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# Mental Illness in the Workplace: An Interdisciplinary Review and Organizational Research Agenda

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*Given the prevalence of and consequences associated with mental illness in the workplace, we believe this review is both critical and timely for researchers and practitioners. This systematic review broadens the extant literature in both theoretical and practical ways in an effort to help lay a foundation for the organizational scholarship of employees with mental illness, a group that has traditionally been underrepresented in the management and industrial-organizational psychology literatures. After defining and conceptualizing mental illness as a social identity, we systematically review the existing empirical research on employees with mental illness across multiple fields of study. Using research that accounts for individual, other, and organizational perspectives, we present a model that outlines the performance, employment, career, and discriminatory outcomes that characterize the experiences of individuals with mental illness as well as individual and organizational strategies that moderate the relationship between having a mental illness and experiencing those outcomes. Together, this article provides a synthesis of what is known about employees with mental illness while also highlighting avenues for future scholarly attention.*

**Keywords:** *diversity/gender; identity; well-being; quality of work life; occupational health & safety*

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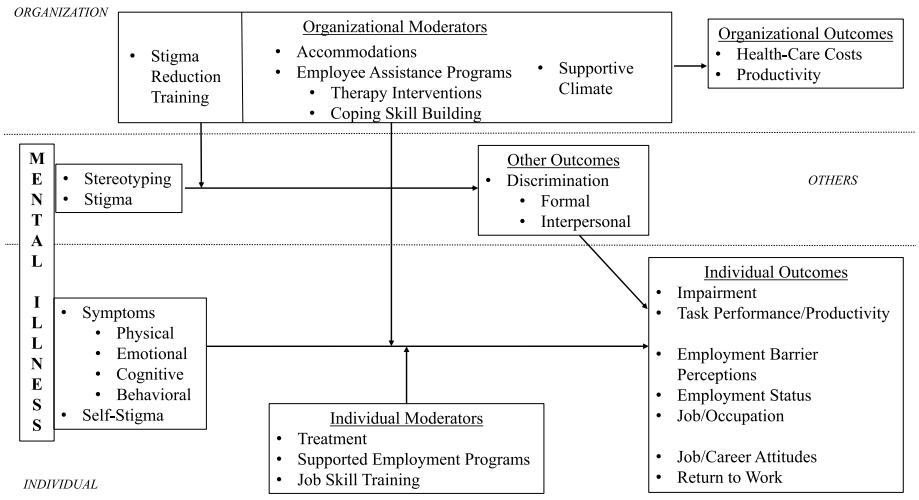
In the United States, it has been estimated that 1 in 17 adults experience a serious mental illness each year (World Health Organization, WHO, 2017). In totality, more than 44 million adults are affected annually by mental illness, many of whom are also active within the workforce (Sanderson & Andrews, 2006). Though mental illness shapes the cognitions, affect, and behavior of many workers (Haslam, Atkinson, Brown, & Haslam, 2005), the fields of industrial-organizational psychology and management understand little about their experiences.

From a business standpoint, mental illness poses a serious challenge for organizations. Prior research has shown that mental illness contributes to both direct (e.g., health care) and indirect (e.g., lost productivity) costs that exceed billions of dollars per year (Greenberg, Fournier, Sisitsky, Pike, & Kessler, 2015) through increased absenteeism, presenteeism (e.g., Koopman et al., 2002), and health-care resource utilization among employees. Indeed, neuropsychiatric disorders are now the leading reasons for why people in the United States need disability assistance (WHO, 2017). Moreover, the rate of individuals experiencing mental illness is on the rise (Weissman, Russell, Jay, Beasley, Malaspina, & Pegus, 2017), indicating the economic impact of mental illness on organizations may continue to escalate in the near future.

As a type of disability, persons with mental illness are legally protected from being discriminated against in business decisions under the Rehabilitation Act of 1973, Americans With Disabilities Act of 1990 (ADA), and the ADA Amendment Act of 2008 (ADAA). Furthermore, persons who have a mental illness still have knowledge, skills, and abilities that contribute towards organizational effectiveness. Despite this, the societal stigma faced by individuals with mental illness contributes to structural discrimination in workplace settings, such that individuals with mental illness have reduced access to quality jobs and are less likely to be perceived as promotable (Corrigan, Markowitz, & Watson, 2004). Sadly, discrimination can worsen circumstances by minimizing the ability of individuals to recover from their condition (Ilic et al., 2012). All things considered, despite the organizational costs associated with employees with mental illness, eliminating these individuals from the workforce is neither legal nor practical. Instead, the challenge for both researchers and practitioners is to help organizations develop cultures and systems that allow employees with mental illness to thrive in their respective roles while minimizing the costs for workers and the companies who employ them.

