model

The HWFM is principally envisioned to address principal injuries or illnesses. Given the prevalence of depression across the working population and its impact on OWs, the HWFM

will enable an understanding of depression among OWs while focusing on the physical, psychosocial and organisational input. The HWFM has been useful in identifying and constructing my worldview about the experiences of OWs who had depression. The utilisation and adaptation of this model mean that the study will focus on the broader issues presented by depression among OWs within the contemporary workplace. The research does not explicitly focus on just depression or the workplace or the OWs; it encompasses a holistic view of these multiple constructs. This approach is very crucial to understanding OWs' experiences of depression in the contemporary workplace. As the avenues of influence are interrelated, an impact on one area (physical work environment) is likely to affect the others (psychosocial work environment), as an example.

The issue in a negative work environment could be exemplified in work settings with poor job design, role ambiguity, high pressure and workload, among other issues. These might culminate in stress leading to mental health illness if it becomes protracted. Siegrist et al.'s (2012) study has highlighted the link between work-related stress and depression among OWs. These issues might be further compounded by a lack of support from colleagues and direct line managers for OWs who are mentally unwell, which might be against the backdrop of management's perception of health issues as the employee's responsibility. The experiences of an employee with depression are likely to be challenging within such a work context. These are likely to be some of the multifaceted issues within a work context, which would demand a relevant conceptual framework.

2.6 The application of HWFM in previous studies

Although the HWFM has rarely been employed in studying the experiences of OWs with depression, partly because there is a lack of research in this area generally, the definition of HWFM is beginning to develop an understanding of OH to include psychosocial and personal health practice factors (WHO, 2010).

The following two studies utilised the HWFM: Kar et al. (2015) and McCarthy et al. (2019). These two studies utilised the HWFM in understanding healthy workplaces within organisations and nationally. Both were conducted on meso- and macro-levels, while this current empirical study will be conducted on a micro-level. Neither study utilised the model in understanding individual experiences as proposed in this current study. Therefore, as these studies are not directly relevant to this current thesis, they have not been discussed here.

As the HWFM is designed for employers, workers, policymakers and practitioners (WHO, 2010), it is considered appropriate to explore OWs' experiences of depression, at the micro-level. The HWFM was applied in this study, as indicated in [Fig. 2.2](#) and [Table 2.1](#). In this study, the HWFM will be used to capture individual experiences within a wider work context. It will help to situate OWs' experiences into the broader work context and give voice to OWs. The HWFM was comprehensively researched, flexible and developed with multiple disciplines such as OH, medical professionals, and scientists in mind (Burton, 2010). Nevertheless, it is not without its limitations and pitfalls.

2.7 Limitations and potential pitfalls of HWFM

One of the limitations and potential pitfalls of the HWFM is that it has not been previously utilised in exploring the experiences of OWs with depression. Although the framework does not predict each area's result, it shows some of the different influences. For instance, it highlights that the avenues of influence are inter-related. Nevertheless, the schematic representation of the HWFM does not highlight the severity of an impact of an illness or injury on the four avenues of influence. For instance, for an OW with depression and experiencing tiredness as a symptom, the physical work environment could also be impacting or vice versa. The process of identifying the different interaction produced within the avenues of influence during an experience of depression would be subject to individual workers' work environment, causes of their depression, and individual work contexts. An interpretative stance will facilitate an understanding of these interactions and their likely impact on the study outcome. One of

the benefits of using a conceptual framework is the flexibility and adaptability in its use (Adom et al., 2018).

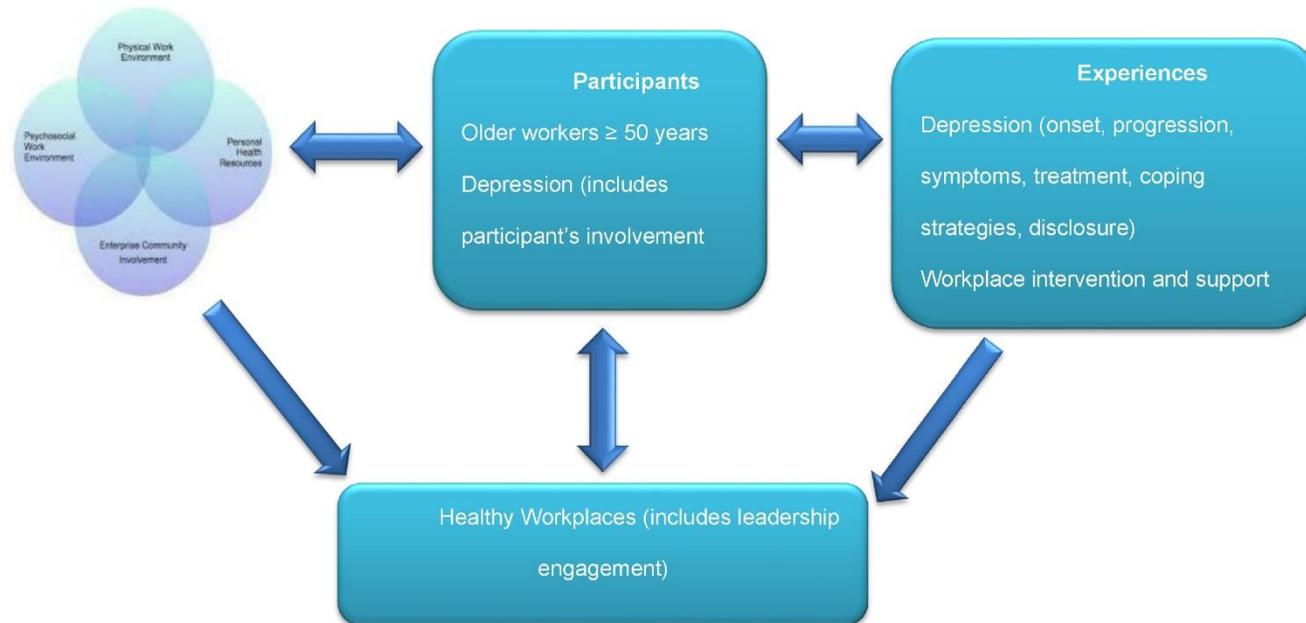


Fig. 2.2 An application of Healthy Workplaces Framework and Model on older workers' experiences of depression within a healthy workplace. (From the WHO: HWFM, Burton, 2010)

Table 2.1 Healthy Workplaces Framework and Model for Individual experiences

Healthy Workplaces Framework and Model for Individual experiences					
Four Avenues of Influence	Physical work environment	Psychosocial environment	work	Personal health resources	Enterprise involvement community involvement (ECI)
Process for implementing a healthy workplace support intervention	Mobilise and Assemble -Establish contact with OW	Assess the situation -Line manager meets with OWs -OH Referral	Plan and Prioritise -Treatment -Return to work (RTW) -Remaining at work -Remaining off work	Do -Implement plan	Evaluate and Improve -Evaluate the implemented workplace support intervention (WSI). Has it worked? What do you need to improve?
Core Ethics and Values	Leadership engagement <ul style="list-style-type: none"> • Line managers' understanding and empathy • Workplace support, i.e. employee assistance programme (EAP), OH • Workplace culture 			Worker involvement <ul style="list-style-type: none"> • Ability to negotiate workplace interventions • Disclosure • The decision to access workplace support 	

2.8 Summary

It is believed that the utilisation of the adapted HWFM in this study would enable a positive paradigm shift in how depression among workers/OWs is viewed, as a meso- and macro-level issue rather than having the narrow view of it being a micro-level issue. This current understanding might help organisations see the issue in a broader sense and give better consideration to tackling the workplace problem. Against the backdrop that health impacts on work and vice versa, the application of the HWFM in this study is justified in the following ways: 1) it is based on a comprehensive healthy workplace model that is adaptable to various work contexts; 2) its applicability in understanding the physical, psychosocial, personal factors in the work environment as well as the enterprise community impact; 3) its usefulness in understanding the recommended levels of support to employees including OWs experiencing depression; 4) its value in understanding the creation of a healthy work environment that does not cause a reoccurrence of injury or illness following return to work from sickness absence, whether work-related or not; and 5) ultimately, its importance in targeting the provision of a supportive, inclusive and accommodating work environment for OWs or those with chronic diseases or disabilities, such as depression. The limitations experienced with the utilisation of this HWFM were identified and addressed, as indicated in Section 2.7.

The next chapter will discuss the systematic review for this thesis. Within Chapter 3, COR theory will be discussed.

Chapter 3

WORKERS' EXPERIENCES OF WORK FUNCTIONING DURING AND AFTER DEPRESSION

3.1 Introduction

The purpose of this systematic review is to develop an in-depth understanding of workers' experiences of work functioning (WF) during and after depression. The review question for this synthesis is, "Among workers who have experienced depression, what were their experiences regarding WF during and after depression?" The context of its development is detailed in [Chapter 1](#). It is believed that this question would provide a broad understanding of the overall phenomenon under consideration in this thesis, which could inform the development of the empirical study.

This study's rationale is based on the increased prevalence of depression across the entire working population and its impact on workers, organisations, and the global economy, as highlighted in Chapter 1. Depression is highly prevalent in many countries, and it exerts substantial negative impacts on WF, with consequent productivity losses and eventual work exit (Adler et al., 2006; Ivandic et al., 2017; Kessler et al., 2009). This review is also plausible because impaired WF has been highlighted as a precursor of early work exit due to disability and weakened professional trajectories (Kessler & Bromet, 2013; Stynen et al., 2015). Additionally, the WHO's World Mental Health survey called for empirical studies to address the global burden of depression (Kessler et al., 2009). Synthesising qualitative studies on this topic would partly enable the fulfilment of this recommendation. Thus, to reduce the individual, organisational, and societal burden of impaired WF, a better understanding of workers' experiences during and after depression is necessary.

To date, most primary studies on this topic have been cross-sectional or longitudinal quantitative studies (for example, Adler et al., 2006; Andrea et al., 2009; Hawthorne et al., 2003; Ivandic et al., 2017) and therefore, most of the reviews on this topic are also quantitative

(Lagerveld et al., 2010). While quantitative studies have provided useful insights into the phenomenon by investigating general predictors for WF, this methodology is inherently unsuitable for capturing the complex individual experiences characterising depression-related impaired WF. This topic's complexity and potential impact call for a thorough qualitative systematic review, facilitating a greater theoretical understanding to redress the methodological imbalance. A qualitative systematic review is also useful in drawing out findings across qualitative studies to generate new insights and understandings (Saini & Shlonsky, 2012). It can provide a range and depth of meanings, experiences and perspectives of participants (Tong et al., 2012), which can be useful to organisations and policymakers. To the author's knowledge, no systematic review of qualitative studies has yet been conducted on WF experiences during and after depression. This review was explained using the COR theory (Hobfoll et al., 2018). In this theory, health is conceptualised as a resource and it focuses on how individuals or organisation protect, gain and preserve resources (Hobfoll et al., 2018).

3.2. Conservation of Resource Theory

Developed thirty years ago as a leading work-specific theory of job demands-resources model of stress, conservation of resources (COR) theory, a motivational theory, is now widely used in organisational psychology and organisational behaviour (Hobfoll et al., 2018). Its critical tenet is that individual appraisal, that is, individuals' perception of their ability to obtain and retain resources for future needs, is secondary to what is centrally valued and universal among people (Hobfoll et al., 2018). Health, well-being, family, self-esteem, WF, expertise, experience, and a sense of purpose and meaning in life are several commonly valued resources. Although reflecting the same core elements, the appraisal of these constructs differs culturally. In this review, a resource can be exemplified as obtaining and preserving mental health to enable effective WF. Therefore, COR theory's tenets make it a valuable tool in anchoring WF experiences during and after depression.

Although its main uses have been in the quantitative arena, COR theory also seems relevant when exploring workers' experiences of depression. It provides broad definitions of resources that are useful for accommodating a wide range of individualised experience, which again supports the purpose, aim and the review question for this meta-synthesis. Therefore, in this review, a resource is defined as WF concerning depression as experienced by workers. COR theory lens might be useful in highlighting individual appraisal and experiences of depression-related WF in the selected studies. During the discussion, it might also highlight individuals' effort to obtain, retain, foster and protect their WF in the face of depression.

COR theory comprises four principles: *Primacy of Loss*, *Resource Investment*, *Gain Paradox* and *Desperation principles*. Additionally, it comprises of *Resource Caravans* and *Resource Caravan Passageways' Principles* as well as three Corollaries, which will be defined in [Table 3.1](#).

Table 3.1 Conservation of Resource Theory: The Principles, Resource Caravan and Corollaries

<p>Principle 1. The <i>Primacy of Loss</i></p>	<p>This holds that resource loss is disproportionately more salient than resource gain. It includes object resources (such as tools for work), condition resources (e.g., employment, seniority), personal resources (e.g., essential skills and personal traits such as self-efficacy and optimism), and energy resources (e.g., credit, knowledge, money). In this research, workers' mental wellbeing is likened to tools for WF. WF is also a resource.</p>
<p>Principle 2: <i>Resource investment</i> principle</p>	<p>This holds that people must invest resources in protecting against resource loss, recovering from losses, and gaining resources. An investment in recovering from resource loss could be explained as seeking medical help or engaging with workplace support.</p>
<p>Principle 3: The <i>Gain Paradox</i> principle</p>	<p>This holds that resource gain becomes more valuable and important when resource loss is high. This principle could help to increase help-seeking behaviour.</p>
<p>Principle 4: <i>Desperation</i> principle</p>	<p>This holds that an overstretched and exhausted resource could result in defensive, aggressive, and irrational behaviour aimed at preserving oneself. The experiences of depression could result in defensive or irrational behaviour such as refusal to seek help, leading to sickness absence. For example, a UK study conducted by Sallis and Birkin (2014), on those returning to work following sickness absence due to depression revealed the reluctance of some of the participants in seeking help to avoid what was termed a "self-fulfilling prophecy". The study showed that this compounded work function losses and disrupted workplace order.</p>
<p><i>Resource Caravans</i> principle</p>	<p>This holds that resources do not exist individually but travel in packs, or caravans, for both individuals and organisations. For example, the impact of depression on an individual worker does not travel alone, but it impacts other aspects of life, such as work, WF, and productivity.</p>

<i>Resource Caravan Passageways</i>	This theorises that “people’s resources exist in ecological conditions that either foster and nurture or limit and block resource creation and sustenance” (Hobfoll et al., 2018, p. 106). This assumption can be exemplified within the workplace.
Corollary 1	This holds that those with more resources are less vulnerable to resource loss and more capable of resource gain. Conversely, individuals and organisations who lack resources are more susceptible to resource loss and less capable of resource gain.
<i>Corollary 2: Resource Loss Cycles</i>	These assume that individuals and organisations have limited resources to counterbalance resource loss. The loss spirals gain momentum and magnitude because resource loss exerts more power than resource gain and because stress occurs when resources are lost, at each iteration of the stress spiral.
<i>Corollary 3: Resource Gain Spirals</i>	Concurrent with resource loss spirals, resource gain spirals are weaker and slower due to a combination of small resource gains and a slower pace in resource gain. Contextually, loss in WF is considered resource loss and thus, recovery could take longer than expected.

In their recent review of COR theory, Hobfall et al. (2018) explained its departure from stress and strain. The review tested the tenets, corollaries, the dynamics and definition of a resource. Some of the notable extensions of COR theory beyond stress and strain have been the attempt to understand better how individuals allocate and conserve resources in the context of resource gains and losses, which could be due to emotional exhaustion. Such studies have been linked to performance (Demerouti et al., 2014), interpersonal relationships, and leadership at work (Hunter et al., 2017). Thus, the highlighted concepts advancing COR theory's use are within this current review's remit. Evaluating employees' ways of managing their resources at work involves an ongoing assessment of what is available to them, changes in resources and self-regulation to determine resource management investments, and these become targets for change within organisations (Hagger, 2015). COR theory is significant when considering the experiences of workers' WF during and after depression. Thus, an organisation's understanding of workers' experiences of resource loss, gains, allocation and investment concerning depression would help target change for improved WF.

3.3 Aims, Objectives and Review Question

This meta-synthesis aimed to develop a nuanced and comprehensive understanding of experiences of WF among workers during and after depression. The objectives for this review were as follows: (i) to synthesise findings from studies of experiences of WF among workers, during and after depression; (ii) to identify previous research perspectives about this topic and identify research gaps; (iii) to evaluate findings of these studies; and (iv) to make recommendations for managing WF in the context of depression.

The review focused on the following question:

Among workers who have experienced depression, what were their experiences regarding WF during and after depression?

3.4 Methodology and methods

As highlighted above, a qualitative approach will be utilised in this review. Based on the review aim and question, a preliminary scoping search was conducted and used to: determine database inclusion for the final search; define the key concepts and search terms for each database; understand previous research perspectives about the issue; develop and document a search strategy. The SALSA framework (Search, Appraisal, Synthesis and Analysis) was iteratively employed in this process (Booth et al., 2012). The reporting of this review was guided by PRISMA (Moher et al., 2009).

3.4.1 Eligibility Criteria

Inclusion and Exclusion Criteria. The SPICE- framework (Setting, Perspective, Intervention/Interest, Comparison, and Evaluation) (Booth et al., 2012) informed the documentation of an explicit statement relevant to the review question, search criteria, and the eligibility boundaries ([Tables 3.2](#) and [3.3](#)).

Table 3.2 The –SPICE- Framework

The –SPICE- Framework	
<i>Setting</i>	The review included studies from internationally-based work settings, including the UK. Studies of people with depression that are not workplace focused were excluded.
<i>Perspective</i>	A broad focus on the entire working population’s experiences of WF during and after depression as well as before and/or after return to work was adopted.
<i>Interest</i>	Qualitative studies using Grounded theory, Interpretive Phenomenological Analysis, Phenomenology, and other qualitative analysis types that included male and female workers with depression / CMD in any work sector were included. Quantitative studies were excluded.
<i>Comparison</i>	None
<i>Evaluation</i>	WF. In the wake of the limited studies on WF, qualitative studies with the following evaluations were included: return-to-work and sickness absence following depression or common mental health disorders.

Table 3.3 Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
The study explored WF experiences among workers during and after depression (either by self-report or as classified in the DSM 5) or CMD, including during sickness absence and when returning to work.	Studies of individuals with depression that were not workplace-focused were excluded.
The study employed a qualitative methodology and collected data using interview and/or focus groups.	Quantitative studies on WF and depression among workers were excluded.
The study was published in the English language.	Studies with a lack of clarity regarding study methodology (i.e. lack of clarity on the qualitative nature of study) were excluded.
The study was peer-reviewed.	
The study samples were workers.	
Studies with a multi-level exploration of experiences, including workers, managers and occupational physicians, were included where workers' data were identifiable.	
Mixed-methods studies with identified qualitative data that met the inclusion criteria were included.	

The study included direct participants' quotes.	
A sufficient proportion of the study themes were relevant to the review question (i.e. at least one theme or subtheme).	

3.4.2 Literature Search and Information Sources

The search terms in [Appendix 3.1](#) were derived from a combination of the search terms from Lagerveld et al.'s (2010) study and the use of a three-way filter – qualitative study, findings and interview - as advised by Flemming and Briggs (2007).

To generate extensive knowledge and understanding of the topic, a search strategy included studies from 1 January 1990 to 31 January 2019. After an initial scoping search, a comprehensive systematic search of the following electronic databases was conducted: ABI/Inform Complete; Academic Search Ultimate; Business Source Ultimate; CINAHL; and PsycINFO (Petticrew & Roberts, 2006). A manual search of the references in the key literature; grey literature such as the Department of Health and Public Health England; as well as the *International Journal of Management Reviews* was also conducted. The searches enabled the identification of English language and peer-reviewed journals relating to depression or CMD and WF. To ensure that all relevant studies were captured, attention was given to international spelling differences, such as in American and English words (CRD, 2009) (see [Appendix 3.2](#)). To ensure that relevant keywords were used, a Lancaster University's Specialist Academic Librarian was also consulted. Wildcards Asterisk (*) function and truncations, Boolean operators, such as AND, OR, NOT were engaged in combining the keywords or to disregard terms (Booth et al., 2012). To delimit the search scope and ensure that the keywords were exhausted, a systematic search of each area, such as workers, mental health, work status, research method, workplace support and interventions, was utilised.

3.4.3 Study Selection

For eligibility reasons, all the results were initially screened by conducting titles and abstract sifts, respectively. This process was followed by full-text scrutiny of the relevant papers. For transparency purposes, a detailed record of the searched sources, strategies, along with each source's results, were retained (Jesson et al., 2011). Including only full-text and peer-reviewed

literature ensured the selection of quality-controlled papers, thereby allowing for in-depth analysis (Bown & Sutton, 2010).

3.4.4 Quality Appraisal

The Critical Appraisal Skills Programme (CASP) qualitative checklist (2018) was used to assess the internal validity of the selected studies, the methodological rigour, the strengths and limitations of the included studies. CASP (2018) was employed because it is clear, widely used and comprehensive. The answers to the two screening questions in section (A) of the CASP form were determined through an assessment to clarify specific study aims and methodology employed within the individual studies ([see Appendix 3.2](#)). The two questions are: “Was there a clear statement of the aims of the research?” and “Is a qualitative methodology appropriate?” The two questions were answered based on: “No”, “Yes” and “Can’t tell”, as advised by the CASP (2018).

As described by Duggleby et al. (2012), a three-point scoring system was utilised in assessing the selected studies against the remaining eight questions by CASP. One point was assigned to studies with minimum or no explanation for each of the eight areas identified by CASP. Two points were assigned to the studies that addressed each of the eight areas but without full elaboration. Three points each were assigned to studies that offered extensive justification and explanation for each of the eight areas. A total was calculated for the remaining eight questions for each study. The scores ranged from 15-24, with a mean of 20.81 ($SD = 3.03$). Only one study achieved the highest score of 24 and one study scored the lowest, 15. However, as there still seems to be limited empirical evidence on which to base the exclusion of poor-quality studies in the qualitative arena, none was excluded due to their CASP scores (Sandelowski & Barroso, 2007). Instead, sensitivity analyses to assess the possible impact on the review were conducted by assessing the contributions that the selected studies made to the themes (Booth et al., 2012). This included assessing whether the poorer quality study significantly contributed to any of the themes (Booth et al., 2012).

All the studies specified that ethical approval was granted, except for two studies that stated that ethical approval was not required for qualitative studies from the Danish National Committee on Biomedical Research Ethics (Hjasbech et al., 2015; Nielsen et al., 2012). All the studies specified that participants' consent was obtained.

3.4.5 Data Extraction

Data were extracted from the included papers using the modified standard data extraction forms by Munro et al. (2007, in Noyes & Lewin 2011) and the EPPI-Centre (2013), adapted to one data extraction form. The modified form was first reviewed to allow for easy comparison of the study characteristics and piloted with two studies to assess its practicality for this review with subsequent customisation of the tool, as recommended by Noyes and Lewin (2011) ([See Appendix 3.3](#)). The piloted data extraction form was populated with all the texts under the headings "results or findings" from each study and contextual background information ([See Appendix 3.3](#)). For multi-level studies, only the workers' experiences were extracted. Where appropriate, figures and tables were included to aid data presentation. As this review has a focused review question, an index paper was not chosen; all the selected papers were given an equal opportunity in the final thematic synthesis.

3.4.6 Synthesis of findings: Thematic synthesis

Given the review question and aim, a thematic synthesis of the various qualitative data was employed on the selected studies' primary data. Thematic synthesis is based upon thematic analysis, which "is a method of identifying, analyzing and interpreting patterns of meanings within qualitative data" (Clarke & Braun, 2017, p.297). According to Booth et al. (2012), thematic synthesis is useful in producing a comparable type of analysis and combining and integrating findings of multiple qualitative studies within systematic reviews. This synthesis method is also justified because it is useful in synthesising studies that focused on perspectives and experiences (Booth et al., 2012). It includes three principal stages: an

inductive line-by-line coding of the findings of the primary studies; an organisation of these codes into related areas to create descriptive themes; and the development of analytical themes (Thomas & Harden, 2008).

Based on my [interpretive position](#), decisions were made about the characteristics of a theme, coding, and analytic approaches to ensure the synthesis's reliability and validity. Although an inductive method to coding was adopted, the analysis was subjected to the latent approach: examining the underlying ideas, assumptions, conceptualisations and ideologies that are theorised as shaping the semantic content of the data (Braun & Clarke, 2006). COR theory was used during synthesis and to explain some of the underlying assumptions during the discussion.

3.5 Findings and Analysis

3.5.1 Study Selection

The search results and the study selection process are presented in [Fig. 3.1](#). A total of 2028 potentially eligible studies were identified in the literature search. The search engines identified no duplicates. 2006 studies were excluded after a title and abstract sift, 22 studies were screened and, due to ineligibility, another 11 studies were excluded after full-text analysis. The exclusion reasons are detailed in [Appendix 3.4](#). The remaining 11 studies' designs comprised four grounded theory, one ethnography, two IPA, three generic qualitative studies and one phenomenological study. The selected studies were based on the full working-age population (≥ 15 years).

The sensitivity analyses to determine the level of contribution from the lowest quality study following CASP assessment revealed that every study was given an equal opportunity without prioritising the research design of those included, which answered the current review question. Following this review's synthesis, the relative contributions of studies to the final analytical themes and recommendations were analysed. This analysis revealed that the research with the lowest quality score (Haslam et al., 2004) contributed to three of the four overarching

themes. Haslam et al.'s (2004) study, which scored 15, did not have an exclusive contribution to any of the themes.



PRISMA 2009 Flow Diagram

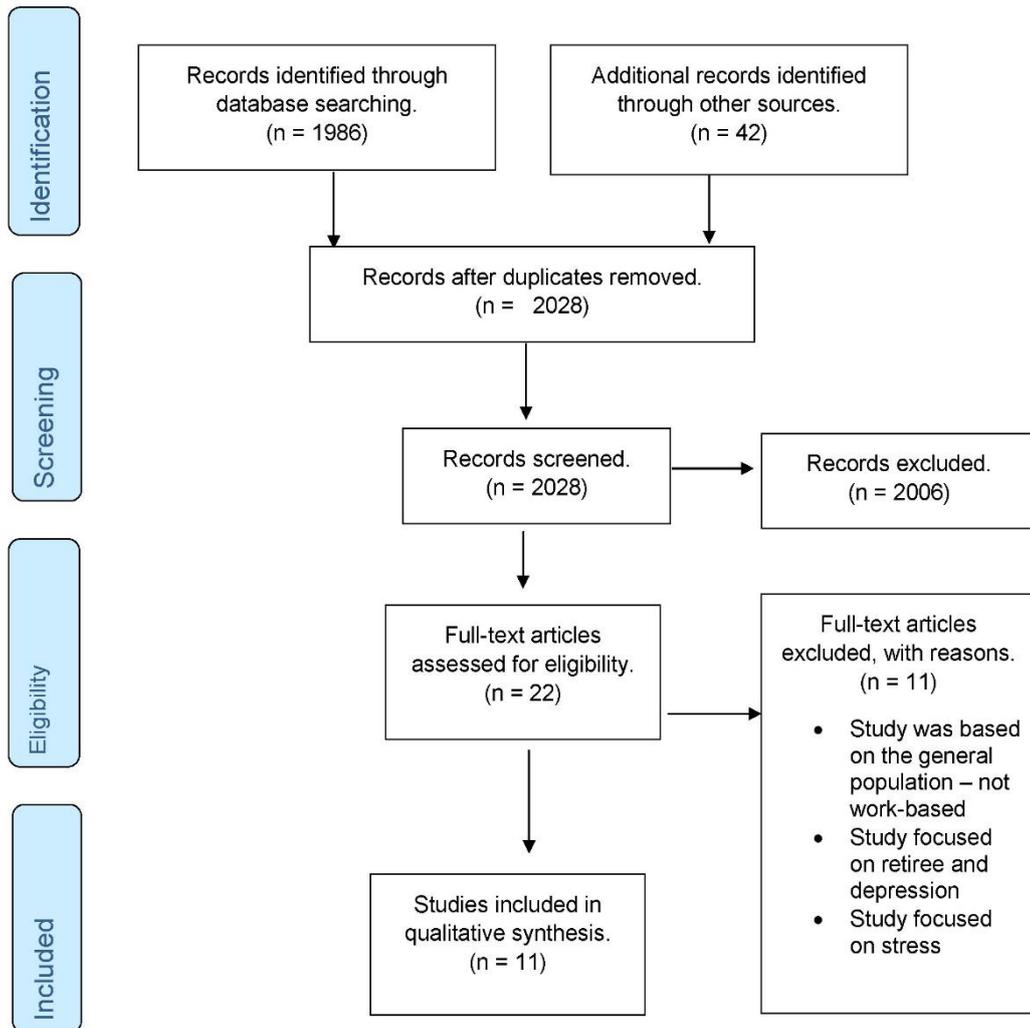


Figure 3.1 – Schematic illustration of the search results and selection process

3.5.2 Reporting of included studies and characteristics

The ENTREQ statement was utilised in developing and reporting the review (Tong et al., 2012). All the 11 studies specified the sample size, the participants' characteristics and included quotations from respondents in the results section ([see Table 3.4 for study characteristics](#)).

Table 3.4 Study characteristics

Study	Country	Data collection method and participant number	Workers' age range	Sample selection	Theoretical approach	Analysis	The principal focus of the study	Quality Appraisal - CASP Score
<p>Abma et al. (2013)</p> <p>Title</p> <p>Workers with health problems: three perspectives on functioning at work</p>	Netherlands	<p>Focus Group</p> <p>Three focus groups were conducted with respective workers, occupational physicians (OHP), and HR managers supervisors.</p> <p>N=19</p> <p>Workers group = 7 (All women)</p>	<p>Workers group with ages ranging from 25 to 60</p> <p>OHPs = Age range – 42-56</p> <p>HR/Supervisors = Age range – 36-53</p>	<p>Multi-level perspective</p> <p>Workers working more than 12 hours per week with one or more health problem(s) were included.</p> <p>Workers' group – 7 participants from a mixture of public and private sectors.</p> <p>OHPs</p>	None	Qualitative description method	To explore (i) why it is that one worker with a health problem can stay at work while another cannot, (ii) to identify signals for decreased functioning at work, and (iii) to explore if and how this can be measured.	20

		OH physicians (OHPs) = 7 (6 men and 1 woman) HR/Supervisors = 5 (3 men and 2 women)		HR/Supervisors				
Bertilsson et al. (2012) Title Capacity to work while depressed and anxious – a phenomenological study	Sweden	Focus groups N= 17 (5 men and 12 women)	Age Range 18-65 – working-age group.	Individuals with differing types and severity of symptoms were invited to take part in the study. Depressed/anxious persons were defined following the International Classification of Diagnosis: F32 depressive episode, F34 persistent mood (affective)	Phenomenological approach	Reflective lifeworld approach as described by Dahlberg et al. 2006 and 2008	To explore experiences of capacity to work in persons working while depressed and anxious, to identify the essence of the phenomenon: capacity to work.	19

				disorders, F38 other mood (affective) disorders, F39 mood (affective) disorder, F41 other anxiety disorders, F43.8 other reactions to severe stress [24]. As well as self-report of symptoms including worry, fatigue and feeling blue were included.				
Danielsson et al. (2017a) Title Working in dissonance: experiences of	Sweden	Interview N=27 (19 women and 8 men)	Age range: 19 - 66 years	Employed adults with a current diagnosis of unipolar depression or anxiety disorder (codes F32-39, F41 and F43 in the	Grounded theory using a theoretical sampling frame PEO model of WF Work Instability concept.	Constant comparative analysis	To explore experiences of work instability in workers with CMDs.	23

work instability in workers with CMD				ICD-10 Classification of Mental and Behavioural Disorders). Participants with symptoms without a confirmed diagnosis and some based on low perceived mental wellbeing.				
Danielsson et al. (2017b) Title Strategies to keep working among workers with CMD – a grounded theory study	Sweden	Interview N=27 (19 women and 8 men)	Age range: 19-65	Employed adults who are currently working or on sick leave for a maximum of 6 months. Those with depression or anxiety syndrome (International Statistical	Grounded theory (Charmaz, 1990) theoretically based on social constructivism and pragmatism. Work instability concept	Constant comparative analysis	To explore workers' strategies to keep working, while affected by CMDs.	23

				Classification of Diseases and Related Health Problems, 10th revision (ICD-10), codes F32–33, F41, and F43, or self-reported mental distress corresponding to a cut-off <50 on the WHO-5 Mental Well-being Index.				
Haslam et al. (2004) Title Patients' experiences of medication for anxiety and depression:	UK	Focus groups (12 focus groups in total) 9 groups involving staff (36 women and 18 men) 3 groups involving OH, HR and Health	Age range: 18-63	<i>Multi-level perspective</i> A sampling of employed workers who had experienced anxiety and depression, taken from a range of	Qualitative, in-depth approach	Not specified Results were presented to an expert panel (comprising practitioners and researchers	To improve understanding of how mental health problems and the treatment for these conditions impact on working life.	15

effects on working life		and Safety (7 men and 13 women) N = 74		occupational sectors. Depression was defined as involving: “depressed mood, sleep disturbance, fatigue, poor concentration, thinking and decision making” (p.205).		in health care and OH) to consider implications for practice.		
Hjarsbech et al. (2015) Title Struggling at work – a qualitative study of working Danes with depressive symptoms	Denmark	Semi-structured interviews N=13 (5 men and 8 women)	Age range: 32-63 years Mean age - 54 years	Participants were recruited from the Psychosocial Work Environment and Workability among Employees with (PEWED), which is a four-wave questionnaire study of Danish employees, who	Grounded theory (Symbolic interactionism)	Not explicit	Explores how a selected sample of Danish employees with depressive symptoms experience the interaction with their work environment	23

				<p>have reported depressive symptoms at baseline in May 2009 (T1).</p> <p>Employees at work, experiencing a depressive illness.</p> <p>Depression was defined as people with a depressive symptom level of ≥ 10 points on The Major Depression Inventory</p> <p>A more detailed description of the PEWED study is published elsewhere</p>			<p>and how they respond to and deal with problems at work.</p>	
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<p>Millward et al. (2005)</p> <p>Title</p> <p>Depression and the perpetuation of an incapacitated identity as an inhibitor of return to work</p>	UK	<p>Semi-structured interviews</p> <p>N=19 comprised six men and 13 women</p>	Age range: 28-52.	<p>Purposive sampling</p> <p>People formally diagnosed with clinical depression.</p> <p>Diagnosis was independently checked using the Beck Depression Inventory (BDI) (Beck 1996) by one of our researchers, formally trained in the use of DSM-IV criteria (DSM 1994).</p>	<p>Qualitative study</p> <p>Sick Identity</p>	IPA	To conduct a qualitative investigation of attitudes to work among people diagnosed with clinical depression.	21
<p>Moll et al. (2013)</p> <p>Title</p>	Canada	<p>Interview</p> <p>Employee participants</p>	Age: Not documented	<p>Multi-level perspective</p> <p>Frontline mental health workers who had</p>	<p>Institutional Ethnography</p> <p>Symbolic interactionism</p>	Stated that several analysis strategies were employed	To explore the experiences of mental health care workers with mental health issues	22

When Health Care Workers Experience Mental Ill Health: Institutional Practices of Silence.		<p>N = 20 (15 women and 5 men).</p> <p>Two students, 14 frontline workers, and four managers were included.</p> <p>N=12 workplace stakeholders</p>		<p>experienced mental health issues</p> <p>Organisational stakeholders who interacted with ill workers.</p> <p>Examination of organisational texts that highlighted structures and processes that might affect the experience of workers.</p> <p>Mental health issues were by self-report.</p>	Critical social theory perspective	but not explicitly documented	and to account for how the social relations of work shaped their experiences.	
Nielsen et al. (2012)	Denmark	Semi-structured interviews		Participants were recruited from the research project	Grounded theory	Employed constructivist grounded	An exploration of how women with mental health	24

<p>Title</p> <p>Healing a Vulnerable Self: Exploring Return to Work for Women with Mental Health Problems</p>		<p>N=16 (All women)</p>		<p>CORSA (Common Mental Disorders, Return to Work, and Long-Term Sickness Absence). The CORSA project participants consisted of employees who applied for sickness-absence benefits from a municipal jobcentre in Denmark. They had applied on the grounds of self-reported mental health problems or difficult life events, such as bullying or bereavement.</p>	<p>Theory of symbolic interactionism Corbin and Strauss's (2008) Paradigm Model</p>	<p>theory for the analysis.</p>	<p>problems experience sickness absence and subsequent return to work.</p>	
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<p>Noordik et al. (2011)</p> <p>Title</p> <p>Exploring the return-to-work process for workers partially returned to work and partially on long-term sick leave due to CMD: a qualitative study</p>	<p>Netherlands</p>	<p>Semi-structured Interviews</p> <p>N=14 (10 women and 4 men)</p>	<p>Age range 25-58 years</p>	<p>Workers who had partially returned to work and were partially on long-term sick leave due to a stress-related, anxiety or depressive disorder were included in the study.</p> <p>Depressive disorder was defined as classified by the Diagnostic Statistical Manual of mental disorders (DSM) IV</p>	<p>Qualitative study</p> <p>Grounded theory research paradigm of Glaser and Straus.</p>	<p>An explorative and inductive approach based on the grounded-theory research paradigm of Glaser and Straus.</p>	<p>To describe the barriers to a full return to work, solutions, communicating to the working environment and the aim of a full return to work, all as perceived by the workers.</p>	<p>18</p>
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<p>Sallis and Birkin (2014)</p> <p>Title</p> <p>Experiences of Work and Sickness Absence in Employees with Depression: An Interpretative Phenomenological Analysis</p>	<p>The UK.</p>	<p>Semi-structured interviews</p> <p>N=7 (two women and five men)</p>	<p>Age range: 30 and 60.</p>	<p>Participants are homogeneous to the extent that they work for the same organisation and have recent experience of depression-related sickness absence.</p> <p>Depression was based on self-report</p>	<p>IPA</p> <p>A cognitive behavioural model of emotional disorders</p>	<p>IPA - idiographic approach</p>	<p>Investigated employees' experiences of depression-related sickness absence to learn what was important and relevant in moving between work and sickness absence.</p>	<p>21</p>
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3.5.3 Features of the selected studies

Six studies directly addressed the review question for this current review (Bertilsson et al., 2012; Danielsson et al., 2017a; Danielsson et al., 2017b; Haslam *et al.*, 2004; Hjarsbech et al., 2015; Moll et al., 2013). Nielsen et al. (2012), Noordik et al. (2011) and Sallis and Birkin (2014) focused on a combination of sickness absence and return-to-work, and WF relating to depression or CMD. Abma et al.'s (2013) study also focused on sickness absence, return-to-work, and low WF signals. However, these were about general health problems using multi-level perspective focus groups. Although the Abma et al. (2013) study included two workers with a range of psychological difficulties, out of the seven workers' focus group, it was unclear whether this was depression or CMD. Nevertheless, the workers' accounts on experiences were identifiable. ([See Table 3.4 for study](#) characteristics and [Table 3.5 outcomes](#)).