Situating mental illness as a workplace issue is a timely topic, given that many organizations are unprepared to support those with mental illness in a way that is reflected in their policies, procedures, and leadership (Fairclough, Robinson, Nichols, & Cousley, 2013). For instance, approximately 25% of organizational leaders reported a lack of confidence in their ability to effectively support employees with depression, while only 13% reported they were “very confident” in their ability (Shann, Martin, & Chester, 2014). One reason why organizations maintain limited knowledge of employees with mental illness is that most of the research regarding this population has been conducted in fields outside of industrial-organizational psychology and management, including clinical psychology, psychiatry, and rehabilitation services. In order to effectively manage and support employees with mental illness, it is necessary for organizational scholars to apply their understanding of workplace processes to existing interdisciplinary work as a means to enrich the study of this population.

**Figure 1**
**Model of Mental Illness and Work-Related Experiences**




This review aims to provide organizational scholars with current developments regarding employees with mental illness, with the ultimate goal of encouraging research toward ways to support and manage these employees. First, we define mental illness, distinguish it from mental health, and conceptualize it as a unique social identity warranting increased attention in management research. Next, we systematically review the existing empirical research on employees with mental illness across fields of study. In doing so, we identify major themes and conclusions that can be drawn from the interdisciplinary research. Finally, we integrate the research findings across multiple disciplines into an overarching framework (see Figure 1) and identify critical directions for research so that organizations can better support employees with mental illness. In doing so, we provide a conceptual framework and research agenda upon which future research may build.

## Mental Illness: Definitions and Distinctions

### *Defining Mental Illness*

The term *mental illness* encompasses more than 200 classified mental health disorders outlined in the fifth edition of the American Psychiatric Association's (APA's) *Diagnostic and Statistical Manual of Mental Disorders* (*DSM–V*; APA, 2013) and refers to diagnosable psychological disorders that are "characterized by dysregulation of mood, thought, and/or behavior" (Center for Disease Control and Prevention, 2016). Mental illnesses range in severity (within and across disorders) as well as continuity, and once diagnosed, individuals may remain susceptible to the disorder throughout the course of their life. Despite the frequently chronic nature of these illnesses, many can be managed with assistance from a trained professional. Although the *DSM–V* provides criteria that are used by professionals to diagnose a person with

one or more mental illnesses, each psychological disorder is characterized by a unique set of symptoms (APA, 2013). As a result, recognizing and accommodating mental illness is not a "one-size-fits-all" approach. Appendix A in the online supplemental material presents brief descriptions, prevalence rates, and onset ages for a selected number of mental illnesses common in the United States. From this, we see steady representation of these different disorders, nearly all of which are present at ages when individuals would need to engage in some form of work to support themselves.

### *Differentiating Mental Illness From Mental Health*

Before discussing how employees with mental illness uniquely experience the workplace, it is first necessary to differentiate our focus on mental illness from psychological health and well-being, which has been more prominently studied in the organizational literature. Scholars have spent decades studying employees' well-being (Bakker & Demerouti, 2007; Warr, 1990) with a focus on identifying specific individual and organizational factors that influence employees' mental health and wellness (Danna & Griffin, 1999; Diener, Oishi, & Lucas, 2003). Employees' psychological health and well-being is often examined as the presence of affective states, such as depressed (Erickson & Wharton, 1997) or anxious (Wagner, Barnes, & Scott, 2014), which is more momentary and often normative in response to certain events. In this way, organizational scholars have largely considered mental health only as a work *outcome*.

Mental health has also primarily been discussed as the absence of mental illness. Yet mental health and mental illness are not mutually exclusive. According to the dual continua model (Keyes, 2005), mental health and mental illness, although correlated, are distinct constructs. Empirical evidence supports the notion that one continuum represents the presence or absence of positive mental health while the other continuum represents the presence or absence of psychiatric disorders (Keyes, 2005). To this end, an individual may have low levels of mental illness while also having low levels of mental health. Likewise, a person with a diagnosable mental illness can maintain functional levels of mental health at a given point in time. This illustrates the necessity of considering mental illness separately from mental health, as employees with mental illness are, in fact, able to function and achieve well-being. Despite their impact on mental health, psychological disorders are usually long-standing and pervasive in nature. As such, to fully understand how mental illness influences employees' work experiences, it is also necessary to consider mental illness as a social identity.

## Mental Illness Identity

Social identities refer to social groups or categories to which people attach value or significance (Tajfel, 1981) and can be categorized as visible and readily observable by others (e.g., gender, race) or invisible and not readily observable by others (e.g., sexual orientation, religious orientation). It is possible for an employee to manifest symptoms of mental illness at work even though other individuals are unable to detect the disorder. Furthermore, given knowledge of a person's mental illness, negative labels stemming from stereotypes may be applied by others, regardless of the actual experiences with mental illness had by that person.

Thus, mental illness represents a unique type of concealable social identity—one that is also devalued and subject to stigmatization.

Discussing mental illness as a social identity allows researchers and practitioners to consider how it alters the lens through which employees perceive their workplaces. Having a mental illness creates a unique perspective through which individuals interact with the workplace, and such a perspective is markedly different from that of individuals without mental illness. Furthermore, association with this identity can affect how others treat employees with mental illness. Importantly, not all employees with mental illness will experience the workplace in the same way. Instead, these experiences will vary across disorders and are shaped by the manifestation of symptoms as well as others' perceptions of the individual or mental illness.

### *Mental Illness: Experiences of Individuals*

To understand how mental illness affects employees in the workplace, it is necessary to recognize that mental illness is an individualized experience that differentially manifests across disorders. A familiarity with the symptomatology of mental illness can help others to acknowledge how these disorders uniquely affect employees' perceptions, attitudes, and behaviors at work. The symptoms of mental illness present themselves in physical, emotional, cognitive, and behavioral ways and can affect one's ability to perform work. *Physical symptoms* are those that affect an individual's body and associated responses. Examples of physical symptoms include loss of appetite, sleep disturbance, and muscle aches—such changes in physiological responses can affect the extent to which an individual is able to fully function and engage in their work. *Emotional symptoms* are those that affect an individual's moods and may have implications for work-related motivation and interactions, given how mental illness affects emotion regulation. For people with mental illness, emotional changes are more than "mood swings" and can last weeks or even months at a time.

*Cognitive symptoms* interfere with perception, acquisition, and comprehension of information. For example, individuals with schizophrenia may show deficits in verbal learning, memory, and information processing speed (Evans et al., 2004), whereas individuals with obsessive-compulsive disorder (OCD) or drug addiction may be distracted by their thoughts and have difficulty paying attention as well as remembering or organizing information (Medalia & Revheim, 2002). Finally, an individual's mental illness may elicit *behavioral symptoms* such that marked changes occur in how one acts, therefore affecting what a person does or does not do as a result of their disorder. Behavioral changes in an employee with attention-deficit/hyperactivity disorder (ADHD) could manifest as fidgeting, excessive talking, or playing with nearby objects when required to sit still for long periods of time. For individuals with anxiety or posttraumatic stress disorder (PTSD), behavioral symptoms may include avoidance of trauma-related or anxiety-inducing locations or objects (e.g., social situations, elevators).

Of importance is the fact that the symptoms of mental illness can impair employees' abilities to engage in or fully meet the requirements of certain jobs. Notably, impaired job performance is not universal and is likely contingent upon multiple factors, including the severity of symptoms and the extent to which one receives adequate treatment. Beyond understanding how the symptoms of mental illness can affect workers, considering symptomatology also helps to inform the stigmatization of individuals with mental illness.

### *Mental Illness: Experiences With Others*

Stigma refers to an attribute or "mark" that is considered abnormal, flawed, or deviant within society and that is apparent to others (Goffman, 1963). Individuals who share a given stigma are categorized as similar and assumed to exhibit (often negative) attributes or behaviors, resulting in their being stereotyped and discriminated against. Mental illness remains one of the most highly stigmatized conditions in society, and such oppression is often perpetuated through the news media, fictional media, and colloquial language (Wahl, 1995). Individuals with mental illness are frequently labeled as unstable, incompetent, crazy, and dangerous (Corrigan, Kerr, & Knudson, 2005)—characteristics that are incompatible with desirable employee attributes. An understanding of the stigma surrounding mental illness is important because stereotypes and misattributions directly affect how others treat persons with mental illness. In addition to public stigma, individuals may apply this stigma to themselves—a phenomenon known as self-stigma (Corrigan et al., 2005)—which can contribute to decrements in self-esteem, self-efficacy, and work-related performance and attitudes (Perlick et al., 2001).

Previous reviews have discussed the stigma associated with concealable identities (Ragins, 2008) and disabilities (Santuzzi & Waltz, 2016). Although mental illness shares stigmatizing attributes with these other identities, the experience of having a mental illness is also set apart by three distinct characteristics: legitimacy, fluctuations, and dangerousness. The intersection of these characteristics poses unique obstacles for employees with mental illness.