Table 3.5 The findings of individual studies

Author/s Year of publication	Analysis -Themes /Subthemes	Authors' Conclusions
Abma et al. (2013)	<p>Themes from Workers' Category:</p> <ul style="list-style-type: none"> • Stay at work, signals, measuring WF • Same for OH physicians, HR managers and supervisors 	<p>This study offers an understanding of the reasons for and against remaining at work. A supervisor is reported as an essential factor when considering functioning at work during an illness.</p>
Bertilsson et al. (2012)	<ul style="list-style-type: none"> • Fatigue • Unequipped to handle the demands of time and pace • Exposed in professional interpersonal encounters • Putting on a working façade – <i>leaning towards presenteeism</i> • The demanding act of being “good enough.” • Deficient work satisfaction and loss of “refuelling.” • Trading leisure-time activity with inactivity to manage work/life imbalance- They achieved this by taking work home 	<p>For efficient work adjustments, rehabilitation processes would benefit from more in-depth knowledge of individuals' capacity to work. This finding has implications in clinical, OH and workplace settings.</p>

	<ul style="list-style-type: none"> • Disrupting workplace order • The dynamics of alienation 	
Danielsson et al. (2017a)	<ul style="list-style-type: none"> • Working out of rhythm • Working in discomfort, • Working disconnected and • Working in a no man's land 	The authors hypothesised the experience of work instability in CMDs as “working in dissonance”, which suggests a varied disharmony at work and an inherent sense of “being caught up, as if in a bubble” p.9. They indicated that occupational and clinical settings could focus on a new approach that will explore how the worker can re-enter their flow at work when disconnected from work.
Danielsson et al. (2017b)	<p>Managing workspace:</p> <ul style="list-style-type: none"> • Forcing the work role • Warding off work strain (to ensure enough room for manoeuvre and allow leeway) • Recuperating from work • Reflexive adaptation 	The result of this study offers various benefits. These include: <ul style="list-style-type: none"> • the provision of deeper insight for rehabilitation professionals on diverse CMD work-related strategies; • the development of improved responsiveness to individual experiences plans for rehabilitation; • its use as reflective and exploratory tools in clinical settings and options and modifications in work and personal domains.
Haslam et al. (2004)	<ul style="list-style-type: none"> • Experience of anxiety and depression and the impact on working life • The effects of prescribed medication for • anxiety and depression 	Individuals felt uninformed about their medication, which would have been more beneficial. Among other things, OH staff and employers' role were highlighted as crucial in managing CMD in the workplace.

	<ul style="list-style-type: none"> • Non-compliance with medication 	
Hjarsbech et al. (2015)	<p>Factors conditioning the struggle:</p> <ul style="list-style-type: none"> • Relationship with supervisors • The collegial spirit • Work pressure and workload • A good worker <p>The struggle:</p> <ul style="list-style-type: none"> • The experience of emotional, cognitive and somatic symptoms • Trying to change <p>Actions and strategies:</p> <ul style="list-style-type: none"> • Tending to symptoms • Altering prospects for the future <p>Consequence:</p> <ul style="list-style-type: none"> • Distancing oneself from work 	<p>This study provided insight into the process of struggling with depression at work, such as employees seeking opportunities for changes that supervisors were non-responsive to resulting in distancing themselves from work situation. The authors concluded that supervisors could play a more active role in creating suitable working environments from a preventive perspective by being responsive to employee's problems.</p>
Millward et al. (2005)	<ul style="list-style-type: none"> • Depression and the perpetuation of an incapacitated identity as an inhibitor of return to work. • Illness identity • Evidence to reinforce their identities 	<p>This study offers insights into the sick role identity relative to depression and the role of health institution practices during functional recovery.</p>

	<ul style="list-style-type: none"> • Viewing normality 	
Moll et al. (2013)	<ul style="list-style-type: none"> • Workers' Practices of Concealment • Strategic Disclosure by Workers 	Silence emerged as a critical underlying process characterising individual and organisational responses to employees with mental health issues. Silence was actively practised having diverse forms; "it was pervasive, complex, and at times, paradoxical. It served many functions for workers and the organisation". (p.167)
Nielsen et al. (2012)	<p>The healing process:</p> <ul style="list-style-type: none"> • Central Problem • Discovering true self • Becoming handicapped or stronger 	Some women felt disabled, while others felt stronger and more self-confident. They reported that "the core of the experience was not the return to work but a process of healing a vulnerable self - the ability both to refocus attention from symptoms to other life goals and to maintain or reconstruct a positive self-image". (p.306)
Noordik et al. (2011)	<p>Barriers:</p> <ul style="list-style-type: none"> • Difficulty of protecting oneself from exceeding the current capacity • Current decreased capacity. <p>Solutions:</p> <ul style="list-style-type: none"> • Getting more relaxed and less tense • Treating mental or physical symptoms <p>Communication at work, at home and in healthcare:</p>	The study suggests that new interventions that focus on helping workers and their environment bridge this gap are required.

	<ul style="list-style-type: none"> • Supportive communication • Unsupportive communication <p>Intentions and plans for a full return to work:</p> <ul style="list-style-type: none"> • Pattern in return-to-work process • Intentions and plans to proceed to a full return to work 	
Sallis and Birkin (2014)	<p>Three interrelated themes were drawn from the participants' accounts:</p> <ul style="list-style-type: none"> • The interaction between depression and work • Illness beliefs • Organisational context and depression 	The authors theorised that individuals' health and work beliefs appear to influence their sickness absence decisions and experiences. These are mediated by their experiences of organisational policies, line manager support and the messages and actions of GPs.

3.6 Synthesis of results

3.6.1 Descriptive and analytical themes

The line-by-line coding of the 11 studies generated a total of 199 initial codes. The codes' grouping resulted in a schematic structure with several layers of organisation, consisting of 10 descriptive and four analytical themes. (See [Fig 3.2](#) for the themes and [Appendix 3.5](#) for the table of articles represented in the themes). Four analytical themes (subthemes in parentheses) developed from the synthesis. These are 1) obstacles to WF (fears and uncertainties, organisational factors and external factors); 2) challenges of impaired WF (challenges of symptoms, medication side-effects, work-tasks and the work environment); 3) consequences of impaired WF (psychosocial consequences and negative coping strategies); and 4) promoters of WF (organisational and peer-level support and individual intelligence). Participants' quotations are included to illustrate each theme.

Analytical Themes		Descriptive Themes	
Experiences of Work Functioning during and after depression	Obstacles to work functioning	Fears and uncertainties	
		Organisational factors	
		External factors	
	Challenges of work functioning	Challenges of symptoms and medication	
		Challenges related to work tasks	
		Challenges related to the work environment	
	Consequences of work functioning	Psychosocial consequences	
		Negative coping strategies	
	Promoters of work functioning	Organisational and peer level of support	
		Individual intelligence	

Fig 3.2 Themes and Subthemes from Depression-related Work functioning

3.6.2 Themes and Subthemes

Theme 1: Obstacles to WF. This superordinate theme addressed the multi-dimensional obstacles experienced pre-diagnosis, during and after depression. Nine papers highlighted various obstacles to WF as experienced by workers. Across a range of situations and contexts, workers encountered multiple barriers to WF—obstacles to WF links with the remaining superordinate themes ([See Fig 3.3 for the relationships](#)).

1.1 Fears and Uncertainties. These challenges characterised every stage of the participants' experiences – before diagnosis, during and after depression. The workers' lack of motivation to seek or accept help was embedded in fear of the unknown, which further inhibited WF (Bertilsson et al., 2012; Nielsen et al., 2012; Sallis & Birkin, 2014). Two UK-based studies found that living with depression was explained as living with fears and uncertainties about the diagnosis, unstable symptoms, dependency on medication, stigmatisation and concerns about future work abilities and employment (Haslam et al., 2004; Sallis & Birkin, 2014). For instance, employees' "outlook on a future work life was affected by their perceived work ability, possibilities on the labor market, and wishes for a future work life" (Nielsen et al., p.307).

Arguably, worries and concerns about the future impact of depression could further affect workers' psychological wellbeing and others' perception of them. For instance, a Netherlands-based study by Abma et al. (2013) reported fear of being labelled as 'the ill worker', and subsequent decision for non-disclosure. Nondisclosure resulted in inaccessible workplace support, which could negatively impact WF and subsequent job loss. In a Swedish study by Bertilsson et al. (2012), the participants reported fears about vulnerability, heightened with disclosure and fear of job loss. There seem to be progressive issues with fears and uncertainties, and these could result in work exclusion if the cycle is not broken.

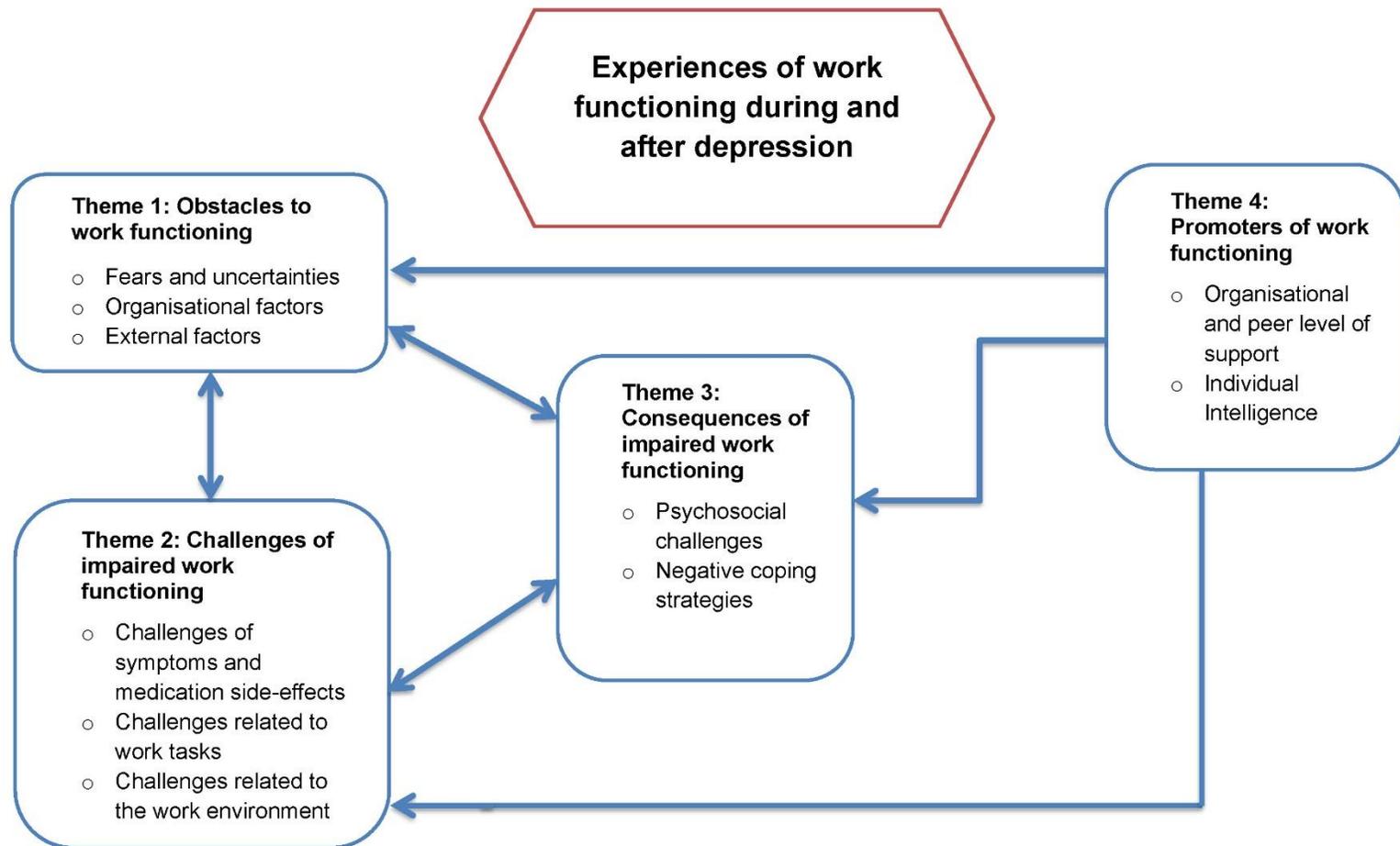


Fig 3.3: Schematic representation of themes and relationships

However, a grounded theory (constructivist approach) exploration of Danish women's experiences of mental health problems, return to work and sickness absence ($N = 16$), found that although the participants feared a relapse, many of them focused on getting better, which was described as 'healing' (Nielsen et al., 2012). Contextually, healing meant "to live an unrestricted life; that is, having the ability to refocus attention from symptoms" (Nielsen et al., 2012, p.306). Focusing on healing could further encourage workers' engagement with workplace measures, which could bolster WF.

1.2 Organisational factors. Participants reported an awareness of their impaired WF. For some, return-to-work met with high and significant expectations on WF, both from managers and colleagues. This experience was perceived as a lack of understanding. This thinking could be related to workers' perception of their organisational culture. Consequently, participants resisted the pressure and high workload. Arguably, workers' ability to manage expectations and interpersonal relationships could be vital to improving WF issues, but these skills might not be readily available to someone experiencing depression. One participant's narrative conveys some of these issues:

From Day One they [supervisor and colleagues] expect that you can manage exactly the same as before. So you have to put your foot down, and that is really difficult. But you just have to practice saying no. Otherwise, you'll become as stressed out as before—or at least there is a big risk that you will. (cited in Nielsen et al., 2012, p. 308)

Arguably, the narrative above suggests that WF is still impacted when individuals have just returned to work. Organisational support when returning to work from sick leave seems important. Thus, participants might need to set their priority to protect themselves rather than respond positively to line managers' or colleagues' expectations if they perceived they were under pressure. Perceptions about the lack of managers' skills or support were widespread. This experience constituted additional issues, such as stigmatisation, non-disclosure, lack of control,

and unsupported communication (Abma et al., 2013; Bertilsson et al., 2012; Hjarsbech et al., 2015; Moll et al., 2013; Nielsen et al., 2012; Noordik et al., 2011; Sallis & Birkin, 2014).

Furthermore, the seven studies contributing to this subtheme accentuated the significance of organisational factors in WF. The studies identified similar issues despite the differences in the study aims, demographics and settings. For example, in their institutional ethnography of employees ($N = 20$) on mental health care workers' experiences, Moll et al. (2013) found that secrecy around depression served as a barrier to obtaining the required organisational support, with subsequent struggles with tasks. Lack of workplace support constituted additional strain on the workers' health and WF. One participant stated:

I'm very cautious with revealing my signals. In the past, after my illness started, I was very open about the signals. But it went wrong several times [. . .] In my experience it is not safe, especially with mental or psychiatric diseases. (cited in Abma et al., 2013, p.23)

As seen in the narrative above, where disclosure is mishandled future disclosures become problematic. Moreover, a grounded theory exploration of the experiences of ($N = 13$) Danish employees with depressive symptoms and their interaction with the work environment found a significantly low interpersonal relationship between participants and managers (Hjarsbech et al., 2015). Although based on IPA of UK-based samples ($N = 7$), a similar finding was also reported by Sallis and Birkin (2014). For example, one participant said,

I'm not saying line managers should all be counsellors or therapists [...], but they shouldn't be frightened of hearing or feel uncomfortable if someone was to come to them and was trying to be open about emotional problems, they should be skilled enough to be able to hear it, and just not be afraid of it. (cited in Sallis & Birkin, 2014, p.475)

Arguably, poor interpersonal relationships between line managers and workers as well as inadequate skills among line managers seem to be evident across all studies. Low interpersonal relationship among workers experiencing depression is a precursor of poor engagement at work, which could further reinforce impaired WF.

1.3 External factors. External factors refer to participants' encounters with healthcare workers, which Millward et al. (2005) situated as reinforcement of the 'sick role'. This finding is partly attributable to the authors' utilisation of this concept and focuses on attitudes to work among those diagnosed with clinical depression (Millward et al., 2005). For instance, the study highlighted the debilitating impact of developing and sustaining an illness identity when depressed, which could inhibit functional recovery and return to work. It found that the health care system can play a role in reinforcing the 'sick role' and in so doing, provide a continued justification for an 'off-work' identity. Millward et al. (2005) concluded that depression could, through institutional practices, become completely part of someone's identity, with important implications for functional recovery. These external factors negatively impacted individuals' perception of WF as they were influenced by healthcare workers' decisions concerning their workability. For instance, one participant said:

The physician kept telling me that I would be ready soon, [...] But when you already feel guilty about being on sick leave, then it feels like pressure, because the doctor says so — and the doctor is an authority figure. (cited in Nielsen et al.'s study, 2012, p.306)

Additionally, being uninformed about medication side-effects and the participants' dependency on GPs' advice regarding their workability further reinforced sickness absence (Haslam et al., 2004; Millward et al., 2005; Nielsen et al., 2012; Sallis & Birkin, 2014). Other obstacles identified by the selected studies are the adverse effects of symptoms and medication; for clarity, these will be discussed under Theme 2.

Theme 2: Challenges of impaired WF. These challenges represent the impact of the obstacles (Theme 1) on WF. These are the problematic work encounters experienced by the workers. Overall, nine of the selected papers highlighted various challenges of WF as expressed by the workers. The participants' experiences were not just based on challenges relating to the effects of symptoms and medication but also on many work tasks and work environment issues. This superordinate theme directly or indirectly links with Theme 1 (obstacles) because an unaddressed

obstacle constitutes a potential challenge, which could occur at any stage of depression ([See Fig 3.3 for the relationships](#)).

2.1 The challenges of symptoms and medication side-effects. Physical and mental symptoms impacted on WF. Poor symptom control was widespread among the participants with consequential non-predictability of WF (Abma et al., 2013; Bertilsson et al., 2012; Haslam et al., 2004; Hjarsbech et al., 2015; Noordik et al., 2011; Sallis & Birkin, 2014). For instance, “There were various mental and physical symptoms that decreased the current working capacity” (Noordik et al., 2011; p. 1628).

The participants’ uncontrolled symptoms and medication side-effects disrupted work order and negatively impacted on work quality. Balancing the symptoms of depression, medication side-effects and work tasks were challenging for the participants, supervisors and in some instances, work colleagues. Arguably, where symptoms remain uncontrolled, with consequent impact on WF, workers’ sickness absence might increase.

Although six studies contributed towards this subtheme, Haslam et al.’s (2004) study, which has the lowest quality, as indicated by the CASP assessment, contributed more substantially to this theme. This finding is attributable to the study’s focus on the impact of anxiety, depression and treatment on working life, together with its inclusion of participants from a wide range of work sectors. The study concluded that the lack of information provision by GPs is unhelpful in managing individuals’ symptoms. This finding could be due to the timeframe in which it was conducted, being the oldest among the included studies.

2.2 The challenges related to work tasks. Seven of the included studies contributed to this subtheme (Bertilsson et al., 2012; Danielsson, 2017a & 2017b; Hjarsbech et al., 2015; Moll et al., 2013; Noordik et al., 2011; Sallis & Birkin, 2014). The highlighted studies reported the following challenges of participants’ work tasks on their WF: issues with multitasking; timekeeping; keeping pace with work; lack of engagement; low work quality; poor coordination; concentration issues with complex tasks; and lack of motivation among other things.

To perform at work was described by some participants as an inner demand, [...] Furthermore, the work performance had to be 'good enough'. This inner demand was considered to be as demanding as the work itself. (Bertilsson et al., 2012, p.1708)

Workers' recovery was prolonged or became impossible due to high work pressure, high demands, lack of control and stress, which further impaired individuals' WF. Lack of control was metaphorically described by one participant as – "an unstoppable train or a ship going down" (cited in Danielsson et al. 2017a, p.7). Balancing workload was challenging; however, combining workload uncertainties with unstable symptoms further impaired functioning. For some participants, balancing was achieved through non-disclosure or selective disclosure of diagnosis due to likely stigmatisation.

2.3 The challenges related to the work environment. Five studies highlighted that the work environment contributed to several challenges on the workers' functioning (Bertilsson et al., 2012; Hjarsbech et al., 2015; Nielsen et al., 2012; Noordik et al., 2011; Sallis & Birkin, 2014). Balancing conflicting, unstable, continuous workflow, a busy work environment and managing individual reputation in the workplace was challenging for the participants who reported negative external stimuli and demands beyond everyday routine. For instance,

Some experienced a strange visual sensation while trying to focus on another person or a computer screen. This was sometimes accompanied by a swaying feeling. The physical sensations were scary and led them to a focus on the body, which made it difficult to focus outwards and to work. (Bertilsson et al., 2012, p.1707)

The participants who could not achieve a balance in the work environment interpreted their experiences as psychological loss, detachment, loss of empathy and consequent non-reliance on a previously successful work adjustment (Bertilsson et al., 2012; Danielsson et al., 2017a; Hjarsbech et al., 2015; Moll et al., 2013). 'Detachment' was either used by workers to hide from others and the work environment or shield themselves (Danielsson et al., 2017a). Some perceived their work environment as a "sensation of a troubling distraction that is difficult to ward off"

(Danielsson et al., 2017a). Arguably, detachment could further impair WF due to non-engagement.

Theme 3: Consequences of impaired WF. This theme occurred at different periods of depression (outset, during or after), either as a response to or to mask medication side-effects, symptoms and WF issues. 10 out of the 11 papers reported on the consequences of impaired WF (Abma et al., 2013; Bertilsson et al., 2012; Danielsson et al., 2017a & 2017b; Haslam et al., 2004; Hjarsbech et al., 2015; Moll et al., 2013; Nielsen et al., 2012; Noordik et al., 2011; Sallis & Birkin, 2014). The subordinate themes include psychosocial consequences and negative coping strategies ([See Fig 3.3 for the relationships](#)).

3.1 The psychosocial consequences. The obstacles and the challenges mentioned above caused ongoing losses in functionality, productivity and subsequently, psychosocial effects. For example, the participants reported heightened emotional sensitivity, such as anger, low self-esteem, feelings of “not being good enough” (Bertilsson et al., 2012, p.1707), lack of confidence, loss of refuelling, emotional detachment, and isolation. Ironically, many of these consequences are also symptoms of depression, which were further reinforced with declining WF. “A self-fulfilling prophecy arose as participants began to notice their declining work performance reinforcing already low levels of self-esteem and confidence in their ability to carry out job tasks” (Sallis & Birkin, 2014, p. 472).

Additionally, impaired WF caused guilt because the participants perceived they were “not pulling their weight” (Sallis & Birkin, 2014, p. 472). This thinking reinforced isolation, low self-esteem and lack of confidence with further impairment in WF (Danielsson et al., 2017a; Nielsen et al., 2012; Sallis & Birkin, 2014). For instance, Danielsson et al.’s (2017a) contribution to this theme is significant because it focused on work instability experiences among 27 participants with CMD. Although Nielsen et al. (2012) and Sallis and Birkin’s (2014) studies interviewed fewer participants ($N=16$ and $N=7$) respectively, their philosophical underpinnings (constructivist, and phenomenological/interpretive stances, that is, the essence and lived experiences of depression)

further enhanced their findings. Both studies also focused on the experiences of depression with sickness absence and return-to-work. Arguably, the psychosocial impact of depression could also drive impaired WF.

3.2 Negative Coping Strategies. As with other workers who do not have depression, optimum WF was important to participants once they were at work. To achieve this or mask impaired WF, participants utilised negative coping strategies to improve or hide impaired WF and handle demanding work situations. Therefore, the workers' struggles remained hidden and consequently precluded much-needed workplace support and the need to function without restriction. Engaging negative coping strategies for improved WF indicates participants' meaning of impaired WF. The utilised strategies were the use of: a 'cognitive barrier' (perfectionism) or 'behavioural barrier' ("checking work repeatedly, taking notes, or putting in extra effort") (Noordik et al., 2011, p.1628); and maladaptive coping, such as the use of alcohol (Bertilsson et al., 2012). Utilising the following mechanisms was also widespread: 'compensatory behaviours' including avoidance, taking sick leave, facade, isolation and sabotaging work/life balance. For example, one participant said, "I manage to hold that façade; it feels nice to be the professional" (Danielsson et al., 2017a, p.479).

Additionally, 'trade-offs' were used to cope with work demands and achieve optimum WF (Bertilsson et al., 2012, p.1708). However, it gave a false sense of wellness and workability resulting in relapse, absenteeism, presenteeism or work exit (Bertilsson et al., 2012; Danielsson et al., 2017a & 2017b; Hjarsbech et al., 2015; Nielsen et al., 2012; Sallis & Birkin, 2014). Almost half of the included studies mentioned the use of 'façade' or appearing 'normal' as a way of coping with WF. Moll et al. (2013) refer to façade as 'concealment.' In another study, one participant said,

I don't talk about getting depressed because it's important to me to feel that I don't let it affect my life [...] I want to be a normal functioning human being and that's why it's important to me not to define things as depression [...] (cited in Sallis & Birkin, 2014, p.473).

As seen above, being able to function is vital to workers experiencing depression. Remaining at work caused subsequent exacerbated symptoms, impaired WF, prolonged sickness absence, poor prognosis, prolonged recovery together with health and safety issues.

Theme 4: Promoters of WF. This overarching theme revealed workers' expectations for workplace support for improved WF. Six of the selected studies highlighted various experiences that promoted WF (Abma et al., 2013; Bertilsson et al., 2012; Hjarsbech et al., 2015; Nielsen et al., 2012; Noordik et al., 2011; Sallis & Birkin, 2014) ([See Fig 3.3 for the relationships](#)). This superordinate theme includes organisational and peers levels of support and individual intelligence strategies.

4.1: Organisational and peer levels of support. As highlighted across the studies, managerial support and communication were vital to participants' WF during and after depression. 'Supportive communication' from managers mitigated the obstacles and challenges of impaired WF (Abma et al., 2013; Hjarsbech et al., 2015; Nielsen et al., 2012; Noordik et al., 2011) as well as mediated organisational understanding of the impact of symptoms, medication side-effects and individual experiences of the workplace issues (Bertilsson et al., 2012; Noordik et al., 2011; Sallis & Birkin, 2014). This sub-ordinate theme also links directly to Theme 1 due to line managers' negative attitude, lack of understanding and skills when dealing with workers with depression. The impact of depression on WF and work expectations meant that understanding from colleagues and managers was often crucial to participants in alleviating their fears and uncertainties associated with WF, remaining at work, expectations about work tasks and the work environment.

Supportive communication. useful [. . .] [I] agreed with [. . .] my psychologist [. . .] and a new supervisor [. . .] to make a schedule for taking pauses during the days I have to work [and] [. . .] that I have to take the pauses at the scheduled times [and] [. . .] write down [. . .]" (Noordik et al., 2011, p.1630).

Thus, the narrative above indicates the benefits of communicated workplace adjustments in facilitating WF among workers returning to work after depression. Nonetheless, a Swedish study

that utilised a phenomenological approach to explore work capacity found a negative perception from other colleagues about providing workplace support to the sick colleague, which they called “special treatment” (Bertilsson et al., 2012). This thinking could be due to their organisational culture. However, none of the UK-based studies included in this review has highlighted this issue.

Receiving effective workplace interventions was found to be imperative for WF. In their respective studies (qualitative descriptive method, grounded theory and IPA), Abma et al. (2013); Noordik et al. (2011) and Sallis and Birkin, (2014) reported the available workplace support. These included OH intervention; reduced work pressure from a manager; relaxing individual’s work objective by supervisors; and work adjustments. Arguably, effective workplace support is beneficial for improved WF. For instance, a Swedish study utilising a phenomenological approach found that work function advice from an OH physician was beneficial to workers because of work adjustments and job match in facilitating remaining at work (Bertilsson et al., 2012). Nevertheless, Danielsson et al. (2017a) found that among workers with repeated depression, previously agreed work adjustments were unreliable. Workers might not want to rely on workplace adjustments and thus continue to struggle at work.

Peer support was highlighted as beneficial for WF. Abma et al. (2013) indicate the importance of peer levels of support as they are often the first to notice WF issues. For instance, Danielsson et al.’s (2017a) study report that a few workers asked for help from colleagues. A sense of belonging to a team, a behaviour influenced by individuals and peers, was reported as beneficial by Bertilsson et al. (2012). Some participants reported the importance of confidential and regular communication with workplace buddies (Abma et al., 2013; Sallis & Birkin, 2014), which could boost confidence and WF. It can be deduced that peers’ support can boost workers’ confidence, improve their sense of belonging and bolster WF.

4.2: Individual intelligence strategies. In their studies based on phenomenological approaches, Bertilsson et al. (2012) and Sallis and Birkin (2014) found optimum WF as a way of ‘refueling’ work energy, which provided subsequent sustained improved performance for some of the

workers. However, these studies also reported that with impaired WF, 'refueling' ceased, which further reduced WF. Therefore, sustaining optimum WF is crucial to future performance. Two studies reported that some participants prioritised leisure time, which resulted in improved WF (Bertilsson et al., 2012; Nielsen et al., 2012). For instance,

Participants previously experienced feelings of work satisfaction, meaningfulness and appreciation from others. These feelings were described as energizing the work performance. However, these previously important sources of gratification and 'refueling' were cut-off due to their illness. This lack of 'energy refueling', which decreased work capacity, was likened by participants to wading through syrup and contributed to an inner resistance at work. (Bertilsson et al., 2012, p.1708)

Achieving optimum WF is dependent on individual workers who have experienced depression and others linked to their work performance.

In summary, some of the theoretical perspectives anchoring the studies contributing to these themes provide explanations for these findings. For instance, Sallis and Birkin's (2014) study drew on the cognitive behavioural model, which highlights the negative view of self, situation and prospects, typical of depression, which is hypothesised to result in decreased goal motivation and subsequent reduced activity, lack of interest, lethargy and avoidance. Sallis and Birkin's (2014) study revealed three interrelated themes: (1) "The interaction between depression and work; (2) illness beliefs; and (3) organisational context and depression". Similar to Millward et al.'s (2005) study, which utilised the 'sickness identity' theory, Sallis and Birkin (2014) concluded that individuals' health and work beliefs are influenced by their sickness absence decisions and experiences, which are mediated by their experiences of organisational policies, line manager support and the messages and actions of GPs. However, there is a dissonance in both studies because Sallis and Birkin's (2014) study is more focused on the workplace while Millward et al.'s (2005) study is more focused on the healthcare system. It is arguable that over time, depression or CMD is constructed in terms of treatment and the workplace experience. Sallis and Birkin

(2014) recognise that the solution to impaired WF due to depression does not only lie with the healthcare worker, but it is also vital to gain individual experiences of the workplace issues and interventions.

3.7 Discussion

3.7.1 Summary of evidence

This review included eleven qualitative studies that explored workers' experiences of depression or CMD. The results or findings from each study were considered as data. Not all the themes and subthemes in this current review are explicit in the primary studies, but they developed from the synthesis. Two critical findings developed from this review. First is the paucity of qualitative studies on depression-related WF issues. Second is the lack of qualitative studies on OWs' experiences of depression. This knowledge gap will be addressed in Section 3.7.3. The first overarching theme, *obstacles to WF*, highlights fears and uncertainties, organisational and external factors. For instance, Nielsen et al. (2012) conceptualised non-acceptance of diagnosis due to fear as a lack of insight. This behaviour aligns with a concept termed "defensive denial" (Freud, 1937), which might mean difficulty seeing a need to seek help and treatment. Of importance is the link this has with the "desperation principle" (Hobfoll et al., 2018). This principle holds that "when people's resources are overstretched or exhausted, they enter a defensive mode to preserve the self which is often defensive, aggressive, and may become irrational" (Hobfoll et al., 2018, p. 106). As seen above, workers who feared disclosure due to negative perception struggled with their WF because their symptoms were hidden to others. Nevertheless, as seen across the primary studies included in this review, stigma is a central issue. Arguably, negative perceptions of people with mental health issues in the workplace are still a real problem and, understandably, this feeds these worries.

The second overarching theme highlights the challenges of impaired WF due to the uncertainties or instability of symptoms, medication side-effects, work tasks, and work environment. The “resource loss cycles” (Hobfoll et al., 2018) bolsters this finding. Hobfoll et al. (2018) have highlighted the strength of resource loss over resource gain and the resultant stress at every iteration of the stress spiral. Consequently, individuals and organisations face challenges to offset resource loss due to reduced available resources because these loss spirals gain momentum and magnitude. An exemplification is seen in studies conducted by Cornelius et al. (2011) and Plaisier et al. (2010), which found that workers with depression have a risk twice as high in experiencing WF problems than other workers. This finding suggests that such workers struggle to offset their WF due to reduced resources as their loss spirals will gain momentum and magnitude. These authors highlighted the need for effective workplace adaptations and modifications for optimum WF. Impaired WF could result in work exit, especially if workers continue to struggle at work, or are nearing retirement age. This thinking aligns with [Corollary 1](#) of COR theory (Hobfoll et al., 2018) which suggests that individuals and organisations who lack resources are more vulnerable to resource loss and less capable of resource gain.

The third overarching theme concerns the consequences of impaired WF. This theme explored its psychosocial implications and negative coping strategies. The analysis of this current review suggests that the combined effects of psychosocial impacts of poor WF: the distorted view of the self, the impact of symptoms and side-effects as well as workload issues mean a quadruple escalation of the problem, which could further suppress WF. Theme 3 could be explicated with the ‘primacy of loss’ (Hobfoll et al., 2018), positing that resource loss is disproportionately more salient than resource gain (Hobfoll et al., 2018, p.106).

Across the selected papers, individual negative coping strategies were dominant elements, as workers described the ‘vicious circle’ of depression, maintaining WF and the various coping strategies employed. This finding aligns with Lazarus’ (1993) theory of coping, posited as a person's cognitive and behavioural effort to manage demands that may exceed their resources.

[Gain Paradox Principle](#) exemplifies this thinking, and it holds that the need for resource gain is powerful in resource loss because of the higher value and importance attached to it. Thus, utilising negative coping strategies such as facade demonstrates the importance and value that workers attached to optimum WF. The use of facade epitomises a finding in one study by Trougakos et al. (2015) that has helped understand the resource gain and loss spiral within the COR. In their research, Trougakos et al. (2015) found that when employees are emotionally exhausted, they start each day with depleted resources and use 'façade' with co-workers, because of lack of resources to address more severe issues, which consequently causes them more exhaustion. Although the use of facade can bolster WF, this is only achieved temporarily.

Moreover, some of these results are explicable by the underlying concepts for the included studies. For instance, utilising critical social theory, Moll et al. (2013) focused on the day-to-day interactions framed within an understanding of interactive processes in a broader organisational and discursive context. Blumer (1969) explained these interactions as interpretation and negotiation processes which are embedded within symbolic interactionism. Symbolic interactionism is the meaning that participants give to their interactions (Blumer, 1969). However, Danielsson et al.'s (2017a) study utilised the PEO model of WF and a phenomenological perspective on depression and anxiety, characterised by a sense of entrapment and disruption of the person's interaction with the world.

The fourth overarching theme is related to the promoters of WF. It highlights the positive organisational, peer-related and individual factors that could promote WF among depressed workers. The analysis highlighted the pivotal role of supervisors/line managers, colleagues, OH, and the benefits of sympathetic communication and understanding in facilitating WF. This theme is theoretically relevant to the '[Resource Investment Principle](#)'. An investment in improving resource loss could be explicated as seeking medical help, investing in effective workplace support for workers recovering from depression, or employees' motivation to engage with workplace support.

3.7.2 Strengths and Limitations

The systematic conduct of this review is considered a strength, as structured search strategies were followed iteratively to minimise the risk of missing relevant papers. Additionally, the synthesis of studies covering three regions, Europe, Canada and the US, highlighted broader international knowledge and insights on the experiences of workers' functioning during and after depression. Also, the synthesis of the subjective experiences of WF of the full working-age population during and after depression is considered a strength. Overall, it can be concluded that there is representativeness of the included studies because all the participants for the selected studies fall within the worker category. Moreover, six of the 11 selected studies directly addressed WF's issue among depressed workers in their research questions.

Regarding generalisability, the aim of qualitative studies is not to generalise. However, theoretically, the reviewer considers the concepts in this current review generalisable in various work contexts because of its systematic conduct and extensive coverage of three major regions in the world and the inclusion of studies covering multiple work settings. Nonetheless, considering the limited studies on the experiences of workers on WF, more studies are required to support this research. Further studies could be useful in understanding how experiences vary across the lifespan or various work sectors.

3.7.3 Current gaps in the literature

There are two striking findings in this review. First, given its importance as a topic, there are relatively few qualitative studies on depression and WF among the full working-age groups. The few available studies on WF and depression are quantitative studies on workers across the full working-age groups (Lagerveld et al., 2010). Second, there are few qualitative studies on OWs' experiences of depression. Most primary studies on this topic have been cross-sectional or

longitudinal quantitative studies (Adler et al., 2006; Andrea et al., 2009; Hawthorne et al., 2003; Ivandic et al., 2017). The few studies that explored OWs' depression were conducted along with other medical conditions (Boot et al., 2016; Stynen et al., 2015) or were quantitative (Stynen et al., 2015). Additionally, most of the qualitative studies were either based on CMD and conducted across the full working-age groups without a sub-group analysis for OWs (Moll et al., 2013). These findings raise questions about how impaired WF during and after depression is currently being addressed across the entire working population (workers aged 16 and above).

3.7.4 Suggestions for further research

Given the ongoing demographic changes in industrialised nations, the impact of depression on workers' functioning, and limited studies on this issue, it is recommended that further qualitative studies are conducted to explore the experiences of OWs in particular. Given the increasing prevalence of depression and its impact on individuals, organisations and society, further studies on this topic are essential. More studies on the experiences of WF among depressed workers are required from other regions such as Asia, Africa and Australia to expand knowledge on this issue. Although the included studies for this current review were focused on a mixture of men and women, without gender conclusions, only one study focused on women. Thus, further studies on the experiences of WF might be useful in understanding gender-related impacts. Further studies are also required on the experiences of OH professionals, line managers and supervisors when addressing WF issues among workers with depression, as this could provide a different perspective on the topic.

3.7.5 Implications for Practice

Previous studies have highlighted persistent impaired WF and high sickness absence among workers with remitted depression (Plaisier et al., 2010). Have et al. (2002) highlighted the

challenge of reduced help-seeking behaviour among people with depression due to the non-awareness of the disorder among individuals. The provision of workplace mental health interventions with opportunities for developing awareness, easy accessibility to therapies and treatments are recognised methods of supporting workers (Plaisier et al., 2010). Responding to the highlighted workplace issues is essential as these contribute to impaired WF, heightened sickness absence level and premature work exit. Addressing the multifaceted challenges, such as stigmatisation and non-disclosure, among many others, is imperative. These are considered as resource investment as described in Principle 2 of COR theory. The following workplace implications are based on the findings of this current review:

- Supervisors should be educated on addressing the challenges of depression and their key responsibility in earmarking useful workplace support/intervention, which might mediate improved WF and reduce further absences.
- Occupational health (OH) professionals could be employed to develop effective training tools for HR, managers, supervisors, and workers to identify and manage WF issues related to depression. For instance, the *resource caravans* posited that resources exist in packs, or caravans, for both individuals and organisations, not individually (Hobfoll et al., 2018). Thus, resources tend to move together, based on the consequences of the individual environment. Therefore, personal resources, such as optimum WF during depression, are likely to emerge from nurturing or supportive social conditions, such as supportive work organisations. This thinking is also embedded within the resource caravan passageways. Training provision for line managers on handling depression in the workplace should be adapted to changing workplace demands.
- Effective training for line managers and workers would be useful in changing unhealthy workplace culture around mental health issues in the workplace. For instance, it has been argued that while providing employee-focused workplace-based support, such

as EAP is useful, addressing the workplace psychosocial factors are essential in managing mental health issues, such as depression in today's work environment (Czabała et al., 2011). According to Bryan et al. (2018), managers are in an influential position to manage workplace-based mental health risk factors because of their knowledge of workplace issues and the ability to implement workplace adjustments to working conditions, thereby improving their employees' well-being. In their systematic review and meta-analysis concerning the effectiveness of training managers to understand and support the mental health needs of employees, Gayed et al. (2018) found that training managers in workplace mental health can improve their knowledge, attitudes and self-reported behaviour in supporting employees experiencing mental health problems.

- Organisations should create a supportive environment that nurtures individuals' WF. This can be achieved by developing healthy workplace policies and culture that encourage line managers' and peers' support for depression and mental wellbeing. Peer-level support and early referral to OH might help manage some of the obstacles and challenges identified in this review before they become consequences. Moreover, within the resource caravan passageways, Hobfoll et al. (2018) theorised that "people's resources exist in ecological conditions that either foster and nurture or limit and block resource creation and sustenance" (p.107). Nevertheless, these authors concluded that due to the field's overwhelming emphasis on the individual level, scholars often miss the organisational level of analysis, which is vital in creating a nurturing or limiting culture. Further, GPs and mental health professionals should utilise this recommendation by ensuring the referral of workers with depression to OH practitioners for an assessment of their fitness to return to work and workability.
- Workplace wellbeing policies and workplace culture should be aimed at reducing stigmatisation when addressing depression among workers. This recommendation

aligns with Principles 1-4 and Corollaries 1-3 of COR theory. For instance, Principle 1 is useful in highlighting resource loss vulnerabilities both from an individual and organisational standpoint. Employees are the resources of any organisation. The vulnerabilities of resource loss by an employee experiencing impaired WF due to depression would eventually translate to vulnerabilities and resource loss in an organisation either through productivity losses, cost of sickness absence and costly mistakes among many other things. Essentially, organisations would indirectly support their productivity by developing and encouraging transparent policies that support individuals experiencing depression.

- Provision of workplace masterclasses for workers diagnosed with depression could help develop personal understanding and self-management tactics that could benefit overall wellbeing. OH professionals could be utilised in developing and delivering masterclasses. For instance, within Principle 4 of COR theory, it is explained that where resources are overstretched or exhausted, people enter a defensive mode to preserve the self. A defensive withdrawal could allow time to either regroup, wait for help or allows the stressor to pass. Alternatively, an aggressive or irrational response may be utilised in developing a new coping strategy or might have the potential to change an array of stressors (Hobfoll et al., 2018, p.106). Therefore, the provision of workplace masterclasses for workers diagnosed with depression could explain how people are likely to react when resources are threatened and how this could be used positively in resource gain. It might help workers understand that there is nothing wrong with accepting help where there are depleted resources, such as mental wellbeing.

3.8 Conclusions

Based on the review question, an essential outcome of this thematic synthesis is that depression exerts a significant impact on individuals' WF during and after depression. This meta-synthesis revealed that some experiences are represented as 1) obstacles to WF (fears and uncertainties, organisational factors and external factors); 2) challenges of impaired WF (challenges of symptoms, medication side-effects, work-tasks and the work environment); 3) consequences of impaired WF (psychosocial consequences and negative coping strategies); and 4) promoters of WF (organisational and peer-level support and individual intelligence). Despite several limitations, this current review contributes to understanding the experiences of WF among workers during and after depression. The result of this synthesis suggests vital areas of focus for supervisors' awareness and understanding in supporting workers during and after depression with a view to earmarking work adjustments for improved WF and attendance. Advice should be aimed at encouraging workers to be transparent about depression and accessing useful workplace support/intervention that could bolster wellbeing. Many workers with depression desire to function without impairment and contribute meaningfully to organisational goals. Therefore, effective workplace support should tap into workers' positive desire for optimum WF while acknowledging the practical realities of impaired WF during and after depression.

Within COR theory, a resource is conceptualised as a phenomenon that can be used up or lost; it has also been demonstrated that resources may also be replenished over time if they are utilised appropriately (Hobfoll et al., 2018). According to Hobfoll et al. (2018), existing global research has focused on identifying resources that protect against further loss and subsequent debilitating behaviours at work. Recent studies have highlighted the functional relationship between health preservation and improved work performance at the individual level. Hobfoll et al. (2018) aligned resource investment and corporate social responsibility at an organisational level, meaning that a combination of these two factors is pivotal for resource gains, maintenance, and

restoration. A combination of individual and organisational levels of resources would enable resource gains. Given the research gap on OWs' experiences of depression, Chapter 4 will discuss the philosophical underpinning and methods for this thesis' empirical study.

Chapter 4 **METHODOLOGY AND METHODS**

Philosophical Underpinning, Methods and Thematic Analysis

4.1 Introduction

Chapter 3 underlined the importance of understanding the experiences of WF among workers who have reported depression and it highlighted gaps in the literature. One of the key findings was the limitation of studies on older workers' (OWs) experiences of depression. Accordingly, the empirical study for this thesis sets out to address this limitation. This chapter aims to discuss the paradigm and philosophical underpinnings of this thesis' empirical study. These underpinnings influenced the chosen qualitative design, recruitment, interview, analysis method and ethical considerations for this study. According to Bunniss and Kelly (2010), paradigms are shared sets of beliefs and practices about research, which enable the regulation of inquiries within disciplines. Paradigms include ontology, epistemology and methodology. Considering these philosophical components enabled the conceptualisation and conduct of this research (Crossan, 2003). Understanding the interrelationships of these components and the theoretical framework in the context of exploring OWs' experiences of depression is essential for theory-driven thinking and knowledge generation. For instance, this study's theoretical framework was useful in selecting the current topic, developing the research questions, conceptualising the literature review, the design approach, and the study's analysis plan, as advised by Grant & Osanloo (2014). Therefore, this chapter, along with Chapter 2 (theories and conceptual framework), are crucial to the formation and the implementation of this current research, which explores the experiences of OWs who have reported depression.

4.2 Research Paradigm

Based on my motivation for this study, which is detailed in [Chapter 1](#), I had the belief that I would be able to research OWs with the intent of understanding and making sense of their experiences of depression. This assumption is because of my 18 years' experience as an occupational health (OH) adviser which has allowed me to assess workers and OWs with depression within various work contexts such as the health, academic, emergency services, local authorities and manufacturing sectors.

4.2.1 Ontology

As a relativist, I assumed that reality is relative to individual perceptions and it is shaped by their contexts. I assumed that multiple versions of reality exist because peoples' experiences are shaped by various contexts, thereby producing different and in-depth meanings (Bunniss & Kelly, 2010). I assumed that OWs' perceptions of truth have meanings attached to them because of their individual experiences. For instance, an OW's reality is subject to change depending on their context, worldviews and experiences. However, I recognise that my stance as a relativist is opposed to realism. Philosophically, the choice of being a realist or relativist is complex because of the beliefs attached to each approach. Given the phenomenon of study, a relativist stance seems justified because of the study aim and research question. This current empirical study aims to understand OWs' realities based on their individual experiences of depression within their work contexts and the meaning they attach to their experiences. This study is not aimed at generalising human experiences based on numbers.

Obtaining multiple realities from individual participants has the power to produce deeper insights into the study phenomenon (Bryman, 2012). As a relativist, I made sense of how different OWs made sense of their experiences of depression and reported the subjective and multiple realities of participants. My philosophical position enabled the facilitation of OWs' interpretation of how depression impacted on their work abilities, work attendance, work

environment and the meaning they attached to their experiences. My underlying assumption was useful when exploring OWs' experiences of depression in different roles and across diverse UK organisations. The use of this ontological position provided an avenue for recruiting multiple experiential experts into this study. During data analysis, multiple understandings of realities were presented using the actual words of different OWs and presenting different perspectives as well as interpreting the meanings associated with their experiences.

4.2.2 Epistemology

Interpretivism involves an active interaction with participants for the purpose of obtaining in-depth knowledge (Bryman, 2012). As an interpretivist, my philosophical assumption allowed me to interact actively with the individual OWs' account to get an in-depth knowledge of what went on during their depression. This philosophical position is a subjective approach to knowing reality (Bunniss & Kelly, 2010). Unlike positivism, which focuses on objectivity and numbers, interpretivism is concerned with obtaining subjective information (Bryman, 2012). Positivists have the assumption that objective measurements can obtain truth and that truth is generalisable (Crossan, 2003). Given its inherent philosophical assumption, the positivist lens cannot be used to understand individuals' reality.

My interpretive and subjective position is justified because it enabled the co-creation of knowledge with study participants. This stance facilitated an understanding of the meanings that OWs attached to their experiences of depression; this position aligns with the underlying ontological assumption for this study. Unless the meanings attached to OWs' experiences of depression are understood, it might be challenging to support or earmark meaningful workplace interventions. The use of semi-structured interviews provided an opportunity to utilise my interpretive stance. It was beneficial in getting into the participants' world through questioning and probing to understand their realities, thereby generating in-depth knowledge. For instance, conducting a semi-structured interview enabled me to know how OWs made

sense of their individual experiences of depression within their work contexts and the meaning they attached to their circumstances. Understanding how these circumstances affected individual OWs required an assumption that I would need to dig deep by talking to them to make sense of their workplace contexts, depression issues, and meanings attached to their contexts and experiences. Using probes, an inductive method to data analysis and subjective reasoning helped me interpret OWs' interpretation of their circumstances, thereby enabling me to organise and reconstruct individual OW's experiences. As an interpretivist, I acknowledge the value-laden nature of my stance and ways of knowing. However, this stance also provided me with the opportunity to report my values, biases, the value-laden nature of the information gathered and my interpretations through reflexivity, as advised by Creswell (2013). Additionally, another layer of interpretation in this study involved using the HWFM (Burton, 2010), COR theory (Hobfoll et al., 2018), and other existing literature to corroborate my findings. Having discussed my epistemological position, the methodology for the empirical study will now be discussed.

4.2.3 Methodology

In line with relativism and interpretivism, qualitative studies are useful in understanding individual experiences of health issues (Creswell, 2003), such as depression among OWs. This approach to research inquiry enabled me to access experiential information and an insider's view from participants. Qualitative approach enables a flexible approach to interviewing participants with open-ended questions and probes to explore areas of interest (Creswell, 2013). The preunderstanding of HWFM offered a logical structure of connected workplace concepts that formed the basis for questioning individual OWs, the context and reality for each OW's depression. For instance, the HWFM was used to formulate questions for the interview schedule. During analysis, patterns were viewed from the dataset through inductive reasoning (Creswell, 2013); that is, a bottom-up approach was used to generate the

required knowledge for the research question. An inductive process to coding is grounded in the original data and it detracts from fitting patterns into a pre-existing coding frame or the researcher's analytical preconceptions (Braun & Clarke, 2006). However, quantitative approaches use mainly deductive reasoning, which involves generating hypotheses and objective data collection (Bryman, 2012), an approach that does not align with my research aim and research question. Quantitative studies sit within the positivist's paradigm (Ritchie et al., 2013). The aim of this study is not to generate a hypothesis. According to Ritchie et al. (2013), a quantitative stance has the assumption that the world is knowable, observable, measurable and objective with numeric representation. While this approach might be useful in specific contexts, it is less suitable for exploring individual and subjective experiences to create in-depth data.

Furthermore, this study's design was subjected to an iterative process, which involved going back and forth on the implementation of the research process and consequently facilitated flexibility and transparency in the conduct of this current research, as advised by Creswell (2009). Nevertheless, the qualitative design is not without its limitations. It has been critiqued for the following reasons: its flexibility; subjectivity; as well as lack of rigour, reproducibility and generalisability (Crossan, 2003; Mays & Pope, 1995). However, in this study, subjectivity was useful in making sense of individual OWs' experiences and meanings (Ritchie et al., 2013). To ensure rigour and quality, the conduct of this study was built upon the principles of sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance (Yardley, 2000; 2017). The following mechanisms were utilised: probes during questioning to confirm the participants' meanings; reflexivity to scrutinise my biases and assumptions during the interviews and analysis; and keeping a reflexive journal throughout the study (Ritchie et al., 2013).

Qualitative methodology is justified for this study because of my ontological and epistemological position, as explained in Sections 4.2.1 and 4.2.2. As this study seeks to obtain in-depth knowledge through individual experiences, within diverse contexts, therefore,

a qualitative methodology seems appropriate. Utilising a qualitative stance is also justified because it enables the use of a semi-structured interview, which was useful in obtaining each OW's account as they had experienced it (Howitt, 2013). The analysis within this qualitative stance enabled the concurrent identification of the essential similarities and uniqueness of each OW's experience. Interviewing each OW meant that their world was made visible by using questions and probes and thereby allowing for the generation of detailed, rich and complex data based on their experiences as suggested by MacKenzie and Knipe (2006). This approach meant that patterns and themes were drawn across the entire data sets, based on the research question, while preserving complexity and the participants' uniqueness (MacKenzie & Knipe, 2006). Thus, the qualitative nature of my study drives the methods utilised in this study.

4.3 Thematic Analysis

Thematic analysis helps identify, analyse, and report patterns or themes generated from study data (Braun & Clarke, 2006). Unlike discourse analysis, conversational analysis and narrative analysis, thematic analysis is much more flexible due to lack of a specific theoretical or epistemological approach (Howitt, 2013). Therefore, it is more applicable across a range of approaches than methods such as IPA (Braun & Clarke, 2006). According to Braun et al. (2019), there are three types of thematic analysis: coding reliability; the codebook; and reflexive thematic analysis. Coding reliability (Boyatzis, 1998; Guest et al., 2012) is generally used within a positivist paradigm and is based on scientific logic (Braun et al., 2019). The codebook approach is similar to coding reliability because all the codes are predefined, but it is used when analysing extensive qualitative data (Braun et al., 2019). However, the reflexive approach (Braun et al., 2019), chosen for this study, is theoretically flexible and different from the previous two approaches. A reflexive approach is justified because it aligns with my philosophical assumptions and values within the qualitative approach and interpretivism. It is also justified because only one coder is required for this study. This approach allowed me to

conduct subjective interpretive work, which fits with my ontological and epistemological assumptions. Thus, reflexive thematic analysis is unlike the codebook approach and coding reliability thematic analysis that requires multiple coders with boundaries, agreements to coding, and reduced subjectivity (Braun et al., 2019). As the only coder, I was able to create new knowledge through data interpretation. Nevertheless, this approach's subjective nature also suggests it demands quality and transparency (Creswell, 2013). Quality is ensured through reflexivity, keeping a reflexive journal as well as clarifying, documenting and utilising the six stages of thematic analysis (Braun & Clarke, 2006).

Although thematic analysis has been criticised for shortfalls, such as the previously mentioned lack of a universally accepted protocol in conducting research and a lack of theoretical boundaries, Braun and Clarke's (2006) approach is now developed and widely used in analysing studies as previously highlighted. Addressing these limitations required that Braun and Clarke's (2006) six-stage systematic and transparent approach was utilised. The six stages are as follows: familiarisation with data by immersion; generating initial code; searching for themes; reviewing themes; defining and naming themes; and producing a report (Braun & Clarke, 2006). The six stages of thematic analysis are discussed under the methods section. Also, to mitigate the challenge of lack of theoretical boundary, the documentation of the theoretical and epistemological positions for this current study has been made explicit (Braun & Clarke, 2006). Engaging with the study participants' data also ensured that the codes and themes reflect the data. Having established the philosophical underpinnings and the analytic method for this study, the aim, objectives, main research question and sub-research questions for this study, and the methods engaged in this research project are discussed below.

4.4 Aim and Objectives

This empirical study sets out to explore OWs experiences of depression and how they make sense of their experiences. The objectives are as follows:

- To explore the impact of depression on OWs' experiences of work attendance, functioning and participation;
- To understand the workplace issues that were related to OWs' experiences;
- To explore the meaning that OWs gave to their experiences of depression;
- To explore the participants' experiences about workplace support provisions.

4.5 Research and Sub-research Questions

The research question for this study is, "What are the experiences of older workers (OWs) who had depression in the contemporary workplace?" The following sub-research questions were explored during individual interviews:

- How does depression affect OWs' WF, participation and work environment?
- How supportive are line managers and supervisors to OWs with depression?
- How useful and easily accessible is workplace support to OWs with depression?

4.6 Methods

4.6.1 Study Setting

This study was conducted in the UK. The study participants are mainly from England. According to the ONS (2019), the UK population is 66.44 million with a life expectancy of 80.96 years (The World Bank, 2016). As indicated in Chapter 1, there is no formal retirement age in the UK.

4.6.2 Population

This study's participants were drawn from various UK-based (England and Wales) work settings by utilising platforms such as online forums, multiple workplaces, call for participants' platforms, and community mental health forums. The population includes UK-based OWs

(male and female) who had depression at ≥ 50 years but had been stabilised for at least three months. Including those who had been stabilised for at least three months was necessary to reduce the risk of exacerbating symptoms, especially for those whose depression was linked to workplace issues. This population includes OWs who had depression and those who had concurrent anxiety, but those with other mental health issues were excluded. Retirees who had experienced depression as an OW were also included. OWs who self-diagnosed their depression were included.

4.6.3 Eligibility Criteria

Determining the participants' depression status was by self-report. To ascertain that OWs were sufficiently stable for participation, assessing the individuals' eligibility for the study included asking the following two questions to the participants after consenting, but before the interview: Are you currently clinically diagnosed with depression? If "Yes", for how long have your symptoms been stable? ([see Table 4.1](#)).

Table 4.1 Eligibility Criteria.

Inclusion Criteria	Exclusion Criteria
UK-based OWs (male and female) who had depression at ≥ 50 years but have been stabilised for at least three months.	Older workers (≥ 50 years) with current depression and other mental health conditions other than anxiety; workers diagnosed with depression but < 50 years.
OWs who had depression along with other common mental disorders (CMD) such as anxiety.	Non-UK-based; non-English speakers; workers who are ≥ 50 years with and/or without any experience of depression; persistent depression. Those who have not recovered from depression for at least three months.

Retirees who experienced depression at age ≥ 50 but while still at work.	The researcher's former or current patients.
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4.6.4 Sampling and Sample Size

Purposive and snowball sampling was utilised in recruiting participants for this study. Purposive sampling encompasses recruiting participants who meet the inclusion criteria for a study (Flick, 2008). It is justified because it has the power to generate richly textured data relevant to participants' experiences in comparison with sampling methods based on statistics such as probabilistic sampling (Vasileiou et al., 2018). For snowballing, an initial sample was recruited as detailed in the recruitment section below, which allowed for snowballing. Snowballing involves asking those recruited purposively to pass the researcher's contact details and the project information to potentially eligible individuals (Bryman, 2012). Unlike other analytic methods, such as IPA, which suggests a smaller sample size and homogeneity (Smith, Flower & Larkin, 2009), the flexibility of thematic analysis makes it suitable for either homogenous or heterogeneous samples (Braun et al., 2019). This understanding has been useful in this study as a heterogeneous sample was interviewed. Understandably, the study participants differed in their job categories, their experiences of depression and in their various jobs and work settings across the UK. It is also clear that a heterogeneous sample is likely to result in different experiences among the participants because different job categories require different skill sets (Howitt, 2013), and organisations differ in their culture. This approach is justified as it provides an opportunity to recruit from across the UK. It also reduces the challenge of lack of trust among participants when recruiting directly from organisations.

Regarding sample size, thematic analysis does not specify a sample size due to its lack of theoretical boundary (Braun et al., 2019). Therefore, it was difficult to ascertain the sample size for this study. However, to allow for a rich, quality dataset and to accommodate attrition

(if a participant decided to withdraw less than two weeks after interview) a sample size of 20-24 seems justified. Data saturation, that is, a stage where the essential elements of meta-themes are present, was considered with an assumption that it would guide the sample size for this study. Nevertheless, it is understandable that the use of data saturation within qualitative studies has been the subject of extensive debate (Vasileiou et al., 2018). Guest et al.'s (2006) study on data saturation and how many interviews are enough for thematic analysis found that saturation occurred within the first twelve interviews. However, these authors highlight that the fundamentals for meta-themes were present as early as the sixth interviews.

Nonetheless, Bryman (2012) has argued that saturation is dependent on the utilisation of a homogenous sample, which may not be replicated in a heterogeneous sample, as similar studies with different samples and topics are required to confirm this assertion. In their exploratory study on achieving saturation in thematic analysis, Ando et al. (2014) concluded that 12 interviews were enough to generate codes for thematic analysis where higher-level concepts were being investigated. Thus, to ensure that quality and rich data were gathered, this study's sample size was guided by my satisfaction that enough and rich data were captured to answer the research question for this study. Thus, these explanations justify the sample size selection for this study.

4.6.5 Participants

Twenty-eight people were recruited for the study via online platforms and community mental health forums to broaden the individual experiences included in the study. Five of the recruited people were excluded for non-eligibility reasons. Two people dropped out, but no reason was provided. Sample characteristics are discussed in Chapter 5.

4.6.6 Recruitment strategy

Following ethical approval from Lancaster University, the [‘Participants’ Information Sheet \(PIS\)](#), [the project flyer](#), [the ‘Expression of Interest’ \(EOI\)](#) form together with the covering letter were strategically posted to the various settings stated above (See Section 3.4). A hashtag - #Olderworkersexperiencesofdepression was also shared via professional social media platforms, such as Twitter. The identified recruitment documents facilitated the provision of information to the public and highlighted the researcher’s contact details. An indication of an individual’s interest through the EOI form or an email precipitated individual discussion to confirm eligibility, clarify any questions about the study and obtain [demographic details](#) (Bell, 2005). [Consent forms](#) were sent to the participants after the discussion if they met the eligibility criteria. The researcher allowed at least 24 hours for participants to read the information and ask further questions before the interview (Offredy & Vickers, 2010).

Following the recruitment, the various settings were notified that the required number of participants had been reached. When recruitment was below the size of the sample needed, the same processes indicated above were repeated (Offredy & Vickers, 2010).

Recruiting for the Pilot study. For reliability reasons, the indicative interview schedule was piloted (Silverman, 2010) with an OW who had had depression. The same recruitment strategy indicated above was also utilised. However, the PIS was employed to inform the participant of the pilot nature and the study aim. See Chapter 5 for the justification for non-inclusion in the overall findings. Following reflections on the interview questions and subsequent discussions with the project supervisors, the indicative interview questions changed. However, the previous titles in the indicative interview schedule were preserved (see Appendix [4.9](#)).

4.6.7 Data collection

An in-depth, semi-structured, qualitative interview with open-ended questions was flexibly employed for data collection (Howitt, 2013). Individual interviews were conducted either face-to-face at the participants' residence or workplace, over Skype or by telephone. All the participants were informed of the need to be in a private room during the interview. This requirement was particularly emphasised to the participants undergoing Skype and telephone interviews. The same privacy rule applied to me, as the interviewer. A pre-constructed [indicative interview schedule](#) was utilised to delimit the probable areas of questioning (Howitt, 2013). Skype and face-to-face interviews allowed for the visualisation of non-verbal cues that needed probing. The utilisation of telephone and Skype interviews offered easy access and reduced the challenges associated with distance, travel and finding appropriate meeting rooms when recruiting from across the UK. The interviews were digitally recorded for future reference and transcription (Howitt, 2013).

An overview of the topics discussed include 1) a background understanding of OWs' depression, the diagnosis, symptoms experienced, help-seeking behaviour and treatments received; 2) the impact of OWs' depression on workplace functioning, work participation and the work environment; 3) the available and accessed workplace interventions as well as workplace culture, and 4) closing questions and reiterating further support from on online mental health team.

4.6.8 Reflexivity

A reflexive stance was facilitated by keeping a reflective journal of the interview. Accordingly, notes were taken during and after each interview and open-ended questions were asked to avoid leading the participants' responses. As an OH specialist for about 18 years, it is possible that my previous understanding of the workplace issues concerning OWs'

experiences of depression could have impacted on the meanings and conclusions drawn from this current study. I was conscious of my biases, values and experiences that could influence the data analysis (Creswell, 2013). The analysis was grounded in data rather than interpreting the data to reflect my previous experiences of the issue. Keeping a reflexive journal of the various decisions and my justification has been useful ([see Appendix 6.2](#) for my reflexive journal).

4.6.9 Approach to Data Analysis

The analysis process was planned from the project outset. It was based on the researcher's epistemological and ontological stances. The coding and data analysis were also guided by Braun et al.'s (2019) approach to reflexive thematic analysis. The themes generated from the analysis were related to the main and sub-research questions, but these were not used as the overarching themes (Braun et al., 2019).

Analysis procedure. The analysis was guided by Braun and Clarke's (2006) analysis stages, as described in [Table 4.2](#). The data were transcribed verbatim by the researcher, and about eight to ten hours transcription time was used for an hour of interview. Following transcription, the data were migrated to Nvivo® version 12 for coding. Nvivo® is a software tool for managing extensive qualitative data but depends on the researcher to use it effectively (Davies, 2007).