Although a mental illness is a serious psychological condition, it is often perceived as less *legitimate* than physical disorders or conditions. A number of physical disorders have developed etiologies that can be detected via laboratory tests; however, such mechanisms are not readily available for mental illnesses and contribute to the perception that mental illnesses are not true disorders (Wakefield, 2007). For example, in a study of absenteeism, employees from both Canada and China rated depression as a less legitimate reason to be absent from work than bad weather, poor transportation, or illness of a family member (Johns & Xie, 1998). A common misconception about individuals with mental illness is that the condition is "all in their heads" or that individuals have the ability to "snap out of it." As such, the management of a mental illness in the workplace is often complicated by having to first prove that it is a genuine condition.

Related to the legitimacy of mental illness are *fluctuations* in the symptoms an employee exhibits at work. An individual might appear sufficiently able to work on some days but experience more severe manifestations of mental illness on other days. These fluctuations can harm an employee's credibility, as others may have the expectation that legitimate conditions should yield stable symptoms. Inconsistencies in symptomatology may be misinterpreted as cues of the employee's disposition or level of engagement rather than a legitimate psychological disorder. While individuals with physical disabilities (e.g., multiple sclerosis) may experience day-to-day variability in manifest symptoms, these conditions are commonly considered genuine medical conditions—credence generally not granted to mental illness.

Finally, the perceived *dangerousness* of individuals with mental illness differentiates it from many of the social identities traditionally studied in workplace contexts (Angermeyer & Matschinger, 2003; Corrigan et al., 2005). For instance, individuals with mental illness have been perceived as unable to handle criticism, control their emotions, resolve conflicts, and cooperate with others, in addition to being capable of violent behavior (Hand &

Tryssenaar, 2006). Beliefs such as these may underlie the more negative hiring outcomes and performance expectations for individuals with mental illness versus other identities (e.g., physical disabilities; Ren, Paetzold, & Colella, 2008). Furthermore, perceptions of dangerousness likely intersect with fluctuations in symptoms, such that variability yields perceptions of instability and unpredictability. In turn, this seemingly erratic behavior may pose a perceived risk to others in the workplace.

Despite the crucial need to understand employees with mental illness, organizational research, to date, has not adequately represented the perspectives or experiences of these employees. Consequently, much of the existing research on this population has occurred in fields outside of management but provides organizational scholars with foundational knowledge about employees with mental illness. For this reason, we conducted a systematic review of the research on employees with mental illness from across multiple fields of study in order to identify what is currently known and what remains to be studied.

## Mental Illness in the Workplace: A Review of What We Know

### *Literature Search Method*

The systematic review was conducted via the Social Science Citations Index through Web of Science. The search was guided by identifying articles published between 1980 and 2017 that included the terms *mental health, mental illness*, or the titles or abbreviations of the mental illnesses described in Supplemental Appendix A. In addition to one of these terms, the articles had to include any of the following to capture the work context: *employee, occupation, organization, workplace, worker*, or *manager*. Given that much of the research has been conducted outside of traditional management outlets, we incorporated outside fields of study, including psychiatry, clinical psychology, occupational health, rehabilitation, public health, and social work. This search yielded 1,088 published articles.

Articles were reviewed and retained if they were empirical (i.e., used qualitative or quantitative methods), published in peer-reviewed journals with impact factors greater than 1.00, and available in English. The studies needed to use samples of employees or job seekers with prior-diagnosed mental illness or examine mental illness as a predictor of work-related experiences. We did not review articles that examined mental health and well-being as outcomes. After excluding articles that did not meet the inclusion criteria and examining the reference lists of the obtained articles for additional studies, we retained 117 articles. A summary of all articles reviewed and a full list of review article references are included in the online supplemental material (see, respectively, Appendices B and C).

### *Study Characteristics*

The review of the extant literature yielded several research trends related to the study of employees with mental illness. A synthesis of these trends helps to explain how mental illness research has typically been situated as a workplace phenomenon. In this section, we present observations regarding where the data were collected, how mental illness was conceptualized, how mental illness was measured, and the fields of study that were most represented as a means to provide an initial summary of the existing literature.