Table 4.2 Stages of Thematic Analysis

Stages of Thematic analysis	Except where otherwise stated, these stages are from Braun & Clarke (2006)
Stage 1 Familiarisation with data by immersion	The analyst familiarised herself with the data by transcribing the data and immersion, reading through the transcribed data repeatedly and actively, searching for meanings, and patterns.
Stage 2 Generating initial code	Initial codes were generated and a list of ideas of what the data contains was obtained by systematically reading the data and being attentive to the themes and patterns relating to the research question (Braun & Clarke, 2006). An inductive approach to data analysis was adopted. As the analyst, I engaged with relevant literature and theories in the discussion section. This approach facilitated the reduction of bias, which might have arisen from focusing on specific aspects of the data at the expense of other potential crucial issues.
Stage 3 Searching for themes	This phase was heralded by the completion of initial coding and collation of the data. The different codes were sorted into potential themes, collating all the relevant coded extracts within the identified themes. The latent approach was chosen over a semantic one to determine the level at which themes were identified. The latent approach seeks to identify the features that gave the themes its form and meaning. This stage involved my interpretation of OWs' experiences and the construction of their reality. Thus, the analyses produced are not just descriptive, but they were theorised. This approach is different from a semantic approach, which involves identifying themes within the explicit or surface meanings of the data where the analyst does not look for meanings beyond the participant's statements. Thus, the data were organised to show patterns in semantic content, and summarised into interpretation, theorising the significance of the patterns and their broader meanings and implications. These findings were related to literature in the discussion section.

	<p>Theme identification with annotations of major themes from the transcript was made (Howitt, 2013). The interconnections between the different codes were noted, which facilitated the development of overarching themes and sub-themes. To facilitate an organised presentation of the themes, a systematic table of themes was developed to present the superordinate and subordinate themes from the analysis, ordered according to the individual OW's account (Howitt, 2013). The same steps were followed for subsequent participants. Individual structures were combined to present a general view of OWs' experiences of depression (Howitt, 2013).</p>
<p>Stage 4 Reviewing themes</p>	<p>The themes were reviewed by collapsing themes and breaking them down into separate entities. In this phase, I sought meaningful data coherence with a clear and identifiable distinction between them. Themes were reviewed on the following two levels: level one involved reviewing the coherence of participants' themes. The second level enabled the determination of the validity of individual themes with the data set.</p>
<p>Stage 5 Defining and naming themes</p>	<p>This stage began with a thematic map of the data, and it involved the definition and naming of the themes. The themes were defined and further refined for the final analysis, that is, what each theme depicted and captured was identified. A detailed analysis was conducted and written for each theme.</p>
<p>Stage 6 Producing a report</p>	<p>The development of a set of fully worked-out themes resulted in the progression of the analysis into writing the findings.</p>

4.7 Ethical considerations

4.7.1 Ethical Approval.

This study's conduct was guided by the ethical principles of the World Medical Association's Declaration of Helsinki (1964) and the Nuremberg Code (1947). The ethical consideration for this study is applied throughout the six stages of the research described by Creswell (2013). These are: before conducting the study; at the beginning of the study; data collection stage; data analysis stage; data reporting stage; and the dissemination the study information.

Lancaster University granted ethical approval for this study ([See Appendix 4.1](#) Faculty of Health and Medicine Research Ethics Committee (FHMREC) form and proposal, and [Appendix 4.2a for the approval](#)). The persistent recruitment challenges to the project resulted in seeking a review of the initial ethics approval in 2018. This review was aimed at widening the boundary of the project advertisement and seeking approval to incentivise participants. This revision was granted ([See Appendix 4.2b](#)).

4.7.2 Recruitment.

The steps detailed in the recruitment strategy were utilised to avoid coercion during the recruitment phase (See Appendices: [4.4](#), [4.5](#), [4.6](#) and [Ethics application](#) – Section 3.4). The avoidance of coercion meant that the PIS and EOI forms were provided to every participant. Also, participants were allowed at least 24 hours to digest the information and an opportunity to ask questions using the EOI form or sending an email before recruitment. Participants were only contacted and provided with a consent form once the EOI form or an email indicating their interest

had been received. Additionally, recruitments were not conducted with my current place of work or my previous patients.

4.7.3 Consent

For privacy and dignity reasons, where possible, informed consent was obtained with participants' original signature on the form as advised in the Nuremberg Code (1947) ([See Appendix 4.7](#) for the consent form). Where obtaining consent with an original signature was impossible with one participant due to the study's remote nature, the participant's consent was obtained verbally and recorded at the beginning of the interview. ([See Ethics application](#) – Section 3.9a & b).

4.7.4 Safety

It was not expected that this study would cause participants undue distress or danger. However, it could create some emotional disturbance, especially if participants' depression was linked to work-related issues. There were plans to pause the interview to restart based on the participant's decision in such circumstances. A participant's inability to continue with the interview would trigger an immediate signposting to their GP. All the participants, including the ineligible individuals, were routinely signposted to an online mental health support team ([See Ethics application](#) – Section 3.10). Skype-based participants were informed of the risks of an internet-based interview (See Ethics application – Section 3.5 and [Appendix 4.3](#)). The potential risk of lone-working during face-to-face interviews was mitigated as documented in Section 3.11 of the [Ethics application](#) and [Appendix 4.5](#). Throughout the research project, there was no identification of a severe risk, such as planned suicide, which could have triggered immediate notification of the police and the project supervisors ([See Appendix 4.5](#)). There was no physical or psychological

harm to the researcher throughout the stages of the research. According to Creswell (2013), researchers are warned not to 'use' participants by gathering information without giving back or providing rewards to participants (p.58). Thus, 18 participants were rewarded for their time with a £15.00 Amazon gift voucher. The others were interviewed before obtaining ethical approval to incentivise.

4.7.5 Anonymity and confidentiality

The boundary of anonymity was clarified with the participants at the outset (British Sociological Association, 2017), and this involved mechanisms, such as the use of pseudonyms, the separation of personal details from all code identified data and the separation of the consent form and the demographic information from the interview data. Before the interview, the participants were informed of their right to reject the use of data-gathering devices, such as audio-recorders (ESRC, 2015). All the participants permitted notetaking and recording during the interview ([See Ethics application](#) Sections 3.14a &b). The participants' anonymity was preserved according to the Data Protection Act (2018). For confidentiality reasons, the participants' electronic data were stored with password encryption. Paper copies of EOI form and consent form were securely locked in a filing cabinet. Data access was limited to the researcher and the project supervisors ([See Ethics application](#) Section 3.14a &b).

4.7.6 Acquaintance Interview

My former or current patients were excluded from the study. However, Braun and Clarke (2013) suggest that in qualitative research, it is perfectly acceptable to interview people one knows. Therefore, two people that I know, but not my current or previous patients, who persistently

expressed their interest in the study and met the inclusion criteria were included after much consideration.

The following ethical considerations were ensured: that new information about these participants was handled confidentially; only the audio recorded information would count as data, any information that I knew about these participants before, which was not part of the interview could not be included in the study (Braun & Clarke, 2013).

The participants were informed of withdrawal timeframes. If they wished to withdraw two weeks after the interview, every effort would be made to remove their data despite the difficulty of achieving this at this stage. Regarding the possibility that they might feel unable to disclose certain information, I had to respect their position, which could mean that I would not probe further in those areas. I had to consider the overall information to confirm it answered my research question.

4.7.7 Data management

The data-in-transit was managed by ensuring its transfer to encrypted password-protected storage at the earliest opportunity, such as a USB, a laptop, or a desktop computer. The multiple storages allowed for data backup and subsequent deletion from the recorder. The data were protected during and after the study within the Data Protection Act (2018) and the General Data Protection Regulations (2018).

This record would also be bound by the FHMREC guidelines storage of ten years within encrypted storage on the Lancaster University server. The lead supervisor (Professor Carol Holland) would be responsible for data stewardship, such as the archiving and destroying the data after ten years ([See Ethics application](#) Section 3.6 & 3.7). The data would be deposited in Lancaster University's institutional data repository, Pure (Publications and Research), and used

to hold, manage, preserve and provide access to the data sets produced ([See Ethics application](#) Sections 3. 8a&b).

4.7.8 Dissemination

Participants were informed at the outset about how the information collected during the interview would be utilised. (see Section 4.8 for more details). Each participant was sent a report that informed them of the study's key findings to thank them for their participation (Creswell, 2013). The anonymity of every participant was protected by using pseudonyms and removing specific demographic information.

4.8 Dissemination plans

The general findings of this study were presented at the 'Belonging Brunch' conferences at Lancaster University. They will be shared in the researcher's thesis and sent in an email to the study participants. The findings of this study will be submitted for publication in books and academic and professional journals, such as *Occupational Health and Wellbeing*, as well as workplace health and safety journals. Publishing the final report with open access is currently being sought. However, this cannot be guaranteed ([See Ethics application](#) Section 3.16). It is hoped that this study impacts OH practice, workplace wellbeing strategies, policies and workplace culture.

4.9 Summary

This chapter has highlighted the philosophical, methodological and analytical underpinnings and the methods used in this study. As a relativist and an interpretivist, my philosophical assumption meant that the study had to be positioned within qualitative research. These positions

are embedded in subjectivity and understanding the meanings and contexts attributed by individual OWs to their experiences. Guided by the HWFM, the research/sub-research questions and the interview schedule were developed. A semi-structured interview was chosen over focus groups because it provided an opportunity to generate in-depth knowledge from individual participants. As participants were invited from across the UK, semi-structured interviews appeared more realistic and reasonable than considering focus groups. Knowing when to stop data collection was challenging due to the flexibility of thematic analysis.

Nevertheless, despite the criticism of data saturation, the application of this concept was useful in concluding the data collection along with being satisfied that in-depth data was sufficient to answer the research question. Furthermore, the research methods utilised in recruiting and data collection were discussed. The challenges encountered due to the slow recruitment of participants meant that the project was delayed. This challenge was addressed by seeking a review of the ethical approval, which allowed for promoting the study to a broader audience. Other analytic methods such as IPA and grounded theory were considered; however, thematic analysis was chosen because of its theoretical flexibility. The next chapter, Chapter 5, will discuss the findings of this study.

Chapter 5

ANALYSIS AND FINDINGS

5.1 Introduction

Chapter 4 highlighted the philosophical underpinnings, processes and methods engaged throughout the conduct of this empirical study. This chapter presents the findings that respond to the research question, “What are the experiences of older workers (OWs) who had depression in the contemporary workplace?”. In line with the interpretive paradigm of this study and thematic analysis, the themes presented in this chapter were formed through the participants' experiences. However, as a qualitative researcher, I recognise my role as active in the analytic process and constructing knowledge (Braun & Clarke, 2013). The names used in the themes and quotations are pseudonyms.

Understanding the characteristics of the data set is essential to the findings of this study. Therefore, this chapter begins by highlighting the descriptive characteristics of the pilot study and data set. This section will be followed by the themes and sub-themes from the main study.

5.2 Descriptive characteristics of the pilot study

The pilot study participant was first diagnosed with severe depression in her late thirties, resulting in a loss of earnings and diminished career trajectory. During the pre-interview discussion, the participant gave an impression of being in employment as an agency healthcare assistant in a nursing home. However, during the interview, it transpired that she was unemployed. Much of her experiences of depression at work were from before the age of 50. Therefore, I have reflected on the inclusion of her data in the main study. Given that the pilot study aimed to focus and review the interview schedule, it has served its purpose. After much consideration and further discussion with the project supervisors, the pilot study's data was not included in the principal analysis. ([See Appendix 5.1 for the details](#)).

5.3 Descriptive characteristics of the data set - the main study

Excluding the pilot study, 21 interviews were conducted. Eleven (52.38%) participants were male, and 10 were female. The study sample comprised OWs with an age range of 50-65 years ($M = 55.48$ years; $Mdn = 54$ years; $Mo = 52$ years) and a mixture of roles in professional (38.09%), managerial (33.3%), administrative (14.28%), and elementary roles, such as cleaning (14.28%). Almost half of the participants worked in the health and social care (42.85%), 23.8% in the academic sector, 9.52% in the financial sector and 23.8% in other sectors, such as construction and cleaning. Over half (61.9%) were from South East England, 19.04% were from the West Midlands, 14.28% were based in North East England and 4.76% were based in North Wales. ([See Table 5.1 for the statistics](#)).

Regarding employment, 18 participants were in work during the interviews. Two participants, Amanda and Liz, resigned from their roles three months and one month, respectively, before the interview. One participant had retired 10 years before the interview due to job loss from depression. Colin had experienced depression at the age of 55, while he was still in full-time employment. Five participants were either on temporary contracts or agency roles (George, Louise, Beth, Matt and Ben).

Table 5.1 Participants' Characteristics

Pseudonym	Participant number/order	Gender	Age (years)	Work Sector	Job Category	Region in England	Occupation	Duration of depression	Onset of Depression
Colin	Participant #1	Male	65	Others	Managerial	South East	Coordinator/ Retired	Ongoing but has been stable for three months	First episode
Anna	Participant #2	Female	56	Academic	Managerial	West Midlands	Asst Registrar	Ongoing but has been stable for three months	First episode
Mat	Participant #3	Male	58	Academic	Professional	South East	Freelance Consultant /Researcher	Ongoing but has been stable for three months	Adult-onset with various episodes
George	Participant #4	Male	52	Others	Elementary	West Midlands	Cleaner	Two years +	First episode
Liz	Participant #5	Female	57	Health and Social Care	Professional	North East	RGN - Senior Continuing Healthcare Assessor	Two months +	Adult-onset with various episodes
Ben	Participant #6	Male	52	Others	Elementary	South East	Cleaner/Sales Worker	Ongoing but has been stable for three months	Adult-onset with various episodes

Kyle	Participant #7	Male	52	Financial	Professional	West Midlands	Tax Consultant	Three months +	Second episode
Sam	Participant #8	Male	55	Academic	Managerial	North East	Head of Business Intelligence	Seven months +	Second episode
John	Participant #9	Male	52	Academic	Managerial	North East	Business Intelligence Analyst	12-18 months	Adult-onset with various episodes
Beth	Participant #10	Female	60	Health and Social Care	Elementary	South East	Healthcare Support Worker	Ongoing but has been stable for three months	Teenage onset with recurrences
Shaun	Participant #11	Male	52	Academic	Professional	South East	School Teacher	Three months +	Second episode
Grace	Participant #12	Female	58	Health and Social Care	Administrative	South East	Administrator	Ongoing but has been stable for three months	First episode
Rosalyn	Participant #13	Female	54	Health and Social Care	Managerial	South East	Manager	Two years +	First episode
Louise	Participant #14	Female	53	Financial	Administrative	South East	Secretary	Two years +	First episode
William	Participant #15	Male	50	Health and Social Care	Professional	South East	Social Worker	Three months +	Second episode

Sandra	Participant #16	Female	60	Health and Social Care	Professional	North Wales	Mental Health Nurse/Manager	Three Years	First episode
Craig	Participant #17	Male	52	Health and Social Care	Professional	South East	RGN - Senior Staff Nurse	Ongoing but has been stable for three months	First episode
Julie	Participant #18	Female	54	Health and Social Care	Professional	South East	Senior OH Adviser	Three weeks +	Adult-onset with various episodes
Steve	Participant #19	Male	54	Others	Managerial	South East	Business Development Manager	Nine months +	First episode
Amanda	Participant #20	Female	60	Others	Managerial	South East	Manager	Three weeks +	Adult-onset with various episodes
Gill	Participant #21	Female	59	Health and Social Care	Administrative	West Midlands	Administrator	12 months	First episode

5.4 Findings

5.4.1 Characteristics of depression among older workers

This section presents the findings from the interview. Almost half of the OWs started experiencing depression at age ≥ 50 . Approximately one-third of the new episodes of depression at age 50 or above were attributed to work-related issues or lack of consistent employment. Other causes were attributed to a family, relationship, medical issue or a mixture of all the above. Two individuals attributed their depression to a chemical imbalance in the brain. Overall, 10 participants reported their first episode and four participants reported second episodes of depression at age 50 or above. The remaining seven were a mixture of early onset of depression below the age of 50, but with recurrences above the age of 50. ([See Table 5.1 for the tabular representation](#)). Three participants were self-diagnosed (Amanda, Liz and Rosalyn). As the ethics application for this study does not exclude self-diagnosed participants, additional questions were asked to these participants pre-interview to ensure they met the criteria.

5.4.2 Participants' interview characteristics

Regarding the interview sites, 15 were conducted by telephone, four over Skype and the remaining two were conducted face-to-face either at the participants' residence or workplace. The interviews lasted between 20 and 90 minutes ($M = 49.16$ minutes). Five participants consented to be contacted again if further information was required. One of the interview sessions was discontinued after 20 minutes due to the participant's faulty telephone line despite several weeks' attempts to rectify it. All participants were reminded to seek further help through their local mental health support or GP if they felt distressed following the interview. The interview data were transcribed and coded line by line by me using NVivo® 12

Plus for Windows. The six steps by Braun and Clarke (2006) were followed throughout the process. My notes and reflections enriched the analysis of the empirical data.

5.5 Themes and Subthemes from the main study

Three overarching themes with seven subthemes emerged from the data analysis. These themes are interlinked and crucial to understanding the experiences of OWs who had depression in the contemporary workplace. Thus, there are a few overlaps. The themes and subthemes are detailed in Table 5.2.

Table 5.2 Themes and Subthemes

Themes	Subthemes (ST)
Theme 1: Disclosure and nondisclosure among OWs	Subtheme 1: The negative meaning of depression among OWs
	Subtheme 2: The influence of organisational culture on disclosure
	Subtheme 3: The art of hiding among OWs
Theme 2: OWs' struggles during the depression and organisational support interventions	Subtheme 1: OWs' struggles at work due to depression
	Subtheme 2: Intrinsic and extrinsic factors influencing organisational support intervention uptake among OWs
Theme 3: Future outlook: the importance of work participation during and after depression	Subtheme 1: Weighing the cost of mental wellbeing at age 50 or above
	Subtheme 2: The importance of work participation among OWs with depression

Excerpts from the participants' interviews are included to illustrate and support each theme and subtheme. [...] denotes that text has been omitted. [Fig 5.1.](#) presents a schematic representation of the relationships between the themes (See Appendices [5.2](#) & [5.3](#) for excerpts of NVivo® coding and the coding process).

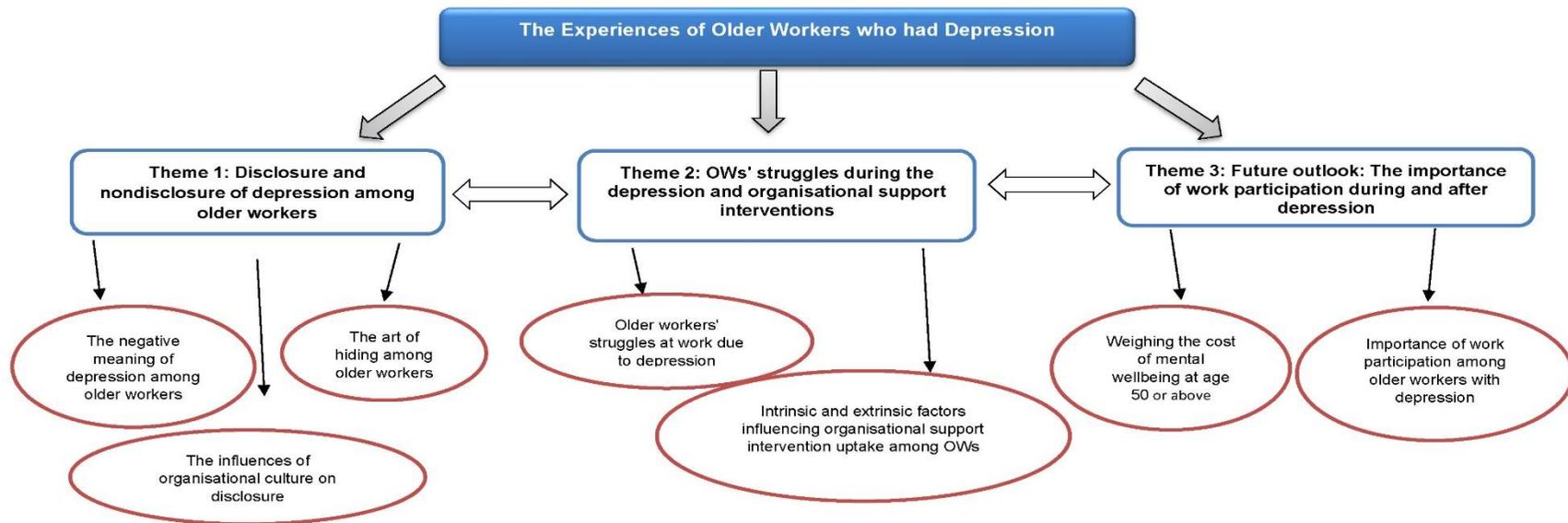


Fig. 5.1 Relationships between the themes

5.5.1 Theme 1 – Disclosure and non-disclosure of depression among older workers.

Theme 1 emphasises the importance of OWs' interpretations of depression in terms of disclosure and nondisclosure in the contemporary workplace. OWs interpreted depression in particular ways, which was predominantly negative, describing it with such words as 'taboo', 'shameful', and 'embarrassing'. All the participants expressed the meanings they attributed to their experiences of depression as an OW.

There are three subthemes to this overarching theme. The subtheme, *the negative meaning of depression among OWs*, explores the negative meanings that anchored OWs' perception of depression and the influences of these meanings on their choices about disclosure. The subtheme, *the influence of organisational culture on disclosure*, explores the challenging but positive side of disclosing depression at work. The first part of this subtheme describes disclosure as harmless. The second part situates disclosure as harmful and shameful, leading to multifaceted vulnerabilities. This subtheme unveils the organisational culture, which influences both the positive and negative experiences of disclosure. Across both disclosure and nondisclosure is a tension: the strong belief that disclosing depression to organisations is harmful to OWs. The subtheme, *the art of hiding*, addresses the various ways in which OWs concealed their symptoms at work. Masking their symptoms due to work impairment was essential for the reinforcement of nondisclosure.

This superordinate theme links with the remaining themes because whatever happens at this stage has the power to influence OWs' experiences across the workplace.

Subtheme 1.1 – The negativity of depression at age 50 or above. Being diagnosed with depression at an older age has several meanings to OWs, which were predominantly negative. Participants described experiencing depression at an older age as 'disappointing', 'daunting' and

'shocking', viewing it as intrusive and undesirable. For example, one participant said, "I was shocked when my GP said this is depression. I thought, 'what?' I just never considered it" (**Grace**).

Grace's account demonstrates the shock and perplexity of the diagnosis, which meant that it was unexpected at her age. Overall, participants expressed the challenges of lack of awareness with the first episodes of depression. Interestingly, participants initially attributed their symptoms to other severe health conditions, which were not associated with depression. This experience shows the impact of depression on individuals. For instance, Colin said, "Er, I was diagnosed by a doctor after talking with me. He said that I was depressed. You know, you don't know you're depressed at the beginning".

Some participants experienced mixed feelings of relief and disappointment after diagnosis. Others explained the challenges associated with the persistence of their symptoms. Concerns from colleagues or family members was a wake-up call to seek medical help. Delay in seeking help impacted on recovery timeframes. The account below conveys some of these issues:

I think my generation of people did not take mental health as seriously [...] for the majority of my life, I felt embarrassed [...], about my depression, but I didn't speak to anybody about it. Erm, yeah, I feel like I have lost out many decades of treatment because of that and I sometimes feel very angry and annoyed and frustrated because of it (**Shaun**).

Arguably, a delay in help-seeking behaviour has psychological implications for OWs. Participants' reluctance to seek help was entrenched in their negative belief and association of depression at their age with 'shame', 'stigma', 'taboo' and 'embarrassment'. Therefore, participants would rather not admit or accept the diagnosis. Some chose not to seek medical help for fear of diagnosis. Participants who are healthcare workers worried about the documentation of depression in their medical records. Arguably, some of these meanings were culturally situated – both organisationally and within disciplines. The following participants' accounts convey some of

the negativities of depression: “[...] because of the stigma of mental health, it is a terrible thing [...] the stigma, which is the most awful thing” (**Ben**).

[...] experiencing depression at age 50. I mean, I don't really look at age because people can have depression at any time. But when you reach this age, maybe it becomes a bit of taboo. Because I'm working in this [...] health and social care, so you know what it's like. Erm, if I went to my doctor, my doctor will put me on tablets, then if I have to travel as in, they would ask me [...], are you on medication? And then you say, oh, I'm on antidepressants. This goes on your record. They become more aware. So, and erm for me, it's more taboo (**Rosalyn**).

Based on Rosalyn's account, depression at an older age was interpreted as socially restrictive. The perception of participants working in the healthcare sector further strengthened the negative belief as they expressed their worry about the impact of the diagnosis on their professional trajectory. This may indicate that OWs' in the healthcare sector believe that they are expected to remain mentally well for their duties. Arguably, in their quest to meet this expectation, obtaining a diagnosis or making a disclosure was not their priority.

Participants reported diminished confidence, low self-worth, defeat, feeling useless and worthless. They worried about the impact of the diagnosis, especially over redundancy or future employability. These experiences could potentially reinforce the symptoms of depression thereby hindering recovery. The participants' accounts below capture some of these meanings:

I felt worthless about it, really. I didn't like it at all. I felt used, useless [...]. I haven't been able to cope, but then I realised that the reason I was in the situation wasn't as a result of myself even though my work has some managerial issues at [...] directorate level and no action had been done. I just felt defeated, I suppose, really. I think that's a good word, 'defeated' (**Anna**).

Anna constructed the belief that her depression was work-related and consequently, out of her control. She expressed that she felt 'used' and 'defeated' after her diagnosis. Anna situated her meaning of depression as a war or battle between two camps: Anna versus her organisation. She perceived her diagnosis as losing to her opponent. This meaning influenced her experiences of depression in her workplace.

Additionally, participants expressed opinions that their age and depression are incompatible in the 21st-century workplace. OWs viewed their age as a negative for depression due to vulnerability to job loss compared with their younger colleagues. Some frequently described their fear of vulnerabilities, rejection, isolation and employability issues. For example, two participants said, "Okay, so I also suppose that we have more to lose, the older employees than the younger ones" (**Kyle**). "Erm, yeah, I think there was few things in which I'd say being an older worker and it [depression as an OW] doesn't necessarily go hand-in-hand, but I was beginning to feel as though I was too old" (**Amanda**).

Thus, fear of losing their jobs to the younger workers further reinforced the negative feelings of shame and embarrassment. Arguably, this could threaten further segregation in society and a loss of their 'normal' world. Keeping depression undisclosed would mean acceptance and freedom from the associated vulnerabilities. The above meanings anchored OWs' interpretations of depression and influenced their disclosure decisions, nondisclosure at work and accessing workplace support.

Participants explained depression as a loss of their natural abilities, dignity and mental wellbeing, which threatened job loss at their age. Nevertheless, a few participants explained their experiences of depression at work as positive because of the sympathy they received and being at a similar age as their line manager. Some felt able to express their minds because of their age. For example, one participant said, "My age might have benefited me in in the sense that ... I felt more able to speak my mind and express my views" (**Liz**).

Thus, it can be deduced that being at an older age when experiencing depression could be beneficial. For instance, Liz used her age positively by being more assertive. The confidence to express herself might mean being able to defend herself at work without fear.

Subtheme 1.2 – The influences of organisational culture on disclosure. This subtheme explores the polarised nature of disclosure. Some participants expressed their transparency about disclosure. One-third of the participants explained that they disclosed their depression just to their line manager. A few participants admitted that disclosure at work was without any fear of stigmatisation or vulnerability, which sharply contrasts with the participants' negative accounts highlighted above. The participant's account below captures some of these experiences:

I have been able to talk to people. [...] I have spoken to colleagues here, helping me as part of my return to work. Having more coaching so that I can understand more why I ended up where I was so that I don't fall unwell again (**Anna**).

Anna's organisational culture seems to be key to her disclosure. Anna's openness with her colleagues provided an understanding of her depression, which could help guard against future episodes. In this account, disclosure seemed harmless, although participants admitted that disclosure was challenging. Nevertheless, participants admitted they felt better after the disclosure. Arguably, disclosure could provide some psychological benefits to individuals. For instance, Anna said, "It was hard to tell people, but I felt better after I did".

Additionally, participants who disclosed in their previous organisations found that it boosted their confidence to disclose to their new employers. A sharp contrast to the negative meanings of disclosing depression, especially at an older age, was that some participants reported acceptance following disclosure. For instance,

When I went for the interview, I disclosed that I was taking medication for depression and they said that's fine [...]. I actually feel quite proud myself that I'm talking to somebody else

about this than I was. So, go back a few years ago, I probably would have burst down in tears but not today, good (**Grace**).

Thus, as seen in the accounts above, the disclosure provided satisfaction, bolstered self-esteem and confidence. Arguably, disclosure was therapeutic if it was felt to be received positively.

Several reasons for disclosure were revealed from the data. Some participants' disclosure to their employer was because they considered the likely impact of their depression and a concurrent medical condition on their WF and attendance. Participants expressed that disclosure was useful for organisational understanding, sympathy, and support with WF. Below is an account that captures these experiences:

Because not wanting them to think that I was not committed to the job, swinging the lead, there was nothing wrong with me I was just taking the mickey, anything like that [...] and if they notice that I wasn't performing well at work, they would say then, what's going on, so they'd understand (**Gill**).

However, this sharply contrasts with the participants who chose nondisclosure because of other underlying medical conditions known to their organisations. Thus, it is arguable that having other ongoing health issues was a factor for disclosure or nondisclosure, especially if employees perceived that organisations had a limit to what they could accommodate.

Nevertheless, those who disclosed depression also expressed trust in their organisation, confident that the disclosure would be inconsequential of discrimination or vulnerability. Anna's account captured this phenomenon as follows: "But you know, I haven't been discriminated against here when I came back [...]. But I don't think there's any discrimination at all".

Anna's account indicates the fundamental ethos of how depression among OWs was perceived in her organisation. Some organisations were positively responsive to the disclosure. Nevertheless, some participants revealed that disclosure to their organisations met with mixed or

adverse outcomes. Participants highlighted that their organisations' response to the doctor's fit note highlighting their diagnosis and time off work was negative. For instance, Grace said, "So, I started taking this tablet and took my certificate into work, but my boss was not impressed, and I said, I told you I was struggling".

Other findings revealed the benefits of disclosure due to the opportunity to access workplace support interventions, sympathy from the line manager, and relief from carrying the burden. Nonetheless, those who were self-employed or in temporary contract jobs, such as agency workers, felt they did not have any option other than nondisclosure due to fear of job loss. A participant reported that men were not getting enough workplace support and sympathy despite depression affecting more men than women.

Having explored disclosure, the next few paragraphs will explore the issue of nondisclosure among OWs, which interprets disclosure as harmful. The study findings also revealed that two-thirds of the participants chose not to disclose their depression at work because of the negative meanings attributed to experiencing depression as OWs. Participants worried about the uncertainties following disclosure; they feared rejection by the organisation and their colleagues, highlighting the influence of organisational culture on disclosure. Participants feared stigmatisation and discrimination and expressed their fear of vulnerability to job loss due to depression, age, and lack of trust in the organisations' culture. The following accounts captured some of these issues: "To be given a label, to be given a label, which didn't help in any way" (**George**).

Even if you talk about your depression or anxiety, there is the possibility of losing that job, [...] it's the way the workforce is now. You know, if you can't, someone else possibly younger will come and take your job (**Ben**).

From Ben's account, being an OW with depression was associated with loss of WF. There seemed to be two camps in the workplace: OWs versus younger workers. Participants felt that

their position in the OWs' category and a concurrent experience of depression translates to vulnerabilities. Ben's account echoes some of the OWs' lack of trust in organisations. Participants had learnt from previous experiences of how their organisations treated those who disclosed their depression; they could decipher their organisational culture, the unspoken rules that govern the disclosure of depression regardless of age. Participants explained that being encouraged to disclose depression did not always translate into a positive experience. Louise's account bolsters this concern:

The reason I didn't was because [...] I have seen other people disclose information about mental health issues or depression [...] and erm, [this] hasn't always, worked in their benefit as far as I could see (**Louise**).

Louise's account revealed participants' worries about being trapped as previous employees who disclosed. Others felt unable to disclose due to a lack of an explicit protective legal framework against job loss following disclosure. Despite legal frameworks such as the Equality Act (2010), one participant felt that the Act did not confer immunity against job loss or demotion following disclosure. Therefore, the participant interpreted disclosure as harmful. For instance:

I feared the loss of my job. I know that there is legislation that people shouldn't be discriminated against. Still, erm, I've witnessed some things, which were of concern should we say of others' mental health issues where the, and erm, and job has been downgraded and I don't want that to happen to me if [...] I declared my depression (**John**).

John's account exemplifies participants' lack of trust in organisational policies and legal frameworks. The participant seemed to be calling for further action from the Government; seeking explicit documentation that supersedes the current Equality Act (2010). Below is a participant's account:

Erm, I think, a cast, the first thing is a cast-iron guarantee that disclosure of mental health issues would not lead to redundancy [...]. Is there a fundamental ground rule and that ground rule has to be there because if it's not there? (**John**).

Arguably, OWs perceptions about their organisations' culture influenced decisions about nondisclosure. Participants explained that disclosure meant opening themselves up for vulnerability. It could be deduced that participants were unwilling to compromise without further protection following disclosure.

Furthermore, participants provided other reasons for nondisclosure. These are fear of their depression becoming an issue in the workplace, unsympathetic line manager, concerns about ethnicity, being a private person, and line manager's attribution of other workplace issues, such as making an error due to the depression.

Remarkably, one participant was caught between disclosure and nondisclosure. Rosalyn looked for opportunities to disclose depression at work, which her employers missed. She shared her frustration about giving her employer several opportunities to decipher her message about her depression. She expected that her employer would decipher her signals during one-to-one meetings but was disappointed as she felt that her employer was too insensitive to grasp her signals. Therefore, she felt that verbal disclosure was unnecessary. She interpreted her experience as a lack of care by the employer as they did not 'unpack' or decode her message.

Below is her account:

And I thought, this is not what I want to hear. I'm giving you a message, unpack it. Give me the opportunity to be free and talk with you. So, when you have people like that, that's not picking it up, and I'm like, there's no need (**Rosalyn**).

Rosalyn's account reveals that providing opportunities and freedom to disclose is vital. The negative meaning that OWs gave to their depression meant that some preferred an indirect way of disclosure. Where the opportunities for disclosure are absent, then OWs' interpretation of lack

of interest by line managers and organisations concerning their depression could further influence nondisclosure. Arguably, when line managers and organisations are insensitive or unable to decipher their employee's message, then the opportunity for disclosure could be lost, thereby reinforcing the partitioning wall between OWs and their organisations. For example, one participant said: “[...] she set up a meeting with HR [human resources], and she didn't attend it herself, her boss attended it, [...]. There was no follow-up from that anyway” (**Amanda**).

With another episode, Amanda felt that disclosure to her line manager or the organisation was unnecessary. Organisations' dealings with OWs who had depression could be significant to future disclosure. Conversely, another participant explained their preference not to be asked about their welfare by management. These examples suggest individual differences and preferences, which call for line managers' understanding. The next few paragraphs will explore the tension between these polarised areas: disclosure versus nondisclosure.

On the one hand, the study revealed that disclosure did not necessarily mean that participants could receive the necessary workplace support interventions. Participants' disclosure did not signify immunity to job loss; neither did it result in job loss. Individual circumstances such as the organisational culture, individual's perception and sickness absence level appeared to be a significant contributory factor to job loss rather than OWs' age, as conveyed by the participant below:

I was off sick initially for 12 weeks [...], afterwards I went long-term sick... and I left my employment for about 18 months after [...] I'm a nurse; they needed me on a proper basis. So, obviously, I had meetings with my employer throughout that time, and we came to the agreement that I would resign, you know, there's no, no cloud on myself or anything like that. That would allow them to then employ a full-time senior staff nurse (**Craig**).

From Craig's account, disclosure resulted in job loss, although it seemed to be through mutual agreement. Craig was working in an organisation that seemed to have robust workplace support.

However, due to the non-feasibility of sustaining his long-term sickness, he felt he had to part with or let go of his job.

On the other hand, there were consequences with nondisclosure even though OWs thought it was safer than disclosure. Participants' nondisclosure resulted in their inability to access adequate workplace support or work adjustments, which could have been beneficial for facilitating sustainable work attendance or WF. A lack of workplace support could mean an ongoing struggle at work and eventual job loss. Although some of the participants escaped the consequences of nondisclosure, some experienced severe impacts, such as job loss. The following statements are two participants' accounts about the consequences of nondisclosure: "I didn't tell them because I feared losing the job, which eventually I lost at the time" (**Colin**). "Not very much. The input was not very much because you know I did not tell them" (**Kyle**).

Arguably, disclosure and nondisclosure were primarily influenced by organisational culture and OWs' understanding of the phenomenon. Many of the participants felt that nondisclosure was safer. Subtheme 3 will explore the personal measures engaged at work by OWs to hide their depression.

Subtheme 1.3 The art of hiding, among older workers. This subtheme explores the multifaceted measures engaged by OWs when hiding depression symptoms at work. The participants who chose nondisclosure utilised various measures to mask their symptoms at work. The measures utilised included using a facade, that is, trying to appear different from the way they were. OWs used 'acting', frequent sickness absence, hiding behind physical health issues, self-isolation from colleagues, avoidance, not socialising with colleagues, silence, and maladaptive coping strategies, such as alcohol. For instance, Sandra said, "In a way, I suppose it didn't really affect, affect my work as such because I tried so hard erm to be efficient, [...] to be a good actress".

Participants felt that interacting with others at work, such as talking and being in colleagues' company might reveal their struggles. A sharp contrast to avoidance is "being a good actress"

(Sandra). It seemed essential to some OWs to conceal their symptoms and impaired WF to blend into the work environment. Being well and 'normal' as some of the participants referred to life without depression, was essential to them. Participants built strong, invisible and impenetrable walls and these were either used to protect themselves from vulnerabilities or hide their symptoms and impaired WF. For example, Rosalyn said, "Actually, people see me, they see the facade, I know the thickness of my wall, yeah, but people don't see it".

Arguably, participants knew that their colleagues were not encountering their real person. Some had masked their symptoms for so long; they felt very competent at it. Participants expressed the benefits of ongoing work attendance despite experiencing unstable symptoms. For example:

So, I was coming, and I know that was the time I had to be strong. You know being strong as the external sign, that's the facade, and because you know your job well, this needs to be done, [...] you [are] delegating, so you oversee, what needs to be done [...]. Then take the wall down, and you could have seen, weak like nothing else, yeah. If people were saying that, okay, let's take this facade down, they would have seen I was in pieces nobody could see [...]. But from the moment that I'm here, (at work) at the entrance, closed, strong and nothing. It is, erm, how d'you say it, its erm, you know when you have something, and water can't get through, erm, it's sealed (**Rosalyn**).

"So that's what you're referring to as closed" (**Interviewer**).

"Yeah. It is sealed" (**Rosalyn**).

As seen in Rosalyn's account, a participant's wall could be likened to an invisible fortress; no one would be able to breakthrough. However, the interview findings revealed that some participants' masks and walls were penetrable by line managers and colleagues. Consequently, the jobs that some of the participants were trying to protect through hiding were eventually lost.

Participants explained that they had improved their skills in concealing their depression at work because of their age: “you learn how to hide it better” (**Rosalyn**).

Interestingly, the participants who were also healthcare workers had ways of masking their symptoms once they commenced work. OWs in healthcare put their profession/job above their depression. They were able to psychologically migrate between their role and depression, depending on where they were. This experience is captured in the following accounts: “[...] You just enter your role when you are at work” (**Craig**).

Well, I think, all nurses out there, I mean you leave your problems at the door when you go to work and slapped a smile on your face a-n-d erm, everything is fine to do because you've got a job to do [...] and go for a sly cigarette erm, that sort of things and then go back. Put a smile on my face (**Sandra**).

Participants felt there was an increased need to perform at work, “because you’ve got a job to do” (Sandra). Therefore, optimum functioning was more important in their professional capacity.

Thus, OWs masked their symptoms for various reasons, such as fear of others knowing of their depression, uncertainties about disclosure, vulnerability to job loss, fear of being labelled or stigmatised and shame.

In concluding Theme 1, OWs' interpretation of the meaning of depression largely impacted their decisions on disclosure or nondisclosure. This interpretation stemmed from their perceptions about organisations', colleagues' and line managers' thinking. Arguably, these impacts reflected on participants' WF, relationship with their work environment and accessing the available workplace support measures. Theme 2 will explore OWs' struggles and the workplace support measures. (See [Fig. 5.1.](#) for relationships between themes).

5.5.2 Theme 2 – OWs' struggles during depression and the factors influencing the uptake of organisational support interventions

As highlighted in Theme 1, OWs' perceptions and choices about disclosure directly or indirectly impacted their experiences of depression in the contemporary workplace. The subtheme OWs' *struggles at work* explores the challenges of WF due to the impact of their symptoms. The subtheme, intrinsic and extrinsic factors *influencing organisational support intervention uptake among OWs* addresses the personal and workplace interventions. All the participants expressed the challenges experienced at work during their depression.

Subtheme 2.1 OWs' struggles at work due to depression. Participants reported their struggles with WF during depression. The ensuing struggles at work were commonplace: inability to complete tasks, feeling overwhelmed, reduced ability to function on the job, difficulty with performing tasks, challenges dealing with unrealistic deadlines, handling new tasks at short notice, or managing the psychological demands of the role, panic attacks during meetings and struggles with managing day-to-day workloads. A participant's account below conveys some of these issues:

When those symptoms are there, it takes longer time for me to complete my tasks, especially my reports. I still meet deadlines, but I know the struggle that I have within me, [...], to make those deadlines. [...] I still do my day-to-day work, but it takes me longer, and the work is harder for me to complete (**Julie**).

Julie's account reflected her inner struggles, which impacted cognitive function, due to limited ability to process information. Participants commonly questioned the future impact of their symptoms and functioning capabilities, which had a further psychological impact. Some of the struggles are exemplified in a participant's account: "I sort of lost hope, erm, not only in my surrounding but in my ability to be able to function (**Steve**).

Participants associated their symptoms and impaired WF with age and other age-related issues, including menopause and loss of their usual self because they struggled with the things that they were able to do naturally. Participants explained that differentiating between depression and ageing was sometimes challenging. Participants compared themselves with their younger colleagues who they thought had better cognitive and physical functioning than them because of their age difference. For example, Amanda said, “I don't have the clarity of thoughts, the speed of thought and the energy level that he had or has”.

Arguably, age could be an exacerbating factor in depression. A few participants expressed that their struggles were frequently visible to colleagues. In contrast, others felt that the non-visibility of the symptoms made coping at work challenging because of criticism at work for poor work performance. OWs found such criticisms challenging to handle when it came from younger colleagues. Beth's account highlights the issue, “But [...] it's difficult, this thing depression [...] is something you can't prove. People criticising me, and again when people are lots younger than me, it hurts, it hurts even more”.

Arguably, a lack of understanding among managers and colleagues about depression could further reinforce negative experiences among OWs.

Although most participants sought medical help about symptoms management, a limited number accepted medication as a treatment option, suggesting that their struggles might have been prolonged. This experience could further impact on WF and productivity. Rather, participants preferred self-help measures to enduring medication side-effects. For example:

So, I found a gym instead of medication. Then, I stopped taking the medication. I woke up one day and I thought, you know what, this is making me worse than it's making me better now and I just stopped, I just stopped taking it (**Craig**).

Nevertheless, some participants reported that their self-help strategies were ineffective, but provided some relief, meaning that OWs might not be struggle-free at work due to unstable symptoms.

Some of the participants went off sick, but experienced setbacks when returning. Experiences of frustrations and challenges when returning to work were commonplace. These were due to the impact of ongoing symptoms and the management of workplace support process. Participants found that their bodies and mind were not in sync, which delayed return to their full tasks. For instance, a delay in return to full tasks caused frustrations about participants' work plans and role. For instance:

And part of me, my head is saying at least you need to be getting on and doing more, but my body is saying 'no' you can't go any quicker. So, I'm finding it quite frustrating (**Anna**).

Thus, reconnecting with work was challenging after long-term sickness absence. Participants reported frustrations, such as engaging with changes that had occurred in their absence, working in a different role after return to work, having another colleague in their role during phased-return-to-work or experiencing ongoing issues with their line manager. These experiences caused much tension between participants and their colleagues. These psychosocial issues exacerbated OWs' depression because of the combined impact of the workplace issues and their ongoing symptoms. A participant's account captured some of these issues:

So, I'm finding it quite difficult because while I've been away, people have acted up, there has been a development link to the area of [...] that I have been involved in. And I'm finding it quite difficult to find my feet and re-establish my path in the role. Before, I was taking the lead in a lot of things. I wouldn't say the word 'power', but I was able to direct the service and task with and making contributions to it [...]. But now I'm on the other side where I'm really not enjoying it because I can't get back into it. I'm frustrated with myself because my phased return is taking longer than I thought it would (**Anna**).

Based on Anna's account, regaining control over her role was vital for improved wellbeing. As a manager, her inability to achieve this was interpreted as a loss of power and control. This perception reinforced psychological struggles, such as feelings of low self-worth and vulnerability. Arguably, return to work after depression, especially for those in leadership roles could add another layer of struggle.

Over half of the participants went off sick. The remaining participants chose to remain at work through their struggles due to fear of job loss or dislike for sickness absence. Two of the participants who chose to remain at work despite their struggles eventually lost their jobs due to impaired WF. For instance,

I usually just like to carry on working because I feel like I can physically do the work [...]. They [manager] send me home because they'll say, 'we can't have you working, you're just crying' [...] I end up losing, I lost three jobs in quick succession recently over the last three years, and I just ended in tears. I left crying and erm (**Beth**).

Arguably, the consequences of impaired WF, such as eventual job loss, worry about employability, and disciplinary issues are real. Remaining and hiding depression at work despite struggling are precursors for eventual job loss. The persistence of depression without disclosure or support can be costly.

However, OWs in senior positions who remained at work without disclosure, self-addressed impaired WF by adjusting daily duties as their symptoms required. Given that OWs are likely to be in more senior roles, they might have an edge in managing their symptoms better than younger colleagues with depression. For example:

I advise the scheduler, [...] I need erm, some, [...] consultant's time [...] to do other work. [...], I may just do about two cases [...]. When I'm not feeling too well, I may not even do any case at all that I would need to speak to people and then do the report. [...]. I'll just [...] confine myself to erm, [...], to some managerial work or it could be giving advice to

colleagues over the phone, making myself available [...] to be a support to colleagues, [...] (**Julie**).

Arguably, having a level of control over one's role could help manage the impact of work on symptoms. Lack of control at work among some participants resulted in utilising other measures discussed in [Subtheme 1.3](#).

A sharp contrast to the above accounts was that some participants relied on work through immersion in their tasks to make them feel better. Work was viewed as a distraction or escape route from their symptoms. Participants believed that using work as a distraction was particularly useful for coping. One participant expressed that:

My work is to do very much with other people. It's complete self-sacrifice; I don't even exist, I don't matter, I'm just at work, [...]. I'm focused on them so also, that's good for depression because that takes me out of myself (**Beth**).

Beth's account reflects that some participants used work as a coping mechanism. Participants depended on work to help them through the day; working with others in need, giving themselves to their jobs and others' service was beneficial. Work was situated as a powerful sense of distraction that took over their being; it was almost like a sense of depression being overtaken or engulfed by work. As seen previously, Beth eventually lost three jobs in quick succession as she continued to rely on work to manage her symptoms.

Participants reported that their struggles impacted on their WF and relationship with colleagues. Feeling irritable with colleagues, or challenges with decision-making and concentration were commonplace. For example: "I would have to take things very [...] slowly. I was very agitated in situations when normally it would have just been a breeze, and I just couldn't do those decisions" (**Anna**).

Participants reported the following challenges in their work environment: irregular work attendance, fear of attending work, not wanting to communicate with customers, issues with

managing disruptions at work and managing unrealistic expectations from managers, poor interpersonal relations when dealing with patients' relatives, colleagues, students and parents, inability to manage the classroom as a teacher, impatience with students and colleagues, and dealing with the psychological impact of tasks. The account below conveys some of these issues:

But there were challenges in terms of the amount of work, [...] disruptions and [...] changes to the workload. Erm, I struggled with that, but obviously, I think that's why I didn't socialise with my work colleagues (**Louise**).

Subtheme 2.1 has revealed the challenges that confronted OWs within the work environment. In Subtheme 2.2, *factors influencing organisational support uptake among OWs* will be discussed.

Subtheme 2.2 Intrinsic and extrinsic factors influencing organisational support uptake among OWs. This subtheme has two parts. The first part addresses the factors that influenced the uptake of workplace support interventions among OWs. These include the availability and accessibility as well as line managers' support. These are the intrinsic and extrinsic factors of workplace support uptake. As key factors in organisational support uptake, disclosure and nondisclosure were discussed in Theme 1.2. The second part discusses the benefits of workplace support intervention. Overall, 18 participants highlighted their experiences of workplace support.

In terms of availability and accessibility, most participants explained that their workplaces had workplace support interventions in place. The most-reported available workplace interventions are the EAP service or online counselling. A few participants reported line-management support, limited access to a confidential OH service, training, coaching, work adjustment, phased return to work, and informal peer support.

However, some participants explained that there was no known/available workplace support for mental health issues in their organisation. The reasons were because some organisations were small businesses, some had a lack of understanding or due to participants working in a temporary role as a contractor or agency worker. For instance, one participant explained:

Workplace support was non-existent: I mean, non-existent, mental health issues? Non-existence, organisational policies, human resources intervention erm is zero [...] the moment I said to them that I was feeling anxious and depressed, there was no empathy...I had to basically contact, [...] IAPT service [...] to say listen, when am I going to the initial clinical assessment...(William).

William's experiences meant he could not access workplace interventions despite his symptoms. Participants' expectations about organisational support provision seem crucial because they believe that it is the organisation's duty to source community resources for mental wellbeing. Lack of clarity or understanding of organisational support expectations could be a further springboard to nondisclosure of depression among OWs. OWs could reason that if workplace support were not available, then disclosure to management would be unnecessary. This thinking could further drive vulnerabilities at work.

Participants expressed feelings of inadequate or lack of line management support despite disclosure. Despite informing their line manager of workload challenges, participants reported a persistent lack of line management support, which meant that they continued to experience high workload and an aggravation of their depression. Participants also reported the following negative experiences: lack of resources, lack of contact from their organisation or line manager throughout their long-term sickness absence, lack of emotional support or care from line management and limited HR input.

Some participants reported a lack of, or inadequate, workplace interventions, which meant there were limited options or nothing. The availability of organisational support measures would influence their accessibility. One participant reported that there was only one workplace support intervention within their organisation (swimming). Shaun explained depression as a complex phenomenon that required more than just swimming. For example, Shaun said, "Erm, because in

my school there's only one activity and the activity was to go swimming. You know, depression is not such a simple thing where you can just overcome it by going swimming”.

Although most participants felt that support was easily accessible following disclosure, it remained the participants' responsibility to access it. However, some chose not to access workplace support. The reasons for not accessing workplace support despite its availability included: the belief that they did not need workplace support, lack of trust in their organisation, age-related fear of disclosure, feelings of vulnerability to job loss, fear of stigmatisation, the belief that no-one cared, having an insensitive line manager, fear of the unknown and accessing mental health support outside the organisation. One participant viewed organisational support as “ticking a box” and “seen as good” provisions. For example:

My kind of employer [...] they subcontract to the third party [...]. You can call if there is a mental health issue [...]. As much as that sounds good, [...] but somehow, I do feel like almost like ticking a box as an employer nowadays. To be seen as good, you've got to talk about equality, the green agenda (**John**).

It was sorted out for me; I just needed to access it. So, it was there, but it was me that was stopping me from getting it. You know, everything was there in place [...] my age and gender stopped me [...] in getting support in the first place. You know you get to fifty, and you'd try to think, [...] you've seen everything, you've done everything. You've been through lots of things (**Craig**).

As seen in Craig's account, OWs perception about their life experiences might hinder help-seeking behaviour. Those who could access workplace support found mental health support was easily accessible to all in their organisation regardless of age, meaning that they had the opportunity to invest in their mental wellbeing. However, some participants explained that they chose not to access workplace support despite its availability.

Those who accessed workplace support reported its benefits. These included a second chance for work participation, access to specialist support, and useful OH recommendations. Participants found that regular informal meetings with line management, training, coaching, empathy, and understanding, were useful for ongoing emotional support. Participants also found that flexibility with tasks and work attendance resulted in a supportive work environment useful in symptoms management or attending appointments. They reported that these made them feel less vulnerable and comfortable at work. For example:

I met with [...] the charge nurse on the ward, and he said anything you need just come and get me. I know it's your first shift back [...] Absolutely fantastic [...]. You know, and they made everything, super, [...] easy —super, unstressful (**Craig**).

Thus, line managers' support, understanding, empathy and flexibility after returning to work from sickness absence facilitate return to work. Arguably, organisational engagement with OWs might relieve their worries and fears about stigmatisation and vulnerabilities. As seen in Craig's account, line management support played a pivotal role in settling back at work. One agency worker reported they benefitted from workplace support.

Other beneficial support measures described by participants included peer support, creating a caring, helpful, confidential, communicative, implicit, and explicit - accepting and flexible work environment.

Furthermore, it was commonplace for participants to need phased return-to-work following sickness absence and some participants reported mixed experiences. As one participant said,

Well, I actually asked my line manager if I could cut my hours down and he said I can, but I can only do it for three months. Alright, okay, I was perplexed with that, and I asked for a little bit more time for me (**Grace**).

Arguably, phased-return-to-work or a temporary reduction in working hours facilitated OWs' stability at work. However, some participants found it unsustainable or felt they were under

scrutiny with no privacy. Participants on temporarily reduced hours as an adjustment experienced challenges with fitting their tasks into reduced hours. This challenge resulted in ongoing struggles and consequent resignation from their role. Improper management of return-to-work plans can sabotage individual or organisational experiences or both.

Having discussed the struggles of OWs with depression and the factors facilitating the uptake of workplace support interventions, Theme 3 aims to address the future outlook of work participation among OWs.

5.5.3 Theme 3 – Future outlook: The importance of work participation during and after depression

This overarching theme explains OWs' career trajectory and work participation. Participants weighed the balance between ongoing work participation, promotion (career progression) and the need for mental wellbeing. The subtheme, *weighing the cost of mental wellbeing and work participation at age 50 or above*, explores OWs' interpretation of the future impact of work on their recovery from depression, therefore, situating the future as uncertain. A corresponding explanation among OWs is that work is a necessity. The subtheme, *the importance of ongoing work participation among OWs*, captures their desire and the need for paid work. This theme is linked to Themes 1 and 2. OWs' meanings and decisions about disclosure and nondisclosure together with their ongoing struggles and the availability of workplace measures determined the future outlook in terms of work participation.

Subtheme 3.1 Weighing the cost of mental wellbeing among OWs who have had depression. Many had concerns about their future career trajectory and financial sustainability. Participants weighed the cost of remaining at work due to concerns about the likely future impacts on their depression. Some participants feared that remaining in the same employment could exacerbate their depression or cause future episodes.

Participants had the belief that their work environment would likely limit or block their recovery from depression, interpreting their work participation as detrimental to recovery. Approximately one-fifth of participants expressed that it was OWs' responsibility to look after themselves and that their choices could either block or facilitate recovery. Below is a participant's account that conveyed some of this thinking:

The worker has to make that ultimate choice of, you know, whether they want to continue and get depressed further, you know, or basically resign, so they don't have to deal with that [...]. And for me, was the former as opposed to the latter (**William**).

Their resignation was used as an escape route from an unhealthy work environment. Nonetheless, some participants chose to remain in the same workplace, but they had an inner vow never to allow previous work-related causal factors of depression to occur again. Arguably, OWs' experiences of depression in the contemporary workplace initiated a fight or flight response. One participant's account exemplifies this assertion,

And I would never, [...] be bullied like that again [...]. I've said to people; I want to still prove to myself that I can do the job, that's why I've come back because I could have just walked away quite easily (**Anna**).

Arguably, participants used defiance as a double-edged sword to prevent future work-related issues and prove their ability to do their job. Proving themselves in their role was vital because resigning with depression at their age was perceived as shameful. Therefore, participants defied all odds and returned to work following long-term sickness absence. Contrary to what the organisation believed, two participants who had been on long-term sick leave returned to work to demonstrate their victory. Returning to work gave participants another opportunity to prove themselves in their role. As seen in Anna's account above, proving their workability was essential to OWs as they experienced depression due to work-related issues, such as high workload, or lack of managerial support. Their desire to exit the workforce with dignity and not in defeat was

more important. Arguably, among OWs, leaving work during depression was interpreted as defeat and shameful.

As seen in Anna's account, as an OW who took long-term sick leave, she could have exited the workforce because she was nearer to retirement than younger workers. Participants explained their financial advantage over younger colleagues, which means they could choose retirement.

For example:

Potentially in five or six years, I will be in retirement and financially reasonably secure, so those external factors, I thought I'm free to actually make a decision here. And I'm not bound by any of the reasons to have to stay at work [...]. More elderly colleagues that is potentially the advantage they may have over the younger ones who were in the same situation because younger colleagues may not have the freedom to make those choices that I made through the factors that they are not in control (**Sam**).

A sharp contrast is seen between the accounts above and five other participants who showed their defiance by resigning from their jobs. Participants' reasons for resignation were: a lack of or inadequate work adjustment; unsupportive work environment; feeling let down by their organisation; unrelaxed high work demands; lack of control over high workloads; lack of flexibility at work; dissatisfaction with line manager; and feelings that they just did not fit in the organisation any longer. It was commonplace for participants to feel that the ultimate responsibility about their future work outlook lies with them. Grace's account captures some of these issues:

So, I said [...] I can't do these 40 hours a week anymore. If I can't do, do it, I'm gonna have to hand in my notice, and then he [manager] said, 'don't you want to work here anymore?' [...] Then, I said it's not a case of don't I wanna work here? I don't want to do 40 hrs a week; it's too much for me. So, he said they're not going to agree to part-time, Grace. Then I said, [...] as simple as that. I thought I can't [...]. Yeah, I handed in my notice (**Grace**).

It can be deduced that participants had the belief that their working conditions could cause future episodes or fewer chances of recovery.

Those who resigned explained that they felt better after their resignation even without any job. However, the participants reflected on the future of their careers because of their age. Participants' expressed that the three key factors to consider about their career trajectory are age, time and financial sustainability. They expressed their belief that certain jobs are no longer appropriate for them as OWs. For example, "So, it's not about not wanting to work; it's about being able to reflect. To make changes that's appropriate with your age [...] and have the ability to do that" (**Amanda**).

Participants also felt that being an OW would be a barrier to future career opportunities. Others felt that their age would be a barrier to the career opportunities they once had. Consequently, participants interpreted that they must remain in their current role as they felt that no organisation would want them. Arguably, this thinking could further limit OWs' career options. Below is a participant's account that conveyed some of these issues:

[...] decided to, to leave work to give myself time to think about what I want to do really [...]. You know, when you're a bit younger career-wise you're looking into the future; you're thinking about career plans, you are more motivated and 'cos of the age where I'm at now that isn't there anymore. The future isn't there anymore [...] full of the opportunities that I once had (**Liz**).

Another participant said, "When I started looking for another job, that was another thing. I thought who's gonna want somebody my age, but erm, there we go, they did" (**Grace**). The accounts above showed that participants were reflective over their future career opportunities. Comparing career opportunities as an OW with when she was younger, Liz resolved that career planning and motivations were lost with ageing, which was suggestive of relinquishing their career aspirations. Approximately one-fifth of the participants viewed their jobs at the time of their

depression as meaningless. They had the belief that meaningful career aspirations were negatively impacted as they aged. Yet they held that there was a need to pursue more meaningful jobs; they desired to add value to other peoples' lives through their jobs. For example:

Well, I, I didn't want to go back into the kind of job that I had before. Erm, I wanted to do something which was erm got benefit other people and erm, you know, just going after contracts and running after money [...]. So, yeah, there was a complete change of direction (**Steve**).

Arguably, OWs' experiences of depression changed their outlook on their career aspirations. For some, experiencing depression as an OW was a life-changing/career-changing experience. A change of career or organisation was an outcome of their depression. Those who commenced in new roles felt their new organisations accepted them despite disclosure.

Furthermore, participants worried about promotion or additional tasks due to the likely impact of a new and more senior role on their depression or future episodes. Although challenging, some participants managed their long-term symptoms by rejecting promotion opportunities, which reduced their professional trajectory. Participants chose to protect and preserve their mental wellbeing. Mental wellbeing was more important to participants than promotion and all the associated benefits. For example:

Yes, I'm, [...] worried or scared about promotion, which may sound completely new for me. [...]. Where I currently work, I have one person that I line manage, but I do worry about erm being given more stuff. [...]. One thing that I kind of wrestled with is that I have declined promotion. I was offered promotion 18 months ago, more money, [...] I did not say it, I did not bring depression in. The way I phrased it I just said I didn't want the hassle of a bigger team (**John**).

Overall, it was clear that considering their future career was important for recovery, but their options must be carefully weighed out. This subtheme is directly linked to Subtheme 3.2.

Subtheme 3.2 The importance of ongoing work participation among OWs. Despite the challenges of depression, participants desired to be in ongoing paid work as work was important to them. Consequently, many masked their symptoms or managed their symptoms through temporary non-work participation. Participants desired ongoing work participation for the following reasons: personal circumstances, such as being a widow, breadwinner, financial benefits, a sense of purpose, as well as natural desires for ongoing physical, psychological and social benefits of work for improved symptoms or coping. Arguably, participants' personal circumstances drove these reasons. For instance, Grace said, "[...] just thought I need to be able to work; you know. I am widowed; I need to be able to work".

Thus, ongoing paid work participation among OWs who had depression was vital, essential for recovery and sustaining their mental wellbeing. Ongoing work participation was important for all the participants. Many expressed that they strove to attend or remain at work. Participants were pleased to be in employment: "I like working so, usually, I'm quite happy when I work" (**Beth**).

Some participants ended up changing their jobs, and they expressed their satisfaction with their decision.

The above accounts revealed the participants' desire to work. The participants' statements above reflect that OWs who had depression desired to remain in paid employment.

5.6 Summary

Three themes developed from this analysis. First is disclosure and nondisclosure among OWs. OWs' meaning of depression largely influenced their decisions about disclosure and nondisclosure due to their heightened perception of shame, stigma and vulnerability to job loss compared to their younger counterparts. They reasoned that age and depression were incompatible. This thinking impacted their freedom to access workplace support; thus, many resorted to personal coping strategies, such as facade. Multiple negativities about depression in

older ages such as vulnerabilities, shame, embarrassment, stigma, and taboo, characterised participants' meanings of depression. Second, participants had significant struggles with their WF. Those who were confident enough to disclose to their organisation could access workplace support intervention, provided it was available. The following were identified as influencing the uptake of workplace support interventions: availability and accessibility of workplace support, disclosure/nondisclosure, and line manager's support. Financially, some of the OWs felt that they were in a much better position for work exit. Third, participants considered the long-term impact of work on their depression and overall mental wellbeing. While it was important for OWs to continue in paid employment, living without depression was crucial for them. Some of the participants felt that their current jobs were no longer suitable for them as an OW. The next chapter will discuss the outcome of this study in the light of existing literature, theoretical and methodological perspectives, and make recommendations to organisations, employees, line-managers and OH specialists.

Chapter 6

DISCUSSION AND RECOMMENDATIONS

6.1 Introduction

This chapter aims to consider the themes identified in the previous chapter in the context of existing literature and theories. It also presents the empirical, theoretical/conceptual and the methodological contributions of the empirical study and their limitations. It challenges the assumption that older workers' (OWs) experiences of depression can be understood and addressed in a similar way to younger workers. Additionally, it offers an alternative conceptualisation of OWs' experiences of depression. The main and sub- research questions for this study are also addressed in this chapter. However, given that the findings, contribution and limitations of the systematic review were discussed in Chapter 3, these will not be discussed here. Finally, a summary of the entire thesis is provided.

6.2 Empirical contributions and limitations

This current empirical study provided insight into the experiences of OWs who had depression. Research on OWs have tended to focus on providing a general workplace intervention (Cloostermans et al., 2015; Poscia, 2016). Many depression-related researches on older people have focused on the general population (Alexopoulos, 2005; Silveira & Allebeck, 2001). Although a few workplace researchers have investigated depression among OWs, these studies were quantitative (Knebelmann & Prinz, 2016; Stynen et al., 2015). The majority of qualitative workplace studies on depression have focused on the entire working-age groups, without subgroup analysis for OWs (Danielsson et al., 2017a & b; Moll et al., 2013; Sallis & Birkin, 2014).

However, as recommended by Koh & Koh (2006) and Lagerveld et al. (2010), this current empirical study has addressed research gaps in knowledge regarding work participation, WF and work environment problems in depressed workers. It also highlights the need for further research on the OH problems of OWs. Thus, the strength of this study is that it has enabled the creation of in-depth insight into the experiences of OWs who had depression.

Thematic analysis was chosen to identify, analyse and interpret the patterns of meaning within the dataset. Analysis of the data led to three superordinate themes: Theme 1 – Disclosure and nondisclosure of depression among OWs; Theme 2 – OWs' struggles during their depression and organisational support interventions; Theme 3 – Future outlook: the importance of work participation during and after depression. The findings of this empirical study highlight the experiences of depression among OWs in the contemporary workplace. The key findings emphasised that: i) Negative perceptions about the combination of age and depression influenced OWs' choices and decisions to disclose; ii) Organisational culture is crucial to disclosure and nondisclosure among OWs; iii) OWs' perception of organisational culture determines the usefulness and accessibility to workplace support in the light of depression-related struggles at work, and iv) Depression can exert a negative impact on OWs' career trajectory.

6.2.1 Negative perceptions about the combination of age and depression influenced OWs' choices and decisions

This section answers the main research question, "What are the experiences of OWs who had depression in the contemporary workplace?". Negative perceptions about the combination of old age and depression was widespread among the participants. The negative meanings impacted on participants' choices and decisions about help-seeking behaviour, disclosure, nondisclosure, work participation and resignation from their roles. Participants interpreted depression as negative due to fear of stigmatisation, vulnerabilities and shame. These thinking further precipitated various

fears among OWs, which included fear of losing their jobs; fear of losing their jobs to younger colleagues; and fear of being promoted at work. OWs negative perceptions about themselves and the impacts on their employment or job could reinforce low self-esteem. Ali et al. (2016) defined self-esteem as individuals' value of themselves, which can impact on trust and relationship in every aspect of life. Arguably, low self-esteem among OWs with depression could further reinforce lack of trust in their organisation or could cause strained relationship with their employers. Although among older people in the general population, existing literature suggest that low self-esteem is a risk factor for depression with subsequent potential for suicide (Ali et al., 2016; Reynolds & Kupfer, 1999). This suggests that among OWs experiencing depression, low self-esteem could reinforce and prolong their symptoms. Thus, the need to address OWs' negative perception about their age and depression seems imperative.

Furthermore, being promoted at work was associated with additional workload and responsibility, which OWs felt could further increase their stress level and, consequently, exacerbate their depression. Because of their age, participants viewed depression as multiple sources of vulnerabilities for job loss, impaired work function (WF), employability issues, and future work exclusion. These findings resonate with previous studies such as Cornelius et al. (2011); Knebelmann and Prinz (2016); Shaw Trust (2017) and Stynen et al. (2015). For instance, Stynen et al. (2015) found that OWs were vulnerable to losses in specific domains of functioning. Studies across the full age range of the working population have highlighted shame, stigma, and vulnerabilities concerning depression (Sallis & Birkin, 2014). However, the fear of the three constructs was heightened among OWs due to their age, the associated deterioration in career opportunities and the heightened perception of stigma as people age (Knebelmann & Prinz, 2016; Leggett, 2007; Stynen et al., 2015). Participants held that depression was an unhealthy intrusion which threatened to end their career. Given the participants' perception of the likely impact of the

combination of depression and being in older age, many of the participants chose to conceal their depression at work.