*Study Location*

The obtained articles represented populations from across the globe, with most of the research being conducted in the United States, the United Kingdom, Canada, Australia, The Netherlands, China, Japan, and Germany. Interestingly, the foci of the research studies varied across geographic locations. For example, of the studies conducted in the United States, approximately 40% were focused on identifying the prevalence of and organizational costs associated with mental illness. These studies aimed to quantify the costs of mental illness. On the other hand, many of the studies representing individual employees' experiences were conducted outside of the United States. Very few studies examined employees from multiple geographic locations, which may limit the extent to which the results were generalizable to other geographic contexts.

*Specificity of Mental Illness*

In total, 42 of the studies examined mental illness as a broad construct, meaning that the research question(s) did not involve a specific mental illness. In this way, the findings were applied to mental illness broadly rather than to employees with specific disorders. The remaining 75 studies focused on employees with specific types of psychiatric conditions as part of the study design. Depression was disproportionately studied relative to other disorders ($N = 55$), which may be a function of the availability of psychometrically sound measures and checklists that identify clinical levels of depression compared to other disorders. PTSD, borderline personality disorder, psychotic disorders, schizophrenia, and substance abuse were examined least, whereas several disorders were not considered at all.

*Measurement of Mental Illness*

The ways in which mental illness was measured varied across research studies. A majority of studies utilized insurance or disability claims data in order to identify individuals who had received prior diagnoses of mental illness. These data provided objective information about individuals' mental illness, but they could not speak to the severity or frequency of symptomatology. Other methods included questionnaires, checklists, diagnostic interviews by trained researchers, doctors' diagnoses, and presence in programs (e.g., supported work) that would have verified an individual's mental illness as criteria for entry.

*Study Design*

The methods by which employees with mental illness were examined in the extant literature varied. Approximately 11% utilized qualitative methods (e.g., focus groups) to examine employees' or job seekers' work experiences. Although 86% utilized quantitative study designs (with the few remaining studies using mixed-method designs), many of these studies were descriptive in nature (e.g., means, frequencies), thereby restricting the ability to draw predictive or explanatory conclusions from the findings. Of the quantitative studies, 15% used longitudinal designs, while 17% used quasi-experiments or randomized clinical trials.

*Field of Study*

The majority of studies were published in journals related to psychiatry ($N = 28$), occupational health and medicine ($N = 23$), and public health ($N = 17$). Other represented

fields included nursing, rehabilitation, and social work. Of the 118 articles, only 7 were published in journals representing applied psychology, business, or industrial relations. These results support our assertion that greater attention to this population is needed in these areas.

In the following section, we provide a detailed discussion of the primary findings as they pertain to employees with mental illness. Together, this section synthesizes the state of research regarding our current understanding of mental illness in the workplace.

## *Delineating a Model of Mental Illness and Work-Related Experiences*

Broadly, the articles included in the review presented three unique perspectives of mental illness in the workplace: individuals with mental illness, others (e.g., coworkers, managers) who view employees with mental illness, and organizations that employ them. We used the research presented from these different perspectives to organize a model of the factors that affect the work experiences of employees with mental illness (see Figure 1). Specifically, we review the work-related outcomes that have been found to occur as a result of mental illness, as well as the factors that can moderate the impact of mental illness on these outcomes. These moderators represent action and interventions that both individuals with mental illness and employing organizations can take to improve the work-related experiences of persons with mental illness.

## *Mental Illness and Work Outcomes*

### *Individual Perspectives*

Given the individualized nature of mental illness, much of the existing research has attempted to portray the experience of mental illness from the perspective of the employee. To this end, researchers have examined (1) how mental illness can impair employees' capabilities and job performance as well as influence their perceptions of workplace barriers, (2) the extent to which the job itself contributes to or exacerbates mental illness, and (3) how having a mental illness influences employees' job and career attitudes. This section discusses these findings in more detail and helps to explain how mental illness affects work-related outcomes through the lens of those with mental illness.

*Impairment*. Having a mental illness not only impairs basic life activities (Mazzoni, Boiko, Katon, & Russo, 2007) but also influences employees' cognitive and behavioral capabilities at work. For instance, through their interviews with Latino farm workers in the United States, Mazzoni and colleagues (2007) revealed that farmers with depression reported significantly more disabilities than those without depressive symptoms, especially in the areas of life activities (e.g., working) and communicating with others. In focus groups of employees diagnosed with anxiety or depression (Haslam et al., 2005), participants reported that their mental illness affected their ability to engage in effective decision-making and, at times, contributed to workplace accidents, including falls and risk-taking behaviors. Among older workers, depression was unrelated to physical workplace impairments but significantly predicted concentration problems and restrictions in social interactions (Stynen, Jansen, & Kant, 2015).