Participants' belief that they were vulnerable to losing their jobs to younger colleagues gave rise to additional fears that a combination of their age and depression suggested they were more at risk than their younger colleagues. Interestingly, this thinking sharply contrasts with Porcelatto et al.'s (2010) qualitative study based on 56 OWs in Northwest England that provided a regional perspective on the relationship between age and work. Although their study was not based on depression, health was revealed as a significant constraint to unemployment and re-employment among OWs. Their study also revealed OWs' concerns about displacing younger workers in the current labour market and were, consequently, considering stepping aside for younger ones' benefit. Arguably, there seems to be a general challenge around OWs employability. However, additional health issues such as depression might be an added constraint. Given the above, this key finding is generalisable to OW in general due to vulnerability to job loss or unemployment. It is also generalisable to OWs with chronic health issues.

6.2.2 Organisational culture is crucial to disclosure and nondisclosure of depression among OWs

This current study revealed participants' expressions of dissatisfaction with organisational management of their disclosure. Additionally, OWs' perception of lack of organisational care resulted in the belief that they have a responsibility to make themselves well. This thinking could be explained and challenged with the [Resource Caravan Passageway](#) and [Resource Caravan Principles](#) (Hobfoll et al., 2018). These principles highlight that resources travel in packs and the environment can either bolster or hinder their generation. Arguably, OWs' experiences of depression call for both organisational and individual redress. However, participants frequently described a lack of trust in their organisation, policies and workplace interventions and, therefore,

interpreted that disclosure was unnecessary. For instance, Moll et al. (2013), in their institutional ethnography in a large mental health institution explored how institutional forces shaped the experiences of healthcare workers with mental health issues. Their study found that workers and the organisation used non-disclosure (silence) in different ways. Although this study included several mental health issues, including depression and was conducted across all age groups, the findings revealed that silence took many forms and complexity about workers' diagnoses within the institution. Arguably, in this current study, participants' experiences of organisational culture about disclosure or response to previous episodes of depression influenced their decisions. They frequently voiced that a combination of depression and being an OW was incompatible with the contemporary workplace because of attitudes to age and organisational culture. Consequently, participants managed their depression at work through nondisclosure and facade.

Facade is a phenomenon which was also used by participants in studies including full working-age groups who had depression (Bertilsson et al., 2012; Danielsson et al., 2017a). This finding suggests similarities in how OWs and the workforce managed their symptoms at work. For instance, out of the 27 participants included in Danielsson et al.'s (2017a) study, eight (one-third) of them were aged 46-66. Similarly, Bertilsson et al. (2012) included 32 participants, with an age range of 30-62 years, in their qualitative study on capacity to work while depressed. However, both studies did not provide a subgroup analysis of OWs. Therefore, among the studies highlighted, it is unclear whether the use of facade was among OWs or younger ones or both. This current empirical study revealed that OWs had to put up an act at work that concealed their symptoms and ongoing work impairment, which impacted productivity. Perhaps this key finding could be generalised to workers with depression or other chronic health conditions as well as OWs with chronic health conditions. Further studies on workers with depression or other chronic health conditions might be useful in determining if the use of façade occurs among this category of workers.

OWs' perception of negative organisational culture, such as likely discrimination due to their age and depression, was the key reason for nondisclosure. For instance, a qualitative study on the management of an ageing workforce by Schroder et al. (2014) shows that regardless of health, certain organisational cultures remain discriminatory towards OWs. Such organisations encourage early exit from work participation due to age. Arguably, OWs who experience depression in such circumstances could, therefore, reason that disclosure could lead to job loss. In this current empirical study, nondisclosure of depression meant that participants did not access relevant workplace support, which further impacted WF. Some of the participants lost the jobs they were trying to protect. Where there was trust in organisational culture and subsequent disclosure, this did not translate to protection from job loss. One participant from this current study called for better legislation to protect OWs with depression from job loss following disclosure.

6.2.3 The effect of depression on OWs' work functioning, work environment and work participation

This section answers the sub-research question, "How does depression affect OWs' WF, work participation and work environment?".

Work functioning. Participants struggled with their WF for various reasons. These include one or a combination of the following: depression symptoms, comorbidity, unrealistic work demands, other workplace issues and additional effects, which may be related to a participants' age. This study corroborates earlier findings that psychological problems negatively affect OWs' WF (Leijten et al., 2014; Styne et al., 2015; Lagerveld et al., 2010). For instance, although quantitative in nature, Styne et al.'s (2015) study underlined the negative impact of depression on OWs' functioning due to concentration issues. Although the Lagerveld et al.'s (2010) study is based on workers of all ages, they also found moderate evidence associated with a more severe type of depression, comorbid physical and mental illness and older age. There is some evidence that

depression can have greater impacts on cognition in older age, although it almost universally impacts concentration at any age (Falba et al., 2009). While it is not a workplace-based study, a longitudinal study on the impact of persistent affective symptoms across three decades of adulthood (from age 23 to age 50) found that an accumulation of affective symptoms was associated with poorer cognitive function in mid-life (John et al., 2019).

This current study revealed that the experience of depression at an older age further accentuated other ongoing physical health issues. Participants struggled with the impact of persistent high workload on their symptoms due to low concentration and interpersonal relationship issues. Participants' challenges and inability to interact with customers, patients' relatives, or manage classrooms align with [Enterprise Community Involvement](#) (Burton, 2010; Stynen et al., 2015). As an element of the HWFM, it highlights the likely impact of an enterprise's activities on employees, communities, or the general public. Nevertheless, OWs in senior positions who did not disclose their depression at work addressed impaired WF by adjusting their daily duties as their symptoms required. In line with findings of this current study, Boot et al. (2016) and Stynen et al. (2015) also found that those who had autonomy over their roles could manage their work according to their symptoms, facilitating work participation.

Prolonged impaired WF aligns with the [Primacy of Loss Principle](#) (Hobfoll et al., 2018), highlighting that the length of time the impact of a loss remains contributes to the challenge, and in this case, impaired WF. Arguably, the longer the WF issue, the more power the symptoms of depression exert on the OWs. Impaired WF was accentuated by a combination of nondisclosure, low organisational justice and inaccessibility to workplace support, which further strengthened OWs' vulnerability to job loss. As seen in the empirical study for this thesis, a participant lost three jobs in quick succession due to impaired WF. Thus, participants struggled to regain their mental wellbeing due to persistent challenges at work. This finding aligns with [Corollary 1](#) of COR theory

(Hobfoll et al., 2018), highlighting the challenge of regaining resources and vulnerability to resource loss among those who lack resource.

Work participation. Only one of the 21 OWs in this study had retired due to their inability to cope at work. Almost a quarter of participants managed their symptoms with intermittent non-work participation. This finding corroborates Lagerveld et al.'s (2010) study. However, the importance of ongoing paid work was emphasised by all the participants in this current study. This finding corroborates a mixed-methods study by Boot et al. (2016), which found that the common factors important for work participation for OWs who experienced depression were better physical and mental health. This study found that autonomy in work and the need for ongoing work participation helped with WF.

Work participation among OWs was facilitated by the importance of working, such as being a breadwinner or earning an income. For instance, participants in the study above by Boot et al. (2016) explained that work provides opportunities for social contacts, escape from symptoms and enhances their self-esteem among peers. Thus, participants' desire for continued work participation was grounded in the belief that work gave purpose in life, the need to maximise employment opportunity, work for a living or the desire to work for life. The findings of the empirical study for this thesis also align with the theory of *selective optimisation with compensation*, which posits that the engagement of the processes of selection, optimisation and compensation results in effective functioning, adaptation, and successful development (Baltes, 1997; Baltes & Baltes, 1990). The engagement of these three behavioural strategies is useful in achieving positive outcomes such as goal accomplishment and wellbeing as it enables individuals to optimally allocate their limited resources (Baltes & Dickson, 2001; Freund & Baltes, 2000, 2002).

Most of the participants reported the benefits of continuing with work despite their unstable symptoms. They selected, focused and prioritised essential goals for work participation based on personal preferences. OWs also engaged optimisation and compensation, which were based on

individuals' resources that were necessary to achieve the selected goals. Optimisation means that participants invested additional resources to achieve their goals, and they compensated by replacing means that did not contribute to goal attainment with more effective ones (Zacher & Frese, 2011). In this current study, participants invested in their resources by utilising various personal measures such as exercise and seeking external specialists' input. These measures are the nurturing social conditions that bolster mental health resource, as explained within the *Resource Caravan* (Hobfoll et al., 2018). However, many OWs did not perceive medication as a way of bolstering their mental wellbeing.

Work Environment. In line with the HWFM (Burton, 2010), OWs had an awareness of the physical work environment and felt that their symptoms or impaired WF could be detected by colleagues. Therefore, concealing these issues was essential for OWs, enabling them to blend into the work environment. This thinking aligns with [the Physical Work Environment](#) of the HWFM (Burton, 2010).

Additionally, the study highlights the challenges of the psychosocial work environment, such as poor work organisation. In line with the HWFM (Burton, 2010) and other existing literature (Cornelius et al., 2011; Styne et al., 2015), poor work organisation includes problems with work demands, workloads, low decision latitude, management style, lack of consultation, negotiation or two-way communication, lack of awareness of and competence in dealing with mental health issues among other challenges.

Participants reported the impact of their symptoms and struggles with WF on their work environment, their relationship with colleagues and the work environment. Notably, this finding aligns with [the Psychosocial Work Environment](#) of HWFM (Burton, 2010). Psychosocial work environment includes organisational culture, attitudes, values, beliefs and practices that are demonstrated daily in an organisation, affecting employees' mental and physical wellbeing (Burton, 2010). Participants highlighted the negative impact of the work environments'

multifaceted transactions on their symptoms, including a sudden change in work schedule, bullying, and an unsupportive line manager. Boot et al.'s (2016) study confirmed the importance of psychosocial resources at work through supervisors and colleagues. One of the participants reported that the usual workplace transactions which could have been dealt with quickly became challenging. Consequently, participants reported fear of attending work, lack of motivation to attend work, and challenges getting out of bed.

Depression is a chronic psychiatric condition that can impact the entire working population. Various studies have highlighted the increasing prevalence of chronic health conditions among adults in industrialised nations and these are strongly related to age (Varekamp et al., 2013). Similar to depression, chronic medical conditions can give rise to various symptoms and functional limitations. Arguably, the findings of this study can be generalised to workers and OWs with chronic health conditions.

6.2.4 Line managers' support to OWs during a depression

This section responds to the sub-research question, "How supportive are line managers and supervisors to OWs with depression?". OWs' experiences of their line managers' support were polarised; a small fraction felt supported while a large fraction felt unsupported.

Workplace and line management support were vital to participants. A few of those who disclosed felt supported by their line manager. Participants expressed that they experienced sympathy, flexibility with work, additional training, temporary work adjustment when returning from sick leave, and regular meetings with their line manager. A participant felt that they received sympathy from their line manager because they were about the same age, which suggests that they might have been treated differently if this was not the case. Additionally, one participant's account shows that even though they were in temporary employment, they benefitted from

workplace support through their line manager. This finding aligns with [the Personal Health Resource](#), which suggests that motivated organisations could choose unofficially to extend workplace initiatives to informal workers (Burton, 2010). This experience exemplifies good interpersonal relationships and communication between management and employee as highlighted through leadership engagement and worker involvement.

Furthermore, participants who experienced their first depression at age 50 or above felt that it was mainly work-related. The following work-related issues were highlighted: unrelenting high workload despite complaints to management, bullying by the line manager, lack of emotional support from line managers, and lack of resources. These workplace issues echo the findings of recent HSE (2019) statistics, which shows that predominant work-related factors for depression are workload pressures, interpersonal relationship issues at work and change at work. Participants who perceived that their depression was caused by work-related factors felt defeated. They reported a lack of support, bullying and being undermined by their line managers. Similar findings were reported by Hjarsbech et al. (2015). Their grounded theory and semi-structured interview of 13 Danish employees with depressive symptoms found that relationships with supervisors and colleagues, workload, and work pressure hardened workers' struggle. Nevertheless, it is understandable that the Hjarsbech et al. (2015) is different from this current study in that it included participants from the full working-age population.

Some participants were dissatisfied by line managers' lack of support, lack of understanding about depression, lack of interest and insensitivity. Participants' experiences were that they were unheard and overloaded with work by their line managers despite reporting the overwhelming nature of their workload. Participants reported a lack of or inadequate HR input as well as breaches in medical confidentiality, which reinforced a lack of trust in their organisational culture and dissatisfaction with their line managers. Some felt that their depression was caused or aggravated by their line manager or lack of a line manager, which meant an inability to access

emotional support and resources at work. This finding underlines the importance of line managers and organisational culture when addressing depression among OWs. This key finding is also generalisable to all workers experiencing chronic health conditions because of their need for line managers' support.

6.2.5 Determinants of usefulness and accessibility to workplace support in the light of depression-related struggles among older workers

This section responds to the sub-research question, "How useful and easily accessible is workplace support to OWs with depression?".

Five factors determined participants' accessibility to workplace support: i) availability; ii) easy accessibility; iii) disclosure; iv) nondisclosure and v) trust and confidentiality. Almost half of the participants found that workplace support for mental health issues was available and easily accessible, meaning that they had the opportunity to invest in their mental health resource within the work environment. This finding aligns with the [*Resource Investment Principle*](#), highlighting the importance of investing in resource to gain (Hobfoll et al., 2018). However, the interview findings suggest that some participants chose not to access support despite its availability and easy accessibility. The reasons included lack of trust in their organisation, fear of disclosure, feelings of vulnerability to job loss, fear of stigmatisation, the belief that no-one cared, insensitive line manager, fear of the unknown, and access to mental health support outside the organisation. Some OWs felt that workplace mental health support is for younger workers. Arguably, available but inaccessible workplace support is a wasted resource. Thus, organisations who have this understanding avert wasted resources by creating a supportive culture. Organisations might think that they have a healthy workplace, but where disclosures are not taking place or encouraged, the workplace might be unhealthy. An unhealthy organisation is developing an unhealthy business.

Participants found that only a few resources were obtainable through their organisation, such as line managers' and HR support. Contrary to the [World Health Assembly's global strategy](#) for occupational health (OH) services provisions for all (WHO, 2007 & 2013), OH recommendations and work adjustments were only available in a few organisations, suggesting that specialist advice may be inaccessible in some organisations.

Approximately half of the participants were unable to access workplace support due to non-availability, which meant that OWs could not obtain relevant workplace interventions for improved WF or participation. For instance, [Personal Health Resource](#) (Burton, 2010) includes workplace support focused on helping individuals maintain a healthy lifestyle. Many utilised various personal coping measures, which resulted in isolation. Masking the symptoms of depression or work impairment further reinforced isolation. According to [Corollary 1](#) of COR theory, individuals who lack resources are more vulnerable to resource loss and less capable of resource gain (Hobfoll et al., 2018). Arguably, recovery from depression was difficult to achieve due to the lack of intrinsic and extrinsic resources. Thus, accessing the available resource both from the community and within an organisation is essential to the trajectory of depression among OWs. Participants who were able to take steps to invest in their resources by seeking medical help or utilising other investment measures, such as seeking external support, experienced improvement in their symptoms. This finding also aligns with [Principle 2, Resource Investment Principle](#) (Hobfoll et al., 2018).

The impact of symptoms on the professional capability of OWs who work in the health and social care meant that the need for resource gain for optimum work functioning became more critical. A few of these participants could not access the required workplace support either because of nondisclosure or non-availability. This meant that they devised means of ensuring they performed at work. This finding corroborates earlier studies by Kessler and Bromet (2013); Stynen et al. (2015); and Lagerveld et al. (2010). This finding aligns with [Gain Paradox Principle](#)

(Hobfoll et al., 2018), where resource gain became important. For about a quarter of participants, this resulted in weakened professional trajectory and temporary work exit. However, some of the participants who disclosed their depression benefitted from workplace support intervention such as work adjustments, understanding from managers and peers.

Impaired functioning, cognitive, psychological, and physical impairment are common issues that could necessitate workplace support among workers with chronic health issues (Varekamp et al., 2013). However, due to fear of stigma and discrimination, disclosure remains a major concern among workers with chronic health conditions despite being covered by the Equality Act (2010). Workers' choice for nondisclosure would mean inaccessible workplace accommodation and consequent struggling at work. Therefore, this key finding can be transferred to all workers with chronic health issues regardless of age.

Regarding the usefulness of workplace support, participants who accessed EAP, a mental health support programme for workers, did not find it useful. Participants felt it brought back negative feelings or interpreted that workplace issues could not be fixed with counselling, resulting in non-engagement. Participants who had temporary workplace adjustments explained that they struggled to fit their entire workload within the temporarily reduced hours, which defeated the purpose of the adjustment. For others, their workplace adjustments were unsustainable by the organisation. Arguably, understanding the workplace intervention needs of OWs experiencing depression is key in managing this issue.

6.3 Theoretical Contribution and limitations

6.3.1 The differences between OWs' experiences of depression compared with similar studies conducted across the full working-age range

This study explored the experiences of OWs who had depression compared with other studies conducted across the full working-age. The perceived heightened level of vulnerability, shame and stigma experienced because of age differentiates this current empirical study from those conducted across the full working-age range, which did not provide sub-group analyses on age. Thus, it was difficult to ascertain the inherent experiences of depression across the older and the younger working groups in studies conducted across the full working-age. This current finding suggests that only generic workplace support based on such studies can be provided, which raises a question about the likely usefulness and effectiveness of such interventions for OWs. This current empirical study is different from studies across the full working-age group because it has provided findings specific to OWs, and could be translated into meaningful workplace support. For instance, this current empirical study revealed OWs' reluctance to disclose depression due to their belief that they are more vulnerable to job loss than their younger counterparts because of their age. The study also revealed OWs' belief that mental health support at work is meant for their younger colleagues, which suggest that OWs might not access available workplace support. Additionally, this current study found that OWs had the belief that medication is ineffective for the management of their depression; they chose other self-help measures over medication.

6.3.2 Reconfiguring the framework and model of the healthy workplace

This empirical study supports the utilisation of HWFM in identifying the workplace factors that could impact OWs' mental wellbeing or vice versa and highlight the needed workplace support.

The HWFM was utilised in constructing the various workplace factors that were explored during the study interviews. Although previous studies that utilised the HWFM have focused on macro- and mezzo-levels, there is a scope for its use at a micro-level.

By utilising the HWFM to explore the experiences of OWs who had depression, this study elaborated on how the different aspects of the workplace impacted OWs' experiences of depression and vice versa. It was also useful in highlighting the link between the [four avenues of influence](#), which showed that an impact on one area affected the other areas. By so doing, this study advanced knowledge through the in-depth and systematic application of the HWFM to explore OWs' experiences of depression in the contemporary workplace. The application of this framework illuminated the individual, organisational and societal influences as well as showed the importance of organisational culture and support interventions for individual experiences. Many other organisational health studies utilised a general theoretical framework to explore issues in the work setting. For example, Sallis and Birkin (2014) utilised the cognitive behavioural model of emotional disorders and Moll et al. (2013) utilised the critical social theory perspective. While utilising non-organisational theories might help explore workplace issues, it might not fully consider every aspect of the workplace and thereby limit the discussion of the findings.

The HWFM further helped in explaining the findings of this study. However, the framework was limited as it could not be fully utilised to explain some of the study's inherent findings. The current HWFM applicability on micro-level organisational studies, such as individual experiences is not clear. Although the HWFM is a comprehensive workplace model, it is limited in exploring topics of this nature at micro-levels within organisations. Therefore, it is proposed that an updated version of the model should encompass its utilisation at the micro-level, particularly exploring individual experiences of health issues within the contemporary workplace ([see Table 6.1 for this proposal](#)). This proposal is justified because of its power in exploring and addressing workers' health issues within the contemporary work setting. The various concepts in this framework were

explained in [Chapter 2](#). The current HWFM addresses prevention and health promotion within the work environment. The limitations mentioned above meant that COR theory and other existing literature (Hobfoll et al., 2018) were utilised in explaining some of the study findings.

Table 6.1 – Reconceptualising the Healthy Workplaces Framework and Model

Healthy Workplaces Framework and Model for Individual experiences					
Four Avenues of Influence	Physical work environment	Psychosocial work environment		Personal health resources	Enterprise community involvement
Process for implementing a healthy workplace support intervention	Mobilise and Assemble -Establishes contact with OW	Assess the situation -Line manager meets with OWs -OH Referral	Plan and Prioritise -Treatment -Return to work -Remaining at work -Remaining off work	Do -Implement plan	Evaluate and Improve -Evaluate the implemented Workplace Support Intervention. Has it worked? What do you need to improve?
Core Ethics and Values	Leadership engagement <ul style="list-style-type: none"> • Line managers' understanding and empathy • Workplace support, i.e. EAP, OH • Workplace culture, values 			Worker involvement <ul style="list-style-type: none"> • Disclosure • Ability to negotiate workplace interventions • The decision to access workplace support 	

6.3.3. A new conceptualisation of depression among OWs: Replacing the cycle of heightened shame, vulnerability and stigma with dignity

The utilisation of COR theory was useful in understanding resource loss and gain among workers, the power of individual perception about organisational influences on OWs' choices and decisions about depression, disclosure, nondisclosure, accessing workplace support and the progression of or recovery from depression. OWs perceived that their level of shame, stigma and vulnerability was higher than their younger colleagues due to a combination of depression and age; the possibility of job loss and the concurrent loss of dignity and self-esteem; together with the challenges posed to future employability. Participants' heightened perception fuelled nondisclosure and consequent inaccessibility of workplace support measures. Thus, the cycle of shame, vulnerability and stigma during OWs' experiences of depression represent a loss of dignity, and there is a need to replace dignity. According to Jacelon (2004), dignity represents humans' inherent characteristic, which individuals can subjectively experience; an individual's dignity is affected by how others treat them. Dignity can be achieved by increasing organisations' understanding of the additional impact of depression on OWs, organisation and society. Given the issues raised concerning OWs' experiences of depression, heightened shame, stigma and vulnerability are proposed as the theoretical foundations aimed at speaking to a new conceptualisation of depression among OWs ([see Fig 6.1](#)).

This current study has explored individual OWs' experiences. Understanding an organisational perspective, such as an experiential study on managers/supervisors, would be useful. Further exploratory research on the combined constructs – organisational (managerial/supervisor's) experiences and OWs' experiences of depression - would be enlightening. In addition, a participant's belief that being an ethnic minority accentuates their vulnerability needs to be researched further. Therefore, further studies would be useful in exploring this assertion.

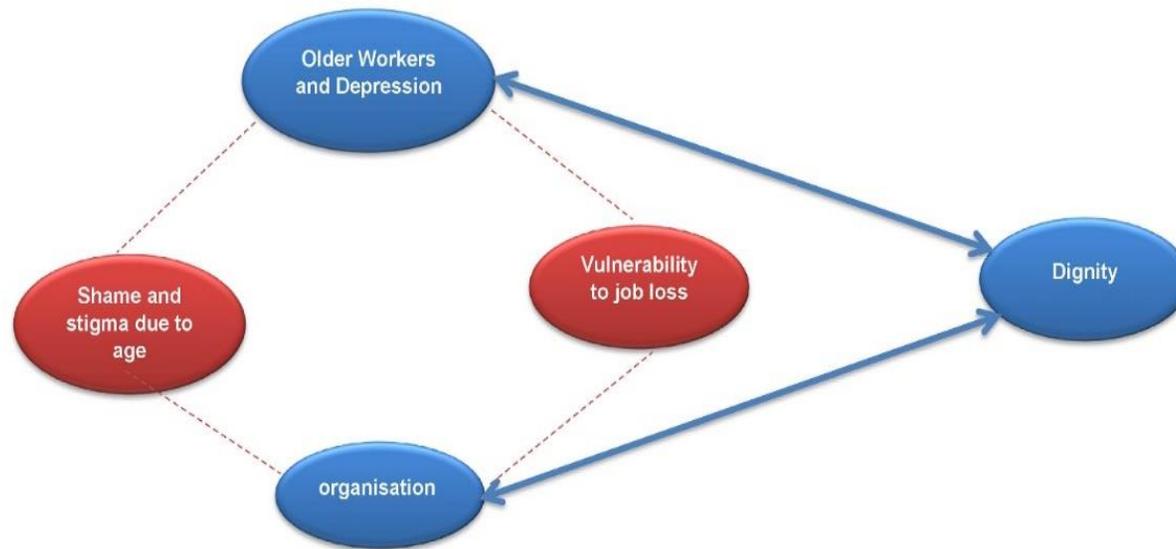


Fig 6.1 Replacing the cycle of heightened shame, stigma and vulnerability with dignity

6.4 Methodological contributions and limitations

6.4.1 Strength and Limitations

This current empirical study provided insight into the experiences of OWs who had depression by using qualitative methodology. To my knowledge, no similar study has yet been conducted. This study's strength is that participants were recruited from various work sectors across the UK, thereby widening the study's scope. Although qualitative studies do not usually aim for generalisability, this study's findings might well apply to OWs experiencing depression in other work settings. Given the theoretical conceptualisations discussed above, this study could be generalised to other work settings. The exclusion of workers below the age of 50 and those with other mental health conditions is a methodological strength because it aligned the study participants with the UK's age definition of OWs. Understanding the experiences of OWs with depression would further speak to a broader provision of workplace support interventions for mental health issues. The current study covers four regions in the UK – predominantly– the South East, West Midlands, North East of England and North Wales - as well as various public and private organisations in the health and social care, academic, financial and other work sectors. Three participants were self-diagnosed; however, they were only selected for the interview after asking other questions to ensure they met the study criteria.

This study has been planned and implemented to a high quality. Quality is a significant aspect of every research process. Several authors have highlighted the verification process for ensuring quality in qualitative studies (Creswell, 2013). This includes assessing the credibility, validity, rigour and trustworthiness of the generated accounts (Creswell, 2013; Lincoln & Guba, 1985; Morrow, 2005). While my interpretations are represented in this thesis, a strength of this current study is that several processes, such as reflexivity, were used to support the research's credibility

and reliability. Each theme which emerged reflected multiple OWs' perspectives. The choice of a qualitative stance also enabled a flexible approach to listening to the participants' experiences. As a researcher who received privileged information, care had been taken at every stage to ensure quality using an overt theoretical framework and interpretation (Mays & Pope, 1995; Smith, 1999). Themes have been grounded in data. Conclusions have been drawn from this study based on the study participants' experiences, as advised by Smith (1999). A 15-point checklist of criteria for good thematic analysis by Braun and Clarke (2006) was used to ensure quality ([see Appendix 6.1 for the details](#)).

Additionally, Yardley (2017) grouped the procedures for enhancing, evaluating and demonstrating quality into four broad categories. These included sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance (Yardley, 2000, 2017). According to Yardley et al. (2017), demonstrating sensitivity to context included showing awareness of the participants' perspectives and setting, the research's socio-cultural and linguistic context. These factors might influence what participants say and how this is interpreted by the researcher. In this study, sensitivity to context was ensured by developing an awareness of individual OWs' organisational contexts and employment conditions. Participants were independently recruited into the study, which helped to reduce lack of trust. The documentation of the research process and ethical considerations were useful in ensuring quality. The linguistic and sociocultural context of 'experiences of depression among OWs' stimulated interest among the participants. All the participants highlighted the challenge of depression at their age. It emerged that participants viewed their experiences of depression as an OW as shameful due to stigma and vulnerability to job loss compared with younger colleagues.

Commitment and rigour have been demonstrated through the in-depth engagement with the topic, data collection, the display of expertise and skills in the methods employed throughout the

study and analysis (Yardley, 2017). Chapters 3 (systematic review) and 4 (methodology and methods) highlight the study's commitment and rigour.

Using a pilot study to shape the interview schedule for this study and my verbatim transcription of the data are examples of maintaining commitment and rigour in this study. Transparency and coherence were also demonstrated by providing detailed information that reflects the interpretation of this study is grounded in the data. This aspect of quality in research involved the documentation of the decisions taken at every stage of the study, following the six stages of thematic analysis and keeping a reflexive account ([See Appendix 6.2 for my reflexive journey](#)). This research's impact and importance meant that useful knowledge was generated to speak to organisations' policies and practices or even change how people think about depression and OWs. This aspect is demonstrated in Sections 6.3 and 6.5 regarding implication for policy, practice and research.

The nature of the phenomenon of study meant that it was challenging to recruit participants; perhaps a secondary analysis of previous data would have been more beneficial. Another limitation of this study was that one interview was incomplete due to technical difficulties with the participant's phone (Steve – Participant #19), which could not be resolved over several weeks. However, it is unlikely that this would have influenced the findings of this study. An additional limitation was that participants were self-selecting, suggesting that they already had an interest in the topic.

6.5 Implications for Policy and Practice

Based on the findings of this current study on the influence of meanings of depression at age 50 or above, a combined effort of intervention at individual, organisational and external levels is suggested. This approach would be useful in addressing the multifaceted challenges of depression in OWs. For instance, the [Resource Caravan Principle](#) of COR theory (Hobfoll et al.,

2018, p. 106) posited that resources do not exist individually but “travel in packs or caravans” both for individuals and organisations. To facilitate employees’ resource (mental wellbeing) restoration, organisations could provide multiple workplace support interventions. A limited range of resources within an organisation might restrict resource gains among workers due to reduced variety. Multiple resource caravans are a springboard to a wider variety of resources.

As already established in Chapter 2, health is a form of resource. The Resource Investment Principle posits that people must invest resources to recover from resource loss or gain resource (Hobfoll et al., 2018). Accordingly, Resource Caravan Passageways (Hobfoll et al., 2018), posit that people’s resources lie in ecological conditions that either foster and nurture or limit and block resource creation and sustenance. Thus, the provision of easily accessible and beneficial workplace support fosters and nurtures resource creation and sustenance. Limitations or blockage of resource creation for the improvement of mental health could be challenging for OWs. This thinking aligns with Corollary 1, which indicates that individuals lacking in resources are more vulnerable to resource loss and less capable of resource gain, thus strengthening the vicious circle of depression.

Based on the findings of this study, I recommend the following:

- Line managers are key in supporting OWs with depression. Therefore, educating line managers on the heightened stigma, shame and vulnerability of depression among OWs due to their age are crucial to recreating dignity, rebuilding self-esteem and improving organisational justice.
- Organisations should develop a culture that supports workers and OWs with depression and mental health issues as well as other chronic health conditions
- Organisations should aim to develop age-sensitive culture and policies that do not discriminate against OWs

- Organisations should develop a comprehensive policy that speaks to key issues impacting workers and OWs with chronic health conditions, such as disclosure, information about how to access workplace support, line managers' responsibilities
- Peer level of support for OWs who are experiencing depression should be encouraged within organisations
- Closing the gaps for disclosure within the Equality Act (2010).
- Provision of easily accessible and confidential OH service for workers that would allow support regardless of disclosure ([see the World Health Assembly Global strategy](#)).
- Inclusion of 'depression among OWs' as part of training modules for managers and HR.
- More organisational health and wellbeing specialists are required to support organisations in developing a culture that is fit for managing mental health issues in the contemporary work setting.

6.6 Conclusion of the empirical findings

This current study extends knowledge by exploring the experiences of OWs who had depression in the contemporary workplace and how they make sense of their experiences. As indicated above, the study findings have important implications for research and organisational policies. This study addresses gaps in the literature concerning OWs' experiences of depression, and how they address their symptoms and functionality in the workplace. The study findings are important because they can inform policymakers, organisations and OH specialists when addressing depression among OWs. This study's recommendations can be a valuable tool in educating line managers, supervisors, HR specialists, OH specialists, OWs and workers. It can provide further insight into OWs' decision about disclosure, the experiential challenges of depression at an older age, the subjective measures engaged in concealing depression at work, and the need for robust

confidential workplace measures. This study's findings underline the importance of understanding the experiences, fears, heightened shame, stigma, and vulnerabilities of OWs who have depression in the contemporary workplace. This study highlights OWs' meanings of being diagnosed with depression at age 50 or above and how these meanings influenced their decision about disclosure, nondisclosure, accessing workplace support and future work participation. The importance of replacing organisational and societal culture about depression among OWs with dignity cannot be overemphasised.

6.7 Summary and conclusion of the Thesis

The systematic review for this thesis aimed to synthesise qualitative studies that explored the experiences of OWs who had depression. However, insufficient existing research on this topic resulted in synthesising studies that included participants across the full working-age population. Thus, the resultant purpose of the synthesis was to gain an in-depth and broad understanding of workers' experiences of WF during and after depression. Despite the original plan to focus only on research among OWs, this approach provided more breadth and depth as it included studies that covered the full working age range, which prepared an understanding for the empirical study. The review revealed four overarching themes: *Obstacles to WF*; *Challenges of impaired WF*; *Consequences of impaired WF*; and *Promoters of WF*. The synthesis highlighted the importance of understanding workers' experiences of WF during and after depression as well as the coping mechanisms utilised to address their limitations. This literature review also revealed a paucity of qualitative studies on this topic.

Furthermore, based on the outcome of the systematic review, the empirical study aimed to explore the experiences of OWs who experienced depression in the contemporary workplace. A significant contribution of this empirical study is the OWs' perception of heightened level of shame, stigma and vulnerability, the influence of age on disclosure as well as the intrinsic (organisational

culture) and the extrinsic (societal) influences on OWs' experiences of depression in the contemporary workplace. Of great importance is this study's contribution to understanding the impact of OWs' experiences of depression.

Throughout the literature review and empirical study, a salient theme was the depressed workers' or OWs' desire for work participation and WF, which caused these groups of workers to consider the implications of disclosure. The heightened level of stigma, shame and vulnerability to job loss was more pronounced among the empirical study participants than those in the literature review.

On reflection on the genesis of my PhD, it is notable that when I embarked on this journey, studies had been predicting the impact of increasing numbers of OWs in the contemporary workplace by 2020. Also, there has since been an increased level of depression across the working population. The associated impacts of these on OWs' health, safety and wellbeing have been a significant challenge for OWs, organisations and occupational health specialists. Despite increasing awareness about mental health issues, addressing the issue of depression across the entire working population remains a significant challenge among policymakers. Yet there is limited evidence on the experiences of OWs' with depression. This was my reason for embarking on this project.

On concluding my journey on this thesis, it is worth mentioning that I have learnt throughout the conduct of this study ([See Appendix 6.2 for my reflexive journey](#)).

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APPENDICES

Appendix 3.1 Systematic Review - Search Terms

Mental Health	Work Status	Research Method/Methodology	Workplace support/Intervention	Working group
Depression	Work functioning	Narrative approaches	Occupational health	Worker/s
Low mood	Productivity	Content analysis	Occupational health service provision	Personnel
Common mental health disorders	Workability	Qualitative	Occupational health service	Employee
Common mental health issue	Functional status	Qualitative study	Work adjustments to facilitate return-to-work	Professional/s
Depressive disorder	Work disability	Qualitative method	Workplace counselling	
	Workplace	Grounded theory		
	Sick leave	Discourse analysis		
	Unemployment	Interviews		
	Work environment	Semi-structured interview/s Interpretative phenomenological analysis		
	Work performance	Focus group		
	Productivity loss	Life-story interview		
	Sickness absence	Episodic interview		
	Return to work	Narrative analysis		
	Return-to-work	Case study/is		

Appendix 3.2 Assessment of methodological quality - CASP w54 (2018) for Qualitative studies

Author/	Abma et al. (2013)	Bertilsson et al. 2012	Danielsson et al. 2017(a)	Danielsson et al. 2017(b)	Haslam et al. (2004)	Hjarsbech et al. (2015)	Millward and Purvis (2005)	Moll et al. (2013)	Nielsen et al. (2012)	Noordik et al. 2011	Sallis and Birkin 2014
A: Are the results valid?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
1. Was there a clear statement of the aims of the research?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
2. Is a qualitative methodology appropriate?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Is it worth continuing?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
3. Was the research design appropriate to address the aims of the research?	3	2	3	3	3	3	3	3	3	3	3
4. Was the recruitment strategy appropriate to the aims of the research?	3	3	3	3	1	3	3	3	3	1	3
5. Was the data collected in a way that addressed the research issue?	2	2	2	2	2	3	3	2	3	1	3
6. Has the relationship between researcher and participants been adequately considered?	1	1	3	3	1	1	2	3	3	1	1
Section B: What are the results?											

7. Have ethical issues been taken into consideration?	2	3	3	3	1	3	3	3	3	3	2
8. Was the data analysis sufficiently rigorous?	3	2	3	3	1	3	3	1	3	3	3
9. Is there a clear statement of findings?	3	3	3	3	3	3	3	3	3	3	3
10. How valuable is the research?	3	3	3	3	3	3	3	3	3	3	3
Total	20	19	23	23	15	22	23	21	24	18	21

Y - Yes, N - No, C – Can't tell.

Appendix 3.3 Data extraction instrument

Citation	
Reviewer	Toyin Adewunmi
Country	
Aims of study <i>Study aim(s) and rationale – consider:</i> <i>Broad aims of the study</i>	
<i>Study research question(s) – consider:</i> <i>Study research questions and/or hypotheses.</i> Focus of study	
Eligibility	
Ethics – how ethical issues were addressed	
<i>Inclusion and Exclusion Criteria:</i>	
The theoretical background of the study	
METHODS <i>Research design – consider:</i> <i>Type of study design used/methodology:</i>	

Sampling approach	
Study setting	
Sampling strategy <i>Recruitment context (e.g. where people were recruited from)</i>	
Details of data collection methods or tool(s).	<i>Who collected the data:</i>
How trustworthiness, reliability and validity of data collection methods or tools were established	
Data analysis approach	
Procedures for qualitative data analysis including data handling	
How trustworthiness, reliability and validity of data analysis methods or tools were established	
RESULTS <i>Describing the sample:</i> Number of participants Participant characteristics (<i>Socio-demographics</i> Age range, work type) <i>Exclusion and reason</i>	
Findings	
Key themes identified in the study (1 st order interpretations)	

Data extracts related to the key themes	
Author explanations of the key themes (2 nd order interpretations)	
Recommendations made by authors	
Assessment of study quality	CASP w54 (2018)
(3 rd order interpretations) Mine	
Comments	

Data extraction form was adapted from: *The Evidence for Policy and Practice Information and Co-ordinating Centre (EPPI-Centre) is part of the Social Science Research Unit (SSRU), Institute of Education, University of London* EPPI-Centre Social Science Research Unit Institute of Education, University of London, 18 Woburn Square, London WC1H 0NR, <http://eppi.ioe.ac.uk/emailssru@ioe.ac.uk> and Standard data extraction form (Munro et al. 2007) Munro S, Lewin S, Smith H, Engel M, Fretheim A, Volmink J. (2007) Adherence to tuberculosis treatment: a qualitative systematic review of stakeholder perceptions. *PLOS Medicine*. 4(7): e238. In Noyes J and Lewin S. Chapter 5: Extracting qualitative evidence. In: Noyes J, Booth A, Hannes K, Harden A, Harris J, Lewin S, Lockwood C (editors), *Supplementary Guidance for Inclusion of Qualitative Research in Cochrane Systematic Reviews of Interventions*. Version 1 (updated August 2011). Cochrane Collaboration Qualitative Methods Group, 2011. Available from URL <http://cqrmg.cochrane.org/supplemental-handbook-guidance>, Accessed [20 August 2018]

Appendix 3.4 List of excluded studies and reasons for exclusion

1. Carmichael et al.

Mixed methods study

Reason for exclusion:

The study is based on older workers about stress, not impact on work functioning.

2. Coduti 2005

Mixed-methods study

Reason for exclusion:

The study is based on ageing workers: work environment as a factor in employee mental health but not focused on work functioning.

3. Boot et al. (2016)

The study is based on ageing workers: but about work participation and multiple health issues such as cardiovascular diseases, depression and arthritis.

4. Hazelton, D. Nurses with mental illness: the workplace experiences

The study is mainly focused on general mental health issues

5. Andersen, Nielsen and Brinkmann (2014) How do workers with common mental disorders experience a multidisciplinary return-to-work intervention? A qualitative study.

Reason for exclusion: The study is predominantly based on workers experiences of consultation about return-to-work intervention. There was nothing to extract with regards to work functioning.

6. De Vries, G., Koeter, M., Nabitz, U., Hees, H., and Schene, A. (2012) Return to work after sick leave due to depression: A conceptual analysis based on perspectives of patients, supervisors, and occupational physicians.

Reason for exclusion: It was unclear whether this study was qualitative or quantitative.

7. Hillborg, H. Svensson, T., and Danermark, B (2010) Towards a working life: Experiences in a rehabilitation process for people with psychiatric disabilities.

Reason for exclusion: This study was excluded because it was based on the rehabilitation experiences of people recovering from major psychiatric illnesses.

8. Moll, S. (2017) The web of silence: a qualitative case study of early intervention and support for healthcare workers with mental ill-health

Reason for exclusion: This study did not address issues relating to work functioning.

9. Pesiah, C., and Wilhelm, K. (2017) Physician don't heal thyself: a descriptive study of impaired older doctors

Reason for exclusion: It was unclear whether this was a qualitative or quantitative study.

10. Silveira, E and Allebeck, P. (2001) Migration, ageing and mental health: an ethnographic study on perceptions of life satisfaction, anxiety and depression in older Somali men in east London.

Reason for exclusion: The sample for this study was not based on the workforce.

11. Verdonk, P., de Rijk, A., Klinge, I and de Vries, A. (2017) Sickness absence as an interactive process: Gendered experiences of young highly educated women with mental health problems.

Reason for exclusion: This study did not include work functioning.

Appendix 3.5 A table of articles represented in the themes

Analytic Themes	Articles contributing to Themes	Statement from original articles
Obstacles	Fear of the unknown: Bertilsson et al. (2012); Haslam et al. (2004); Nielsen et al. (2012); Sallis and Birkin (2014).	<p>“One study found that some perceive that withdrawing the medication might be another hurdle to cross and some still worry about dependence of the medication. Medication can help some people to overcome their symptoms” (Haslam et al., 2004)</p> <p>“Non-compliance with medication for anxiety and depression was common. Individuals took less than the prescribed amount of medication and often discontinued treatment because of side effects or because their symptoms had not improved” (Haslam et al., 2004).</p>
	Organisational factors: Abma et al. (2013); Bertilsson et al. (2012); Hjarsbech et al. (2015); Moll et al. (2013); Nielsen et al. (2012); Noordik et al. (2011); Sallis and Birkin (2014)	<p>“For Patricia the lack of insight was integral to unwillingness to accept depression as the cause of her difficulties. Patricia feared that admitting she was ill may become self-fulfilling (Sallis & Birkin, 2014).</p> <p>“While struggling at work, the women thought that their colleagues and supervisors interpreted RTW as a “return to a normal everyday life” (Nielsen et al., 2012, p.308).</p>

	<p>External factors: Haslams et al. (2004); Millward et al. (2005); Sallis and Birkin (2014)</p>	<p>Another related that she would “pick and choose” what she would share based on her perception of the specific situation. The social context for sharing information seemed to be important as a testing ground to see how others would respond (Moll et al., 2013, p. 172).</p> <p>“She [the physician] kept telling me that I would be ready soon, and I am sure she meant well. But when you already feel guilty about being on sick leave, then it feels like pressure, because the doctor says so—and the doctor is an authority figure” (Nielsen et al., 2012).</p>
<p>Challenges</p>	<p>The challenges of symptoms and medication side-effects: Abma et al. (2013); Bertilsson et al. (2012); Haslam et al. (2004); Hjarsbech et al. (2015); Noordik et al. (2011); Sallis and Birkin (2014)</p>	<p>“. . . your productivity really goes down, you worry all the time, you don’t sleep you get up in the morning and you’re worn out its just day after day you’re going down gradually and the amount of work you can do properly is getting less and less and less” (Haslam et al., 2004, p. 207).</p> <p>“There were various mental and physical symptoms that decreased the current working capacity” (Noordik et al., 2011, p. 1628).</p> <p>“... when I was on Prozac . . . it’s like there is a wall there, you can see what you’re doing . . . but you just feel like you’re distant . . . dislocated from everything” (Haslam et al., 2004, p. 209).</p>
	<p>The challenges related to work tasks: Bertilsson et al. 2012; Danielsson (2017a) and (b); Hjarsbech et</p>	<p>“...feeling stuck between wanting to perform better and not being able to do anything, caught up in a self-repeating pattern” (Danielsson, 2017a, p. 7).</p> <p>“To perform at work was described by some participants as an inner demand, as something</p>

	<p>al. (2015); Moll et al. (2013); Noordik et al. (2011);</p> <p>Sallis and Birkin (2014)</p>	<p>they were compelled to do. Furthermore, the work performance had to be “good enough”. This inner demand was considered to be as demanding as the work itself; if the performance did not reach this personal standard it influenced self-confidence negatively” (Bertilsson et al., 2012, p.1708).</p> <p>“Disrupting work place order or created chaos or being a spanner in the workplace or ‘messaging things up” (Bertilsson et al., 2012, p.1708).</p> <p>“Instead of me doing what I am supposed to do, create clarity, bring order, plan, I created chaos instead... I forgot to arrange for temporary staff. I make a mess of things instead of me doing something well” (Bertilsson et al., 2012, p.1708).</p> <p>“Not being in control of workloads and not knowing what work tasks or demands might ensue were perceived to make it more difficult to remain in work with the symptoms” (Sallis & Birkin, 2014).</p>
	<p>The challenges related to the work environment.</p> <p>Bertilsson et al. (2012); Danielsson et al. (2017a); Hjarsbech et al. (2015); Moll et al. (2013); Nielsen et al. (2012); Noordik et al. (2011); Sallis & Birkin (2014)</p>	<p>Some experienced a strange visual sensation while trying to focus on another person or a computer screen. This was sometimes accompanied by a swaying feeling. The physical sensations were scary and led them to a focus on the body, which made it difficult to focus outwards and to work. (Bertilsson et al., 2012, p.1707)</p>

Consequences	<p>The psychosocial consequences:</p> <p>Danielsson (2017a); Nielsen et al. (2012); Sallis and Birkin (2014)</p>	<p>“I felt that whatever I previously achieved in my career was just a fluke, that I didn’t deserve to be the grade I didn’t even deserve to have anyone thinking anything other than I wasn’t very good at my job, that I was just kind of wasting my time being in work, and that whatever kind of personal or policy success that I’d had up till now I was never ever going to have again” (Sallis & Birkin, 2014, p.473).</p> <p>“There was also the guilt factor as well; that I knew I wasn’t pulling my weight within the team, being able to contribute as much I would like...makes you feel even worse” (Sallis & Birkin, 2014, p. 472).</p>
	<p>Negative Coping Strategies:</p> <p>Abma et al. (2013); Bertilsson et al. (2012); Danielsson, (2017a) and (2017b); Moll et al. (2013); Haslam et al. (2004); Hjarsbech et al. (2015); Nielsen et al. (2012); Noordik et al. (2011); Sallis and Birkin (2014)</p>	<p>“They needed distance from others’ input; as described by one participant, “I’m going into my cave to dive into my work and be left alone” (Danielsson et al., 2017a, p6).</p> <p>“...difficulty in slowing down the work pace and checking their own actions frequently, taking over responsibilities or putting in extra effort” (Noordik et al., 2011).</p> <p>“Concealment meant working hard to disguise current or past experience with mental illness, and to project an image of competence at work” (Moll et al., 2013, p.171).</p>

		<p>“Not knowing what to expect at work and thinking of returning to a similar or worse situation to that which preceded sick leave discouraged participants from going to work (Sallis & Birkin, 2014, p.476).</p> <p>The participants described that they put on a facade, a shell or a costume on “bad days”. With this facade, they could continue working but felt closed off, less flexible and performed tasks mechanically (Bertilsson et al., 2012, p.1708).</p>
Promoters	<p>Organisational and peer level of support:</p> <p>Abma et al. (2013); Bertilsson et al. (2012); Hjarsbech et al. (2015) ; Nielsen et al. (2012) ; Noordik et al. (2011); Sallis and Birkin (2014).</p>	<p>“Supportive communication. useful . . . [I] agreed with . . . my psychologist . . . and a new supervisor . . . to make a schedule for taking pauses during the days I have to work [and] . . . that I have to take the pauses at the scheduled times [and] . . . write down . . .” (Noordik et al., 2011, p.1630).</p>
	<p>Individual intelligence strategies :</p> <p>Bertilsson et al. (2012); Nielsen et al. (2012); Sallis and Birkin (2014)</p>	<p>“All participants described that they had cut down on leisure and social activities in order to have sufficient energy to manage work. This was experienced as a trade-off” (Bertilsson et al., 2012, p.1708).</p> <p>“Some have used the positive side of good work functioning to refuel in their work, which served as a springboard for maintaining their work functioning. Nevertheless, for some their current reduced work functioning meant that they are not able to use positive work functioning to refuel,</p>

		which further reduces their work functioning” (Bertilsson et al., 2012).
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APPENDICES: SUPPORTING DOCUMENTS

Appendix 4.1 Ethics Application Form

Faculty of Health and Medicine Research Ethics Committee (FHMREC)

Lancaster University

Application for Ethical Approval for Research

for additional advice on completing this form, hover cursor over 'guidance'.

Guidance on completing this form is also available as a word document

Title of Project The experiences of depression among older workers

Name of applicant/researcher: Toyin Adewunmi

ACP ID number (if applicable)*:

Funding source (if applicable)

Grant code (if applicable):

***If your project has *not* been costed on ACP, you will also need to complete the Governance Checklist [\[link\]](#).**

Type of study

APPENDICES: SUPPORTING DOCUMENTS

Involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants. **Complete sections one, two and four of this form**

Includes *direct* involvement by human subjects. **Complete sections one, three and four of this form**

SECTION ONE

1. Appointment/position held by applicant and Division within FHM PhD

Student in Organisational Health and Wellbeing

2. Contact information for applicant:

E-mail: t.adewunmi@lancaster.ac.uk

Telephone:

07900195138 (please give a number on which you can be contacted at short notice)

Address: 31 St Georges Close London SE28 8QE

3. Names and appointments of all members of the research team (including degree where applicable)

Toyin Adewunmi Independent Occupational Health and Wellbeing Specialist,
Registered General Nurse, BSc (Hons) Occupational Health Nursing, Certificate
in Leadership and Management

PhD Student

Director, Essential Workplace Health and Wellbeing Ltd

3. If this is a student project, please indicate what type of project by marking the relevant box/deleting as appropriate: (please note that UG and taught

APPENDICES: SUPPORTING DOCUMENTS

masters projects should complete **FHMREC form UG-tPG**, following the procedures set out on the FHMREC website

PG Diploma Masters by research PhD Thesis PhD Pall. Care PhD Pub. Health PhD Org. Health & Well Being PhD Mental Health MD DClinPsy SRP [if SRP Service Evaluation, please also indicate here:] DClinPsy Thesis

4. Project supervisor(s), if different from applicant: Dr Michaela Edwards and Dr Alison Collins

5. Appointment held by supervisor(s) and institution(s) where based (if applicable):

Dr Michaela Edwards Lecturer in Organisational Health and Wellbeing
Lancaster University, Department: Health Research
Tel: +44 (0)1524 594024
m.edwards1@lancaster.ac.uk

Dr Alison Collins- Lecturer
Lancaster University, Department: Health Research
Tel: +44 (0)1524 594852
a.m.collins@lancaster.ac.uk

SECTION TWO

Complete this section if your project involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants

1. Anticipated project dates (month and year)

APPENDICES: SUPPORTING DOCUMENTS

7a. How will you share and preserve the data underpinning your publications for at least 10 years e.g. PURE?

7b. Are there any restrictions on sharing your data?

8. Confidentiality and Anonymity

a. Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications? yes

b. How will the confidentiality and anonymity of participants who provided the original data be maintained?

9. What are the plans for dissemination of findings from the research?

10. What other ethical considerations (if any), not previously noted on this application, do you think there are in the proposed study? How will these issues be addressed?

SECTION THREE

Complete this section if your project includes *direct* involvement by human subjects

1. Summary of research protocol in lay terms (indicative maximum length 150 words):

Demographic changes in industrialised nations such as an increasing older population and a declining younger population along with Government reforms are resulting in increasing number of older workers (OWs) as exemplified in the workforces of the United Kingdom, United States and the Netherlands. Consequently, work participation among OWs is becoming increasingly crucial to sustaining the economy in developed nations. Additionally, several literatures have reported the increasing prevalence of depression across the working population and the dyadic impact of

APPENDICES: SUPPORTING DOCUMENTS

depression on OWs. However, despite the highlighted issues, previous studies are predominantly quantitative in nature and are mainly focused across the entire working population. Underpinned by the Heathy Workplaces Model and Framework (Burton, 2010), the empirical study for this PhD aims to explore OWs experiences of depression. The research question for this study is, “What are the experiences of OWs who have had depression?” Based on qualitative approach, 20-24 participants will be recruited and interviewed with a view of thematically analysing the data. It is hoped that this study will inform occupational health practices and workplace policies.

2. Anticipated project dates (month and year only)

Start date: May 2017 End date December 2019

Data Collection and Management

For additional guidance on data management, please go to Research Data Management webpage, or email the RDM support email: rdm@lancaster.ac.uk

3. Please describe the sample of participants to be studied (including maximum & minimum number, age, gender):

Inclusion Criteria

Male and female UK-based OWs who are ≥ 50 years and have had previous diagnosis of depression, and have been recovered for at least three months will be included.

OWs who had depression along with other common mental disorders (CMD) such as anxiety will also be included.

Male and female individuals aged ≥ 50 years who experienced depression at ≥ 50 years, when still in work but are no longer in employment will also be included.

Determining the participants’ depression status will be by self-reports. To assess the individuals’ eligibility, the following two questions will be asked to participants after consenting but before the interview: Are you currently clinically diagnosed as depressed? If “No”, for how long have you been symptom-free?

APPENDICES: SUPPORTING DOCUMENTS

Exclusion Criteria

Those who are currently experiencing depression; male and female aged ≥ 50 years but diagnosed with depression along other mental health conditions other than anxiety; male and female workers that are diagnosed with depression but < 50 years.

Those who meet the inclusion criteria but are not based in the UK; non-English speakers who meet the inclusion criteria will be excluded due to issues with communication; male and female workers that are ≥ 50 years but did not experience depression when in employment and are no longer in employment; those who have not recovered from depression for at least three months.

The researcher's (former or current) patients will be excluded.

Due to issues with communication, non-English speakers who meet the inclusion criteria will be excluded. Those who are currently depressed and those who have not recovered for at least three months will be excluded.

4. How will participants be recruited and from where? Be as specific as possible.

Ensure that you provide the *full versions* of all recruitment materials you intend to use with this application (e. g. adverts, flyers, posters).

Following an ethical approval from Lancaster University, the 'Participants' Information Sheet (PIS), the project flyer, the 'Expression of Interest' (EOI) form together with the covering letter will be strategically posted to the various settings stated above (See Section 3.4 - Ethics Application). A hashtag - #Olderworkersexperiencesofdepression will be shared via professional social media platforms. The identified recruitment documents will serve the following purposes: the provision of information to the public; and the provision of the researcher's contact details. An indication of individual's interest through the EOI form or an email will precipitate individual discussion to confirm eligibility, clarify any questions about the study and obtain demographic details (Bell, 2005) (See Appendix 4.6). A consent form

APPENDICES: SUPPORTING DOCUMENTS

will be sent to the participants after the discussion, with at least twenty-four hours to read and ask further questions before the interview (Offredy & Vickers, 2010).

Following the recruitment, the various settings will be notified that the required number of participants has been reached. Should recruitment be below the size of sample needed after two weeks, the same process indicated above will be followed (Offredy & Vickers, 2010).

Recruiting for the Pilot study. For reliability reasons, the indicative interview schedule will be piloted (Silverman, 2010) with an OW who meets the inclusion criteria. The recruitment strategy indicated above will be utilised. However, the PIS will be employed to inform the participant of the pilot nature together with its aim, and that the data obtained from the pilot interview will be included in the final analysis (See Appendix 4.5).

5. Briefly describe your data collection and analysis methods, and the rationale for their use.

Data collection

As the study participants will be drawn from on-line mental health support forums, Professional FHM Twitter and LinkedIn, it is possible that participants will be spread across the UK. Therefore, to facilitate data collection, it is planned that the interviews will be conducted through a professional SKYPE account or by telephone. The participants will be advised that the interview would need to be conducted within the confines of a room from both ends to allow for privacy during interview.

If participants prefer face-to-face interview, this will be accommodated, provided the participants are locally based. The individual participants will be interviewed over the researcher's professional SKYPE account or designated telephone for up to one hour (Howitt, 2013). Participants using SKYPE will be informed that the internet cannot be guaranteed to be a completely secure means of communication.

APPENDICES: SUPPORTING DOCUMENTS

The participants will be informed through the participant's information sheet they received earlier that the interview will be tape-recorded for future reference and transcription thereby allowing for validity (Howitt, 2013). A reflective journal of the interview will also be kept for quality reasons and future reference.

An in-depth semi-structured qualitative interview with open-ended questions will be flexibly utilised for data collection; this method has the potential for gathering rich data from each participant's experiences (Howitt, 2013). Through asking questions of what the participants say, a critical deconstruction of the OWs words will be made through probing interesting and important areas. To delimit the probable areas of questioning or think of question construction, a pre-constructed interview schedule will be applied flexibly (See Appendix 4.9).

For reliability reasons, the indicative interview schedule will be piloted (Silverman, 2010) on an OW who meet the inclusion criteria. After obtaining ethical approval for the study, a pilot study will be conducted first by recruiting one participant through an online mental health forum such as Elefriend or through face-to-face recruitment from a local supermarket or a GP surgery by posting PIS online through Elefriend, LinkedIn or Twitter or pitching a stand at a local shopping mall. The same PIS prepared for the main study will also be used except that it will include additional information to state that it is a pilot study and that it is aimed at structuring the indicative interview questions for the main participants of the research (See Appendix 4.5). Participants will also be informed that the data obtained from the interview of the pilot study will be used to restructure the interview questions and included in the final analysis. The researcher has talked to the supervisors of this project, and it is clear that the interview questions will change. The questions are indicative and are subject to change. However, these will follow similar themes as identified (See Appendix 4.9). On receipt of the EOI form or an email contact from the participant, a consent form will be

APPENDICES: SUPPORTING DOCUMENTS

given to the candidate, and they will have at least 24 hours to complete the form and return to the researcher.

The data obtained from the interview of the pilot study will be used to restructure the interview questions and included in the final analysis. If any distress arises during the interview, the session may be stopped to allow time for the participant to decide whether or not they can continue (Offredy and Vickers, 2010). If the participant is unable to continue and the participant in distress will be signposted to local mental health support or advised to see their GP as soon as possible. The researcher will notify the project supervisors immediately if serious risk arises. For instance, in the case of planned suicide, the police will be contacted.

The same process will be used for participants that are interviewed by telephone.

Analysis

Braun and Clarke's (2006) six-step model of Thematic Analysis (TA) will be flexibly used to analyse all the study transcripts. The process will be planned from the beginning of the research project, influenced by the researcher's worldview relating to knowledge construction and reality (Bazeley, 2013). For quality reasons, a reflective stance will be adopted, and this would involve keeping a reflective journal (Howitt, 2013).

TA is justifiable because it has no theoretical boundary like IPA (Smith and Osborn, 2003) or grounded theory, and would, therefore, allow for more flexibility when choosing a theoretical framework for the study (Braun and Clarke, 2006). Because of its relatedness to phenomenology, TA seems useful in exploring the study aim and the research question as it focuses on the human experience subjectively (Guest, MacQueen and Namey 2012), which emphasises participant's perceptions, feelings and experiences. TA is also reasonable because it tends to generate research findings, which are readily understood by the general public and policymakers (Howitt, 2013). One of the purposes of this study is to generate knowledge that will be useful to policy development around the topic of study.

APPENDICES: SUPPORTING DOCUMENTS

6. What plan is in place for the storage, back-up, security and documentation of data (electronic, digital, paper, etc.)? Note who will be responsible for deleting the data at the end of the storage period. Please ensure that your plans comply with the Data Protection Act 1998.

Non-audio data

The data will be protected throughout and after the study within the bounds of the (Data Protection Act, 1988). Pseudonyms will be used for participants, and personal details will be separated from all code identified data. Electronic data storage on devices such as USB and laptop will be encrypted, and password protected and only the researcher and supervisors' will have access. Data will be transferred immediately to the encrypted password protected desktop computers, for backup. Following the research project, the electronic copies of transcripts recordings will be stored by the Faculty of Health and Medicine Research Ethics Committee's (FHMREC) guidelines storage of ten years within an encrypted storage on the Lancaster University server. The lead supervisor (Dr Michaela Edwards) of this project will be responsible for data stewardship such archiving and destroying the data. Personal identifiers will be destroyed following the submission of the final thesis.

Hard copy data

Hard copy data such as the field notes will be stored in a secure locked filing cabinet, only accessible to the researcher. As a permanent archive, hard copy data will be scanned and saved electronically by FHMREC's guidelines storage of ten years within an encrypted storage on the Lancaster University server. The information in this section also refers to consent forms and expression of interest forms. This will allow for the information to be retrieved if further evaluation and research is required. Lancaster University Research Data Management Team will be responsible for the deletion of data after 10 years. The researcher has completed the information security training and will also follow the principles of the Data Protection Act (2008).

APPENDICES: SUPPORTING DOCUMENTS

Data will include both the audio recording of the interview and the transcription of these recordings. Transcribers will be required to sign a confidentiality agreement form as part of the contracting process (See Appendix 4.10). Transcription accuracy checks will be made. Thematic analysis will be undertaken using NVivo.

7. Will audio or video recording take place? no audio video

a. Please confirm that portable devices (laptop, USB drive etc) will be encrypted where they are used for identifiable data. If it is not possible to encrypt your portable devices, please comment on the steps you will take to protect the data.

For data management reasons, during transit, following data collection sessions, recorders holding data will be stored securely in a locked container only accessible to the researcher. This will allow for later transcription. Where portable devices such as laptop, USB drive are used for identifiable data such will be encrypted, and password protected. Data on portable non-encrypted devices such as recorder will be deleted as quickly as possible once it has been transferred to a secure medium. The data will be deleted after the report has been examined and published in case the researcher may wish to clarify some areas. Personal identifiers will be destroyed following the submission of the final thesis.

b What arrangements have been made for audio/video data storage? At what point in the research will tapes/digital recordings/files be destroyed?

Following the research project, the electronic copies of anonymised transcripts will be stored by the Faculty of Health and Medicine Research Ethics Committee's (FHMREC) guidelines storage of ten years within an encrypted storage on the Lancaster University server. Lancaster University Research Data Management team will be responsible for destroying the data after ten years.

APPENDICES: SUPPORTING DOCUMENTS

Digital audio recordings will be deleted as quickly as possible once data is transferred to a secure medium. Personal identifiers will be destroyed following the submission of the final thesis.

Please answer the following questions *only* if you have not completed a Data Management Plan for an external funder

8a. How will you share and preserve the data underpinning your publications for at least 10 years e.g. PURE?

In terms of data dissemination, the researcher will seek to publish with open access wherever possible. Data will also be deposited in Lancaster University's institutional data repository (Pure). Lancaster University's data repository (Pure) will be used to hold, manage, preserve and provide access to datasets produced.

8b. Are there any restrictions on sharing your data?

No

9. Consent

a. Will you take all necessary steps to obtain the voluntary and informed consent of the prospective participant(s) or, in the case of individual(s) not capable of giving informed consent, the permission of a legally authorised representative by applicable law? yes

b. Detail the procedure you will use for obtaining consent?

People who indicate their interest to participate will be recruited after the receipt of the EOI form. An individual discussion will take place to ascertain that they meet the inclusion criteria. Obtaining demographic details at this stage will only involve determining participant's depression status will be by self-report. Two questions will be asked to participants after consenting but before the interview to assess whether or not they are currently depressed and if they answer "NO", another question about the timeframe for which they have been asymptomatic will be asked. Those who have been free of depression for at least three months will be included.

APPENDICES: SUPPORTING DOCUMENTS

Further clarifications about any questions concerning the study will be obtained (Bell, 2005) (See Appendix 4.6). A consent form will be sent to the participants after discussion by email, and they will have at least twenty-four hours to read through and ask further questions before the interview (Offredy and Vickers, 2010). Due to the remote nature of the study where obtaining a consent form with an actual signature might be impossible, consent will be obtained at the beginning of the interview, verbally and recorded. Alternatively, the participant's email will be taken as consent.

10. What discomfort (including psychological eg distressing or sensitive topics), inconvenience or danger could be caused by participation in the project? Please indicate plans to address these potential risks. State the timescales within which participants may withdraw from the study, noting your reasons.

This study is not expected to cause participants undue distress or danger. However, as the study will be exploring the experiences of OWs with depression, the possibility of becoming upset during the interview cannot be overlooked, especially if it is linked to work-related issues. Sharing their experiences of depression may bring unhappy memories. To mitigate this, people who have not recovered for at least three months will be excluded from the study. The participants will be informed in the 'Participant's Information Sheet' of the possibilities of these challenges which may arise during and after the interview. Participants will be signposted to local MIND, and OXLEAS mental health support groups (See Appendix 4.5). Participants would be advised to inform the researcher of any distress during the interview. If any distress arises during the interview, the session may be stopped to allow time for the participant to decide whether or not they can continue. This may mean having to reschedule an interview or permanent termination of the interview. Where an interview had to be terminated due to distress, then such participants will be signposted to the local mental health support groups such as MIND, OXLEAS for further support.

APPENDICES: SUPPORTING DOCUMENTS

Potential participants will be informed of their right to withdraw from the study at any point before and during the interview and up until two weeks after the interview because of the challenges associated with retrieving individual anonymised data. Where this timeframe has passed before seeking to withdraw, an effort would be made to retrieve the data. However, it may be difficult to retrieve individual anonymised data after the specified time frame.

11. What potential risks may exist for the researcher(s)? Please indicate plans to address such risks (for example, noting the support available to you; counselling considerations arising from the sensitive or distressing nature of the research/topic; details of the lone worker plan you will follow, and the steps you will take).

The researcher aims to interview via SKYPE or by telephone and as such physical harm to the researcher is not anticipated. However, there may be a potential risk of verbal abuse or due to the distressing nature of the study.

Verbal abuse challenges will be mitigated by terminating the interview without future appointment. If the researcher becomes distressed, there are plans to speak to her supervisors.

Also, should any psychological distress arise from the interviews, the researcher will be able to self-refer to her GP asking to be referred for counselling or access counselling service through the RCN.

Alternatively, if face-to-face interviews are conducted the researcher will take following steps to protect herself:

The researcher might have to travel to local support groups to interview participants. Thus, there is a potential risk of lone working. This will be mitigated by following the University's policy on lone working. This will involve informing the researcher's next of kin, who will be the first point of contact of the field work. The details of the participant concerned including the location, date, time, the expected arrival at the

APPENDICES: SUPPORTING DOCUMENTS

destination, and contact telephone number will be placed in sealed envelope and left with the researcher's next of kin.

The next of kin will only open the sealed envelope if a risk issue arises.

The researcher's next of kin and the researcher's main supervisor will be informed when setting off and on arrival at the location through a telephone call from the researcher. If the researcher's next of kin does not hear from the researcher within forty-five minutes of the expected time frame, the next of kin will ring the researcher to ask of her whereabouts. If there is no response after 30 minutes, the police will be informed. The sealed envelope will be retrieved following the interview.

The rationale for involving the next of kin is that the project supervisors live far away from the researcher, and it might be difficult for them to pick up calls especially if they are lecturing. This has been discussed with the supervisors.

Nevertheless, the researcher's main supervisor will also be kept informed of what is happening, and she would be able to contact the researcher afterwards about her welfare.

12. While we do not generally expect direct benefits to participants as a result of this research, please state here any that result from completion of the study.

There may not be direct benefits to the participants. Nevertheless, participating in the study may be a positive experience for the participants. Policy makers may get a better understanding on the experiences of OWs with depression in the contemporary workplace. This may inform policy development.

13. Details of any incentives/payments (including out-of-pocket expenses) made to participants:

Participants will be incentivised with £15.00 Amazon Voucher / Cash in order to compensate them for their time. Additionally, participants will be reimbursed with up to £7.50 for their travel.

14. Confidentiality and Anonymity

APPENDICES: SUPPORTING DOCUMENTS

a. Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications? yes

b. Please include details of how the confidentiality and anonymity of participants will be ensured and the limits to confidentiality.

Confidentiality

The data will be confidentially stored electronically with password encryption accessible only by the researcher. The hard copy data will be securely locked away and would only be accessible to the researcher. For confidentiality reasons, the transcriber will be asked to complete the confidentiality agreement for data transcription before the data is released for transcription (See Appendix 10).

Since SKYPE interviews are not wholly secure, the researcher will make this clear to participants and will remind them of this at the start of the interview (See Appendix 4.5).

Limit of confidentiality

Participants will be informed of the scope of confidentiality from the outset as this can only be ensured to some extent. For instance, this will involve areas where the ideas expressed by the anonymised participants will be used in publications. Participants will be informed of this limitation using the 'Participants Information Sheet.'