*Task performance and at-work productivity*. Through both self-report and objective measures of job performance, mental illness was shown to negatively affect employees' productivity. In an early study involving employees in the seafaring industry, individuals who reported difficulty controlling their anxiety and emotions at work scored lower on objective job performance evaluations (Barnes, 1984). More recently, qualitative interviews with depressed employees revealed frequent discrepancies between desired performance and actual performance, which resulted in withdrawal and sickness absences if not resolved (Sallis & Birkin, 2014). Furthermore, depression severity significantly predicted job performance, with individuals experiencing the most severe depressive symptomatology reporting the greatest impairments of performance (Asami, Goren, & Okumura, 2015), although improvements in symptomatology alone may not ameliorate the effects of depression on work performance (deVries, Koeter, Nieuwenhuijsen, Hees, & Schene, 2015). These findings underscore that employees with depression may be motivated to perform well but experience job performance decrements as a result of their illness.

Loss of work productivity is not specific to depression and anxiety and has been realized in employees with ADHD as well as those with multiple (i.e., comorbid) conditions. Fried and colleagues (2012) found that employees with ADHD reported significantly lower performance on timed, structured tasks as compared to individuals without ADHD, while performance on unstructured tasks did not vary as a function of their ADHD. Notably, the symptomatology of ADHD was not visible to observers, suggesting that individuals with ADHD may be able to mask their symptoms from others even though they experience performance decrements. In terms of performance, experiencing comorbid mental and physical illnesses was related to decreased productivity, as measured by absences and lateness (K. M. Parker, Wilson, Vandenberg, DeJoy, & Orpinas, 2009). Thus, organizations may need to attend to both physical and mental illnesses in order to holistically address employees' health, well-being, and functioning at work.

*Barrier perceptions*. Both mental illness symptomatology and associated negative work behaviors contributed to perceived barriers to obtaining and maintaining employment. Using interviews with employees diagnosed with mental illness, Harris, Matthews, Penrose-Wall, Alam, and Jaworski (2014) identified several barriers that affected employees' ability to obtain work, including gaps in their previous employment history, their displays of symptoms (e.g., poor concentration, organization, and planning), low mood, low confidence, and poor communication skills stemming from their mental illness. Similar findings emerged from focus group interviews with 16 individuals with varying mental illnesses who used services at an Australian mental health center (Baker & Procter, 2014). Nearly all of the participants believed that their mental illness had cost them previous job opportunities in part due to negative self-perceptions stemming from their mental illness, symptoms interfering with their work, and loss of their skills and abilities. The losses of job opportunities affected their lives in negative ways, including the minimization of financial support, daily routines, and general sense of well-being.

*Type of job*. Several studies examined the extent to which mental illnesses were present in certain jobs. For instance, across three studies (de Graaf et al., 2008; Kessler et al., 2005; Kessler, Lane, Stang, & Van Brunt, 2009), rates of ADHD were lowest among professional

employees and highest in blue-collar or white-collar technical workers. Using a representative sample of Washington state employees, Fan, Bonauto, Foley, Anderson, Yragui, and Silverstein (2012) reported that while the overall rate of depression was only 5.2%, prevalence was more than 2 times that of the overall state population for individuals employed as machine operators, truck drivers, and health service assistants.

Roberts and Lee (1993) examined the occurrence of major depression and substance abuse in different occupations across the United States using data from the National Institute of Mental Health's Epidemiological Catchment Program. Their results showed that people employed in executive, professional, administrative support, and household services jobs had a higher lifetime risk of developing major depression, whereas laborers and people working in protective services and transportation had a lower lifetime risk of developing major depression. On the contrary, laborers and transportation, production, and farming employees had a greater lifetime risk of developing substance abuse disorders, whereas technicians and household service, professional, and sales employees were at a lower lifetime risk of substance abuse disorders (Roberts & Lee, 1993). These results underscore the need to consider how mental illness influences the job into which employees self-select as well as how unique occupational factors contribute to the onset and continuation of mood or substance abuse disorders.

*Job and career attitudes*. Existing research has generally reported that mental illness negatively affects how employees think and feel about their job or career. Employees with depression, for instance, were more likely to report lower job satisfaction and job-related affective well-being (M. S. M. Lee, Lee, Liao, & Chiang, 2009; Morrissy, Boman, & Mergler, 2013). Furthermore, ADHD symptoms among employees significantly predicted dysfunctional career thoughts, commitment anxiety, and external conflict (Painter, Prevatt, & Welles, 2008).

These negative attitudes could potentially influence how individuals with mental illness feel about their jobs and careers over time. Although this direct relationship has not been explored, longitudinal studies demonstrated how depression (Doshi, Cen, & Polsky, 2008), PTSD (Yu, Brackbill, Locke, Stellman, & Gargano, 2016), and mental illness in general (Harkonmäki, Lahelma, Martikainen, Rahkonen, & Silventoinen, 2006) affected desired and actual early retirement, often beyond demographics, physical health issues, work and family conflict, and negative work conditions (Harkonmäki, Rahkonen, Martikainen, Silventoinen, & Lahelma, 2006). Even though mental illness can influence the desire to leave one's job, these individuals may have no choice but to stay employed in their current jobs. In fact, using a sample of 1,775 Dutch employees, Taris, Bok, and Caljé (1998) found that individuals with depression were less likely to be employed in a different job 4 years later and were just as likely to have depression whether or not they had changed jobs. These findings also illustrate the chronic nature of mental illness and its effects on work experiences.

*Other Perspectives*

Inherent to understanding how employees with mental illness experience the workplace is identifying how these individuals are perceived and treated by others. The systematic review revealed that the attitudes associated with employees with mental illness are mostly negative and, in turn, the expectations for these individuals are generally inaccurate. Even more, the

behaviors that coworkers and supervisors direct toward individuals with mental illness often result in both overt and subtle discrimination, thereby reducing the quality of these individuals' work experiences.

*Stereotyping*. Several studies supported previous findings that mental illness is a highly stigmatizing condition for employees. These studies demonstrated that the general population, employees, and managers have concerns about the employability of individuals with mental illness (Dietrich, Mergl, & Rummnel-Kluge, 2014). One study of Japanese employees revealed that participants lacked knowledge of depression and suicide, including behaviors and beliefs of individuals who are at risk for committing suicide. Furthermore, nearly 25% of respondents reported having unfavorable attitudes toward colleagues with depression (Nakayama & Amagasa, 2004). Similar findings were reported in a case study of a privately owned Canadian company (Hauck & Chard, 2009) in which employees and managers discussed how a lack of understanding about depression affected the way individuals with depression were treated or perceived by others at work. To this end, employees with depression or other mental illness may be perceived negatively due to a lack of knowledge about their disorder(s).

Stereotypic beliefs about individuals with mental illness can further give rise to concerns about their performance capabilities and hireability. Using a mixed methodology, Biggs, Hovey, Tyson, and MacDonald (2010) reported that while job coaches understood the benefits of work for individuals with mental illness and were comfortable putting such individuals forward for jobs, many managers had concerns about the ways in which a disorder would disrupt workers' productivity. As such, managers had reservations about hiring individuals with mental illness. Follmer and Jones (2017b) reported that employees with depression and bipolar disorder were perceived as low in competence and warmth, while employees with anxiety were perceived as low in competence. Similarly, a vignette study portraying employees with borderline personality disorder revealed that negative attitudes about these individuals manifested when they took a leave of absence from work because of their disorder but did not display behavioral changes upon return to work (Sage, Brooks, Jones, & Greenberg, 2016).

*Discrimination*. Research also supported both overt and subtle discrimination against employees with mental illness. Formal discrimination involves blatant mistreatment or inequities in the workplace on the basis of one's mental illness and is illegal in most U.S. states (Hebl, Foster, Mannix, & Dovidio, 2002). In one vignette-based study, personnel managers expressed reluctance to hire an employee who was labeled as depressed (vs. diabetic), especially for high status jobs (Corrigan, Larson, & Kuwabara, 2007). Stereotypes also affected how individuals felt about and treated employees with mental illnesses.

Results based on two nationally representative samples of employees with mental illness further supported instances of formal discrimination toward this employment population. In particular, Baldwin and Marcus (2007) revealed that the employment rates and wages of individuals with mental illness were significantly lower than those of individuals without such disorders, with the wage differentials being greatest for those with the most severe mental illnesses. In a separate study, 20% of employees with mental illness reported experiences

of work-related stigma, and these experiences were most frequent among those with psychotic disorders (vs. mood or anxiety disorders). Although wage differentials were not significant between employees with versus without mental illnesses, employees who reported experiencing stigma also reported significantly lower wages than individuals who had not reported stigma or who did not have a mental illness (Baldwin & Marcus, 2006).