The participants will also be informed that in circumstances where it is apparent that a participant is at significant risk of harm such as self-harm or harm to others, confidentiality will be breached by the researcher through speaking to the project supervisor without obtaining the participant's consent.

Anonymity

The remit of anonymity will be clarified to the research participants at the outset, and participants will be informed of their right to reject the use of data-gathering devices such as tape recorders. When faced with refusal to audio-record during the interviewing, the interview will still proceed without recording. However, permission will be sought to

APPENDICES: SUPPORTING DOCUMENTS

take notes during the interview (Bryman, 2012). This is because it is likely that useful information will be given by the participant (Bryman, 2012). Participants will be reminded that they are welcome to withdraw from the interview up to two weeks after the in interview.

Participants' anonymity will be preserved throughout the audio-recorded data to protect individual identity. This will be ensured by using pseudonyms and the separation of personal details from all code identified data. Pseudonyms will mainly be used during interview, data analysis and publication. As participants will be able to use their personal details on the consent form and demographic details, these data will be kept separate from the interview data, with the personal identifiers. The personal identifiers, that is, the record of pseudonyms that matches the participant's individual details, will be destroyed following the submission of the final report.

15. If relevant, describe the involvement of your target participant group in the *design and conduct* of your research.

After ethics approval, for reliability reasons, the interview schedule will be piloted on one of the participants that meet the inclusion criteria. To delimit the probable areas of questioning or think of question construction, a pre-constructed interview schedule will be applied flexibly to guide the indicative interview questions (See Appendix 4.9). This will allow the researcher to review interview questions where necessary.

The data obtained from the pilot study will be included in the final analysis and used to restructure the interview questions, if necessary.

16. What are the plans for dissemination of findings from the research? If you are a student, include here your thesis.

The anonymised findings of the study will be shared in the researcher's thesis, sent in an email to the study participants and presented at relevant conferences. The findings may be submitted for publication in an academic or professional journal such as textbooks and the Occupational Health and Wellbeing journals. However, publication

APPENDICES: SUPPORTING DOCUMENTS

cannot be guaranteed. The individual results from this study will not be disclosed (Beauchamp and Childress, 2013).

17. What particular ethical considerations, not previously noted on this application, do you think there are in the proposed study? Are there any matters about which you wish to seek guidance from the FHMREC?

As my proposed participants are older workers that might not be computer savvy, will my recruitment strategy gather enough participants?

SECTION FOUR: signature

Applicant electronic signature:

Date

Student applicants: please tick to confirm that you have discussed this application with your supervisor, and that they are happy for the application to proceed to ethical review

Project Supervisor name (if applicable):

Date application discussed

You must submit this application from your Lancaster University email address, and copy your supervisor into the email in which you submit this application

Submission Guidance

1. **Submit the following materials for your study if relevant:**
 - a. **Your full research proposal (background, literature review, methodology/methods, ethical considerations).**
 - b. Advertising materials (posters, e-mails)
 - c. Letters/emails of invitation to participate
 - d. Participant information sheets
 - e. Consent forms

APPENDICES: SUPPORTING DOCUMENTS

- f. Questionnaires, surveys, demographic sheets
- g. Interview schedules, interview question guides, focus group scripts
- h. Debriefing sheets, resource lists

Please note that you DO NOT need to submit pre-existing handbooks or measures which support your work, but which cannot be amended following ethical review. These should simply be referred to in your application form.

1. **Collate the FHMREC form and any relevant materials listed above into a single word document. Submit this document by email to Diane Hopkins**

d.hopkins@lancaster.ac.uk. Before submitting, ensure all guidance comments are hidden by going into 'Review' in the menu above then choosing *show markup>balloons>show all revisions in line.*

2. Submission deadlines:

- ✓ Projects including direct involvement of human subjects [**section 3 of the form was completed**]. The *electronic* version of your application should be submitted to **Diane Hopkins by the committee deadline date**. Committee meeting dates and application submission dates are listed on the FHMREC website. Prior to the FHMREC meeting you may be contacted by the lead reviewer for further clarification of your application. Please ensure you are available to attend the committee meeting (either in person or via telephone) on the day that your application is considered, if required to do so.
- ✓ The following projects will normally be dealt with via chair's action, and may be submitted at any time. [**Section 3 of the form has *not* been completed, and is not required**]. Those involving:

1. existing documents/data only;

APPENDICES: SUPPORTING DOCUMENTS

2. the evaluation of an existing project with no direct contact with human participants;
service evaluations.

Supporting Documents (Note here that you would add the Lancaster University logo at the top of all final versions of supporting documents)

NB Where indicated with * there is a **template on the FHMREC website that you must use** – so download, copy and paste into this assignment document

NB Where indicated as **ESSENTIAL** you **MUST** include this supporting document.

Where indicated as OPTIONAL examples – your supervisors will be able to help you in deciding which if any additional type of documents is needed for your research ethics

Appendix 4.3 OPTIONAL Letter (s)/email (s) of introduction to organisation etc you may be recruiting from OR website introduction to research call etc

Appendix 4.4 OPTIONAL Expression of Interest Form OR website or questionnaire return of interest page etc.

Appendix 4.5 ESSENTIAL Participant Information Sheet

Appendix 4.6 Demographic Details form

Appendix 4.7 ESSENTIAL Consent Form

Appendix 4.8 OPTIONAL Flyer OR other publicity

Appendix 4.9 ESSENTIAL – Qualitative research: Interview Topic Guide

Appendix 4.10 Confidentiality Agreement for Transcription form (Not required)

APPENDICES: SUPPORTING DOCUMENTS

Appendix 4.2a The First Ethics Approval



Applicant: Toyin Adewunmi
Supervisor: Michaela Edwards
Department: Health Research
FHMREC Reference: FHMREC16074

15 August 2017

Dear Toyin

Re: An exploration of older workers' (OWs) experiences of depression.

Thank you for submitting your research ethics application for the above project for review by the **Faculty of Health and Medicine Research Ethics Committee (FHMREC)**. The application was recommended for approval by FHMREC, and on behalf of the Chair of the Committee, I can confirm that approval has been granted for this research project.

As principal investigator your responsibilities include:

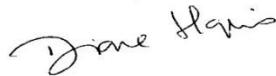
- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer at the email address below (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact me if you have any queries or require further information.

Tel:- 01542 592838

Email:- fhmresearchsupport@lancaster.ac.uk

Yours sincerely,



Dr Diane Hopkins
Research Integrity and Governance Officer, Secretary to FHMREC.

APPENDICES: SUPPORTING DOCUMENTS

Appendix 4.2b The second Ethics Approval



Applicant: Toyin Adewunmi
Supervisor: Michaela Edwards
Department: Health Research
FHMREC Reference: FHMREC18011

07 November 2018

Dear Toyin

Re: The experiences of depression among older workers

Thank you for submitting your research ethics amendment application for the above project for review by the **Faculty of Health and Medicine Research Ethics Committee (FHMREC)**. The application was recommended for approval by FHMREC, and on behalf of the Chair of the Committee, I can confirm that approval has been granted for the amendment to this research project.

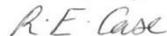
As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer at the email address below (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact me if you have any queries or require further information.

Tel:- 01542 593987
Email:- fhmresearchsupport@lancaster.ac.uk

Yours sincerely,



Becky Case
Research Ethics Officer, Secretary to FHMREC.

APPENDICES: SUPPORTING DOCUMENTS

Appendix 4.3 Introductory or Covering Letter

I'm getting in touch regarding a research project I am conducting as part of my PhD in Organisational Health and Wellbeing. I would like to interview UK-based older workers, those who are aged ≥ 50 years and have experienced depression in the past.

I would value your experiences on this project, which aims to explore older workers experiences of depression. Understanding the experiences of older workers with depression will inform organisational and national policies on these topics. I would be delighted if I could take 60 minutes of your time to conduct an interview over SKYPE and get your perspective.

I am interested in understanding your experiences of depression, your beliefs and attitude about yourself before and after experiencing depression as well as the role of workplace culture and intervention in your experiences of depression.

I can arrange to discuss at a time that suits you, so please let me know if you have availability to meet over the coming couple of weeks. Please see the accompanying 'Participant's Information Sheet' for more detailed information. If you would like to participate, kindly complete the 'Expression of Interest' form and return to me through the email provided.

Alternatively, if you know, anybody else who might be interested in this project kindly pass the researcher's details to them.

Kind regards,

Toyin Adewunmi

APPENDICES: SUPPORTING DOCUMENTS

Appendix 4.4 Expression of Interest Form

An exploration of older workers' experiences of depression

I have read and understood the 'Participation Information Sheet'. I am interested in taking part in this research.

Kindly complete this form indicating whether or not you would like to take part in the study. *

- I wish participate in the study
- I do not wish to participate in the study

Please complete the following but only provide contact details that you are happy to share:

Name: _____

Contact:

Mobile phone:

Email:

Home phone:

Work phone:

Kindly return this form by email to the researcher via the email address provided below, who will contact you to discuss the project, and answer any questions you may have about the research.

Researcher's contact details:

Name: Toyin Adewunmi, PhD Student, Lancaster University

Email: t.adewunmi@lancaster.ac.uk

Tel: 07465099232

***Tick the appropriate box**

APPENDICES: SUPPORTING DOCUMENTS

Appendix 4.5 Participant Information Sheet

Study Title

An exploration of older workers' experiences of depression

My name is Toyin Adewunmi, and I am PhD student in Organisational Health and Wellbeing at Lancaster University, Lancaster, United Kingdom.

What is the study about?

The purpose of this study is to explore older worker's experiences of depression: how depression affected older workers WF, work attendance, and the impact of workplace culture and support.

This study is important because statistics show that the number of older workers is increasing because of an ageing population. Studies have shown that depression is increasing across all working age groups with older workers being more vulnerable due to work participation issues. Many quantitative studies have investigated the impact of depression across the entire working age groups and among older workers. However, to date, few qualitative studies have sought to explore the issue among older workers. Insufficient studies on the experiences of older workers who have suffered from depression means that it might be challenging for policy makers, organisations and managers to understand older worker's perspectives. Therefore, it might be difficult to earmark meaningful, supportive measures for older workers health and wellbeing.

Up to twenty-four male and female UK-based older workers aged ≥ 50 years that have previously experienced depression will be interviewed on a one to one basis.

Why have I been approached?

You have been approached because the study requires information from older workers. Additional criteria for participating in the study include being a UK-based older worker and recovery from depression for at least three months.

APPENDICES: SUPPORTING DOCUMENTS

Do I have to take part?

No. You have total control over your decision to participate or not. You will not be disadvantaged in any way if you choose not to take part. Should you change your mind about participating, you will be able to freely withdraw from the study up to two weeks after the interview.

You will have the right to withdraw from the study at any point before and during the interview and up until two weeks after the interview. Where this timeframe has passed before seeking to withdraw, an effort would be made to retrieve the data. However, it may be difficult to retrieve individual anonymised data after the specified time frame.

What will I be asked to do if I take part?

If you decide you would like to participate, you will be invited to give consent to take part in a 45- 60 minute interview with the researcher either over a professional SKYPE account, telephone, or face-to-face. Your consent will also cover the use of your anonymised data along with other data to document the research findings. At the interview, you will be asked questions about your experiences of depression as an older worker, the role of workplace culture and intervention in your experiences of depression.

Please be aware that when using SKYPE, the internet cannot be guaranteed to be a completely secure means of communication.

Will my data be Identifiable?

Your data will be anonymised to protect individual identity. This will be ensured by removing personal details from all reports and publications and by using pseudonyms in reports.

Will my data be confidential?

The collected data will be stored securely, and only the researchers conducting this study will have access to this data. All data (electronic and audio) collected for this study will be saved on encrypted password protected storage and only accessible by the researcher.

APPENDICES: SUPPORTING DOCUMENTS

After data transcription and the final report submission, the anonymised data will be archived for 10 years in accordance with the Faculty of Health and Medicine Research Ethics Committee's (FHMREC) storage guidelines within an encrypted storage on the Lancaster University server. Hard copies of the data will be securely locked in cabinet only accessible to the researcher.

The typed version of your interview will be made anonymous by removing any identifying information including your name. Anonymised direct quotations from your interview may be used in the reports or publications from the study, but your name will not be attached to them. Your organisation will not be identified in any communications.

There are some limits to confidentiality: if what is said in the interview makes me think that you or someone else is at significant risk of harm, I will have to break confidentiality and speak to my supervisor about it. If possible, you would be informed if the researcher must do this.

What will happen to the results?

The results will be summarised and reported in a thesis and may be submitted for publication in an academic or professional journal.

Are there any risks?

There are no risks anticipated with participating in this study. However, with the nature of the topic, there is a possibility of becoming distressed during the interview. Sharing your experiences of depression may bring unhappy memories. If you experience any distress during or following participation, you are encouraged to inform the researcher so that appropriate action can be taken.

This may include stopping the interview for some time and continuing if possible. This might mean having to reschedule your interview or a permanent termination of the interview. Where an interview had to be terminated due to distress, then you will be signposted to the local MIND, OXLEAS and mental health support groups for further support or your GP.

In cases of immediate and serious risk of harm, the police may be notified immediately.

The resources provided at the end of this sheet can also be contacted.

APPENDICES: SUPPORTING DOCUMENTS

If you are privately interviewed over a professional SKYPE account, other participants will not be aware of your participation in this study.

“Participants using SKYPE should be aware that the internet cannot be guaranteed to be a completely secure means of communication”.

Are there any benefits to taking part?

You may find participating to be a positive experience. Organisations and policy developers might have the opportunity to get a better understanding of how older workers experience depression thereby informing the required support strategy.

To compensate you for your time, you will be incentivised with £15.00 Amazon Voucher / Cash. Additionally, participants will be reimbursed with up to £7.50 for their travel.

Who has reviewed the project?

This study has been reviewed and approved by the Faculty of Health and Medicine Research Ethics Committee.

Where can I obtain further information about the study if I need it?

If you have any questions about the study, please contact the main researcher:

Toyin Adewunmi

t.adewunmi@lancaster.ac.uk

Research Tel. No: 07465099232

Complaints

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:

Professor Carol Holland

Professor in Ageing Health Research

Faculty of Health and Medicine

Department: Health Research

APPENDICES: SUPPORTING DOCUMENTS

Lancaster University

Lancaster LA1 4YD

Tel: +44 (0)1524 510436

c.a.holland@lancaster.ac.uk

Professor Roger Pickup Tel: +44 (0)1524 593746

Associate Dean for Research Email: r.pickup@lancaster.ac.uk

Faculty of Health and Medicine

(Division of Biomedical and Life Sciences)

Lancaster University

Lancaster LA1 4YG

Thank you for taking the time to read this information sheet.

Resources in the event of distress

Should you feel distressed either as a result of taking part or in the future, the following resources may be of assistance.

- Your GP
- For participants in the London area - OXLEAS NHS Trust

<http://oxleas.nhs.uk/services/service/south-london-counselling-servi/>

Address: 6 Eltham Road, Lee Green, London SE12 8TF

Tel: 0208 852 3400 / Mobile – 07957630187

- Support from MIND <http://www.mind.org.uk/information-support/helplines/> Tel:
0300 123 3393

APPENDICES: SUPPORTING DOCUMENTS

Appendix 4.6 Demographic Details Form

ID Code:

Region (UK):

Gender: M

F

Age:

Marital status: Single

Married

Cohabitant

Divorced

Background Information

A. Diagnosis: Please tick as appropriate:

Are you currently clinically diagnosed as depressed?

Yes

No

If "Yes", for how long have your symptoms stabilised?

Was this your first diagnosis of depression?

Yes

No

Were you diagnosed with other mental health conditions

Yes

No

B. Work / Employment sector

What was your job title at the time of your depression?

Which of these sectors do you work? Public sector

Private sector

Own company

For how long have you worked in this sector/role?

C. Job classification:

Under which of the following would you classify your role when you experienced depression: Please circle as appropriate:

Managers

Professionals

Technicians and associate professionals

Clerical

Support workers

Services and sales workers

Plant and machine operators and assemblers

Elementary occupations

APPENDICES: SUPPORTING DOCUMENTS

Appendix 4.7 Consent Form

Study Title: Older Workers Experiences of Depression

We are asking if you would like to take part in a research project to explore the experiences of older that have had depression: how does depression affect older workers' daily activities including work performance, and how supportive are colleagues, managers and policies, how easily accessible are the workplace support and interventions and how useful and helpful are workplace interventions? Before you consent to participate in the study, we ask that you read the participant information sheet and mark each box below with your initials if you agree. If you have any questions or queries before signing the consent form, please speak to the researcher, Toyin Adewunmi.

Please initial each statement

1. I confirm that I have read the information sheet and fully understand what is expected of me within this study	
2. I confirm that I have had the opportunity to ask any questions and to have them answered.	
3. I understand that my interview will be audio-recorded and then made into an anonymised written transcript.	
4. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected; and my data up to 2 weeks after the interview.	
5. I understand that once my data have been anonymised and incorporated into themes, it might not be possible for it to be withdrawn,	

APPENDICES: SUPPORTING DOCUMENTS

though every attempt will be made to extract my data, up to 2 weeks after the interview.	
6. I understand that the information from my interview will be pooled with other participants' responses, anonymised and may be published	
7. I consent to information and quotations from my interview being used in reports, conferences and training events.	
8. I understand that any information I give will remain anonymous unless it is thought that there is risk of harm to myself or others, in which case the researcher may need to share this information with her research supervisor	
9. I consent to Lancaster University keeping audio and written transcriptions of the interview for 10 years after the study has finished.	
10. I consent to take part in the above study.	

Name of Participant _____ Signature _____ Date _____

Name of Researcher _____ Signature _____ Date _____

Note: It's completely up to you to decide whether you take part. You will not be disadvantaged in any way if you choose not to take part. If you change your mind about taking part, you can freely withdraw from the study up to two weeks after the interview.

APPENDICES: SUPPORTING DOCUMENTS

Appendix 4.8 Project Flyer



Lancaster University

Research Project

***Older workers'
experiences of depression in
the contemporary workplace***

Are you aged 50 years or above, currently working in the UK and have previously experienced depression? If so, we would like to hear from you!

What is the research about?

This study will explore the older workers experiences of depression. We are interested in your experiences of depression in the contemporary workplace. Participation is voluntary. Your details will be kept confidential. Any information you provide will be anonymised.

What would be involved?

- Taking part in a SKYPE or telephone interview (approx. 60 minutes).
- Sharing your experiences (benefits and challenges) of being an older worker who had depression.

What are the benefits of taking part?

- Our findings will help organisations to better support the needs of older workers with depression.

Interested in participating? For more details please call or email

Toyin Adewunmi / 07465099232 / t.adewunmi@lancaster.ac.uk

APPENDICES: SUPPORTING DOCUMENTS

Appendix 4.9 Indicative Interview Schedule

Semi-structured Indicative Interview Schedule with older Workers who have had depression

Introduction

Thank you for agreeing to participate in this study which is about exploring the experiences of older workers who have had depression

SECTION ONE: OPENING QUESTION

1. I would like to start by asking you to tell me about your current role. Prompts: role title, location, work sector, i.e. Education, Health, and key activities of your role? For how long have you worked in this sector/role?
2. How would you describe yourself as a person? Prompts: How do you feel about work? Do you enjoy your work? Prompt: why?

SECTION TWO: DEPRESSION QUESTIONS

1. What were your general experiences of depression since age 50 and above?
2. In your experience, what does it mean to be depressed at age 50 and as an older worker? Physically, emotionally, mentally, socially, and career-wise.
3. What were your symptoms like? Probes: how did you relieve your symptoms?
4. How did you address your depression? Prompts: talking to others about your diagnosis, family members, friends and colleagues?
5. How was your depression treated? What was the opinion of your GP or psychiatrist or counsellor about your depression? Medication etc
6. How did depression affect your everyday life? Prompt: getting out of bed, eating, doing your normal chores, sleeping.
7. What made your depression better? What made it worse?

APPENDICES: SUPPORTING DOCUMENTS

Questions to use for probing: Can you tell me more about that? Did anything else happen? Can you give an example

SECTION THREE: WORKPLACE CULTURE AND THE WORK ENVIRONMENT

1. What led to or contributed to your depression?
2. How did depression affect you as an older worker and vice versa? Symptoms, medication side-effects, functioning, attendance
3. About work, how did you address your depression and its impact? Prompts: work functioning, attending appointments, disclosure.
4. How would you describe a normal day at work?
5. What are your experiences when it comes to disclosing your depression to your employer/manager/supervisor/colleagues? Prompt: How did this disclosure go? What were their reactions?
6. What aspect of your work and work-environment gives you the most challenge? Prompt: physical? Psychological? Psychosocial? Or all? In your experience, what makes these aspects challenging? What do these mean to you?
7. How did you cope at work/ with work? Prompts: What helped you to cope at work?
8. How do you feel that your age or gender have influenced your experience of depression? Symptoms, Impact on work, Duration of recovery, organisational support
9. Do you think about the future much? What do you think about it? Prompts: continuing to work, retirement

SECTION FOUR: WORKPLACE INTERVENTION AND OCCUPATIONAL HEALTH

1. Overall, what was your experience of organisational input during the depression? Prompt: What is your experience about how your organisation supports OWs with depression? Any clear process to follow?
2. What was your experience with your line manager's input/support during your depression?

APPENDICES: SUPPORTING DOCUMENTS

3. What workplace support did you receive for your depression? Prompt: What did it feel like to receive workplace support? How beneficial did you find it? (My thoughts - Did you feel it was just a tick box exercise)
4. Which of the workplace support did you find most beneficial?

SECTION FIVE: CLOSING QUESTIONS

Preamble: We have now come to the end of the session. Thank you for talking to me today. In concluding, can I check if there is:

1. Anything else you would like to tell me today? Prompts: About what's important to you.
2. Anything you would like to ask me today? Prompts: about the interview

You will be able to withdraw from the interview up to two weeks after the interview. After this period retrieving your information could be difficult as analysis would have commenced. However, every effort will be made to remove your information at your request. If you feel psychologically distressed by participating in this study, you can access the local MIND, OXLEAS mental health support group for further support.

Appendix 5.1 Descriptive themes from the pilot study

Pre-diagnosis	Barriers to work participation	Impact of impaired WF	Determination	Nondisclosure issues	Workplace support	Coping / facilitators of recovery	Cause of depression	of	Financial/social impact
Workaholic	Work function issues	Danger to patients/society	Initially – Determination to resign	Fears stigmatisation	Communication with manager and colleagues	Work	Separation and abuse from partners	and	Negatively impacts on low mood
Lived with her partner and children	Unstable symptoms	Danger to self	Re-enter the world of works	Fears job loss	Support from colleagues	Music and family	Overworking		Compounded by a difficulty to secure a job
Introvert	Poor concentration	Health and safety issue on the roads	To regain nursing registration	Selective information about depression to manager and colleagues	Referral to OH - unhelpful		Single parenting and breadwinner for the family		
	Lack of motivation	Job loss	To recover		Strained relationship with colleagues				
	Repeated sickness absence	Loss of earnings	An expectation of re-entering her nursing career		Accessibility issues (OH)				

Appendix 5.2 Example of NVIVO Coding

Name of code: Organisation's reaction following disclosure

<Files\\Amanda Transcript.> - § 2 references coded [2.22% Coverage]

Reference 1 - 0.63% Coverage

¶149: Erm, you know, I can't remember what else I said. Erm, and she set up a meeting with HR and she didn't attend it herself, her boss attended it, that was the Director, erm and they met with me to do a work-related stress questionnaire or something like that

Reference 2 - 1.59% Coverage

¶195: Erm, I don't, I suppose if I'm honest it always made me think that after that none, neither of them ever said to me, Amanda how're you feeling now? Are you okay? Neither of them ever said anything further after that meeting but I, you know, it was, they were good people and erm, you know, but I did observe that I did think, yeah, we had a chat and that seemed to be it. We're all in the same boat, we never know, we can't ask after other people's dilemma all the time. So, I wasn't particularly judgemental about that but because I'm mentioning it, you could see that (giggles) it's just the fact. They never actually again allude to it.

<Files\\Craig Transcript> - § 1 reference coded [0.53% Coverage]

Reference 1 - 0.53% Coverage

¶121: And that is why they put in place, you know, the things for me. You know, they put. When I started, I disclosed in the application that I had a mental health issue at the time.

<Files\\Gill Transcript> - § 3 references coded [1.30% Coverage]

Reference 1 - 0.48% Coverage

¶158: Yes, I spoke to one of the managers erm, and she was very sympathetic, and he said if I needed time off, I must take it.

Reference 2 - 0.36% Coverage

¶158: I must look after myself, if there is anything she could do, erm I should let her know.

Reference 3 - 0.47% Coverage

¶158: And she said she had to tell the HR people, she felt there might be something else they could help me and support me

<Files\\Grace Transcript> - § 1 reference coded [0.43% Coverage]

Reference 1 - 0.43% Coverage

¶138: Erm, and as I said, where I work now, they are fully aware that I take medication for this and that I'm stable and they accept me for who I am.

Appendix 5.3 Example of the Coding Process

Overarching Theme	Sub-Themes (final)	Sub-Theme	Codes	Extract
Disclosure and non-disclosure among OWs	The negativity of depression	The meaning given to diagnosis and the symptoms of depression	Being unaware of depression Being ignorant of depression Seeking diagnosis	<p><Files\Anna Transcribed data> - § 5 references coded [1.89% Coverage] Reference 1 - 0.59% Coverage It wasn't until that point that I realised where I actually was. And when I spoke to the Dr at the hospital, they asked me if I had been under any pressure or stress at all. And when I explained to them what was happening that I feel dark, no energy, I've got no laughter or engagement in things</p> <p><Files\Colin Transcript> - § 5 references coded [1.78% Coverage] Reference 1 - 0.40% Coverage You know, you don't know you're depressed at the beginning</p> <p><Files\Louise Transcript> - § 1 reference coded [0.43% Coverage] Reference 1 - 0.43% Coverage</p>
		The psychological impact of diagnosis	Fear of being diagnosed The shock of being diagnosed	
	The influence of organisational culture on disclosure	Disclosure is harmful	OW's perception of what it means to be depressed (stigma, shameful)	
		Disclosure is harmless	Negative perception about self	
	The art of hiding depression	The vulnerability of disclosure	Psychological impact of diagnosis	
		Age and disclosure of depression	Disclosure can't be trusted	

		<p>The vulnerability of disclosure</p>	<p>Negative perception about the link between age and psychological symptoms</p> <p>Age and depression don't mix</p> <p>Depression as an OW is taboo</p> <p>Negative perception about gender and depression</p> <p>Vulnerability to job loss</p> <p>Negative impact of depression</p> <p>OW's perception of disclosure to line manager</p> <p>OW's perception of vulnerability to job loss</p> <p>Opening up to others is challenging</p> <p>Depression is a consequence of poor work culture</p> <p>Reason for not seeking medical help</p> <p>Nondisclosure have consequences</p> <p>Benefit of being at an older age</p>	<p>And erm, I got all the symptoms that I explained to you before, erm. I went to see my GP and I was diagnosed of having depression (Line 54).</p> <p><Files\Amanda Transcript.> - § 1 reference coded [0.33% Coverage] Reference 1 - 0.33% Coverage</p> <p>Now, I'm not blaming anyone on that because if I had turned to someone and said look, I need support, I would have probably got it (line 372).</p> <p><Files\Mat Transcript> - § 1 reference coded [0.36% Coverage] Reference 1 - 0.36% Coverage</p> <p>But also, coming from me I think I'll be quite weary of the consequences of having to open up (Line 229).</p> <p><Files\George Transcript> - § 3 references coded [1.00% Coverage] Reference 1 - 0.52% Coverage</p> <p>At first, they were not sure of what it was they thought could it be depression. But been diagnosed with depression was a shock to me (Line 62).</p> <p><Files\Kyle Transcript> - § 2 references coded [1.08% Coverage] Reference 1 - 0.58% Coverage</p> <p>Yes, yes, yes, because I was the oldest person in the office. most of my colleagues are a lot younger than</p>
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			<p>Negative perception about how organisations address mental health</p> <p>Mixed feeling of disappointment and embarrassment following diagnosis</p>	<p>myself so that also made me also feel a bit worthless (Line 290).</p> <p><Files\\Ben Transcript data 2> - § 6 references coded [2.19% Coverage] Reference 1 - 0.55% Coverage Erm, it would be nice to have a little, erm but because of the stigma of mental health, it is a terrible thing (Line 226). Reference 2 - 0.56% Coverage until a day that this stigma or people start to not, not put people down because of their mental health condition (Line 236). Reference 5 - 0.21% Coverage and Reference 6 - 0.27% Coverage</p> <p>Its just the security of jobs or workers older workers, just the everything in general in relation to the erm, the stigma of mental health, it needs to be taken to the government. To stop stigmatizing people with depression, you know (I- the stigma) the stigma, the stigma, which is the most awful thing (Line 250).</p> <p><Files\\Kyle Transcript> - § 4 references coded [2.14% Coverage] Reference 1 - 0.51% Coverage</p> <p>100-percent taboo definitely taboo. At times I feel a little bit shameful it was definitely taboo you</p>
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				<p>couldn't sit there for very long time (Line 86).</p> <p><Files\\Sandra Transcript> - § 1 reference coded [0.46% Coverage] Reference 1 - 0.46% Coverage</p> <p>It is definitely something, again, the elements of embarrassment that you still have this diagnosis. It was difficult (Line 178).</p>
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Appendix 6.1 A 15-point checklist of criteria for good thematic analysis. Braun and Clarke (2006)

Process	Criteria	Reported in chapter
Transcription	1. The data have been transcribed with an appropriate level of detail, and the transcripts have been checked against the tapes for accuracy.	YES
Coding	2. Each data item has been given equal attention in the coding process.	YES
	3. Themes have not been generated from a few vivid examples (an anecdotal approach), but instead the coding process has been thorough, inclusive and comprehensive.	YES
	4. All relevant extracts for each theme have been collated.	YES
	5. Themes have been checked against each other and against the original data set.	YES
	6. Themes are internally coherent, consistent, and distinctive	YES
Analysis	7. Data have been analysed – interpreted, made sense of - rather than just paraphrased or described.	YES
	8. Analysis and data match each other – the extracts illustrate the analytical claims.	YES
	9. Analysis tells a convincing and well-organised story about the data and topic.	YES
	10. A good balance between analytical narrative and illustrative extracts is provided.	YES
Overall	11. Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over-lightly.	YES
Written report	12. The assumptions about, and specific approach to, thematic analysis are clearly explicated.	YES
	13. There is a good fit between what you claim you do, and what you show you have done – i.e., described method and reported analysis are consistent.	YES
	14. The language and concepts used in the report are consistent with the epistemological position of the analysis.	YES
	15. The researcher is positioned as <i>active</i> in the research process; themes do not just 'emerge'.	YES

Appendix 6.2 An Extract of My Reflexive Journal

I have learnt that research does not exist in a cocoon; it must relate to previous studies and leave a trail for future studies. Thus, my work in this thesis has been connected to existing studies. It has highlighted and filled a research gap on the experiences of OWs with depression. It has considered how other researchers could build on my work by suggesting areas for further studies. I have learnt the importance of planning and indicating timeframes of a project from the outset, allowing room for flexibility. Although this study had many setbacks for various reasons, I was able to recognise and address them appropriately. The need to use a relevant theory in conceptualising and structuring the thesis and selecting a paradigm that fits my study aim provided a template upon which this study was grounded. Aligning my theories with my choice of the analytical tool was also crucial in arriving at findings. I found that my ethics approval was the reference point for quality and ensuring I did what I set out to do. In conclusion, I realised that conducting good research is not enough, but it must be coherently documented to make an impact.

Transcribing my data by myself was a decision that I made from the outset because of its usefulness in bringing me closer to the data. I was able to note useful interpretations that were emerging during transcription. The notes were useful for reference during the coding and analysis stages. Reading and re-reading the transcribed data brought me even closer to the data. It also brought the individuality of every participant out. I had to pay particular attention to similarities and differences in experiences during line-by-line coding and note them down. The data were transcribed one after the other. This approach helped me to scrutinise my data and questioning before interviewing my next participants. It was interesting to see some of the findings that I had noticed in the papers that I selected for my review. Annotating and documenting my thoughts at

every stage was useful as I had a reference point when I was ready to categorise the patterns during the analysis.

It was my first time using NVIVO, and I have had to learn it from scratch. I have found NVIVO particularly useful in organising my data, conducting my line to line coding, and annotating useful observations. It was useful to see how many codes I was able to glean from individual participants. Because I had a lot of codes, organising them was a bit challenging, therefore at some point, I had to first organise the codes manually on paper before trying to replicate it on NVIVO.

As I began to generate themes from codes, I realised that this is a process that took a lot of time because I kept coming back with new themes. Developing the themes became very challenging because there was so much data and they were all crying out for attention. After much consideration and refining themes, I had to revisit my research question and sub-research questions, which eventually helped me to settle for the current themes in this thesis. I realised that it would be practically impossible to use all the data that I have gathered. During my analysis, because I wanted my work to be an interpretive analysis and not just a descriptive one, I began to present theories and existing literature to support my findings. However, I learnt that this approach to data analysis is only acceptable in certain fields. Therefore, I had to separate theories and existing literature from my analysis chapter, which formed part of my thesis discussion section. My findings section are now grounded in data. However, I have ensured that it is still interpretive as much as can be. During the analysis, I realised that numbers and counting are not the focus; every code has been given the same opportunity in the analysis. It does not matter how many people said it.

Being a reflexive qualitative researcher helped me set boundaries between my values and the research process. Ensuring that the analysis's final report is grounded in participants' data was a crucial aspect of the process. My quest for being a responsible and ethical researcher has enabled

me to constantly scrutinise my work, which resulted in constant checking to ensure I did the right thing. The HWFM, although it is a model designed to study organisational health promotion, was adapted to be used on individual experiences. In the beginning, it was my thinking that I might probably abandon it to another theory or model. It took a lot of thinking to arrive at how it could be adapted for exploring individual experiences. However, once I got closer to the model, it became clearer how it could be adapted for individual exploration of experiences. From my literature review, it was clear that no other study has utilised or adapted the model the way it has been used in this study.

Interestingly, having used it for this study, I think it could be adapted, which explains why this has been recommended in Chapter 6. It would be useful to have an organisational model/conceptual framework to anchor a workplace research project. To my amazement, when I started discussing the research findings in Chapter 6, I found that some of the existing literature that I utilised in Chapter 1 were corroborating my findings.

Toyin Adewunmi

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