Unlike formal discrimination, interpersonal discrimination manifests subtly between individuals, appearing as similar to incivility behaviors (e.g., curt tone of voice, glaring, reducing contact; Hebl et al., 2002). Although these behaviors are technically legal, they can be just as harmful for stigmatized individuals as more formal types of discrimination (Jones, Peddie, Gilrane, King, & Gray, 2016). Oftentimes, discrimination is precipitated by negative group stereotypes. For example, in one study, individuals with mental illness induced feelings of fear in others, which predicted avoidance behaviors such as withholding help in obtaining or maintaining a job (Corrigan et al., 2007). Stereotypes of employees with anxiety, depression, and bipolar disorder also predicted intentions to socially distance oneself from these individuals at work (Follmer & Jones, 2017b). Taken together, these studies demonstrate that the ways in which others view employees with mental illness can negatively affect the workplace experiences of these employees.

*Organizational Perspectives*

A large number of research studies examined mental illness through an organizational lens by estimating the extent to which mental illness directly and indirectly affected organizational outcomes, namely, costs. By far, the greatest amount of research attention has been paid to identifying the costs incurred by organizations as a result of employing individuals with mental illness, including ADHD (de Graaf et al., 2008), anxiety (Laing & Jones, 2016), mood disorders (Williams, Shah, Wagie, Wood, & Frye, 2011), and mental illness overall (Hilton, Scuffham, Vecchio, & Whiteford, 2010). In general, these studies demonstrate that employees with mental illness create a significant financial burden for organizations in terms of reduced productivity and absenteeism.

In most instances, insurance and disability claims data provided estimates of the direct costs of treating and supporting mental illness, while absenteeism and presenteeism data were used to estimate the productivity losses attributable to working with a mental illness. Most studies used retrospective database analysis to identify individuals with mental illness and to determine the treatment- and productivity-related costs. Together, these studies highlight the substantial economic burden experienced by organizations in terms of both direct (e.g., health care) and indirect (e.g., decreased productivity) costs associated with various mental illnesses.

## *Moderators of the Relationship Between Mental Illness and Work Outcomes*

So far, the review has identified the ways in which having a mental illness can affect employees' work-related behaviors, attitudes, and performance. On the surface, it appears that these individuals underperform relative to workers without mental illness and are generally less satisfied. However, prior studies have demonstrated that retaining employment is beneficial to continued functioning and recovery efforts, including the maintenance of structure in daily life (Boot, de Kruif, Shaw, van der Beek, Deeg, & Abma, 2016). Moreover, there are several factors that can facilitate or hinder outcomes of employees with mental illness. In particular, there are factors that individuals can choose to engage in outside of their

employing organization, as well as interventions and initiatives that organizations can implement to support their employees with mental illness.

*Individual*

The systematic review revealed individual-level factors that can help to attenuate the negative effect of mental illness on employees' work-related outcomes. Specifically, individuals' employment prospects and job performance improved by obtaining assistance with their mental illness, including treatment for their mental illness or participating in supportive employment and skills training programs.

*Treatment*. In general, employees who received treatment for their mental illness experienced a reduction in sickness-related absences and realized improvements in their performance. For instance, among individuals with moderate to severe depression (Berndt et al., 1998; Dewa, Thompson, & Jacobs, 2011) and ADHD (Fried et al., 2012), receiving treatment was related to reduced symptoms as well as increased productivity and work-related performance. Employees who were prescribed and adhered to the recommended dosage of antidepressants demonstrated reductions in the amount of time needed for depression-related disability (Dewa, Hoch, Lin, Paterson, & Goering, 2003). On the other hand, the relationships between the use of antidepressants and return to work behavior appear to be complicated by depression severity. Analyses of mental health–related disability claims showed that individuals who used antidepressants were slower to return to work than those who did not use them (Dewa et al., 2003; Prang, Bohensky, Smith, & Collie, 2016). Together, these studies suggest that receiving quick treatment helps reduce impairment and can improve workplace productivity, but many questions about the role of treatment-related behaviors on workplace outcomes remain unanswered.

Despite the available options, many employees who have a mental illness fail to seek needed treatment (Mojtabai et al., 2011). Employed nurses, for instance, reported multiple reasons they failed to seek treatment, including embarrassment related to having a mental health disorder and fear of losing their job (Cares, Pace, Denious, & Crane, 2015). Employees may also fail to seek treatment because of recognition (e.g., unrecognized need for help), structural (e.g., lack of resources), and attitudinal (e.g., fear about seeking help) barriers. Using probability modeling in a sample of Canadian employees, Dewa and Hoch (2015) showed that removal of these barriers demonstrated likely increases in productivity. In addition, job satisfaction and security positively predicted treatment-seeking behaviors among employees in the coal mining industry (Tynan et al., 2016), suggesting that the cultivation of positive job attitudes in organizations can assist individuals in obtaining the resources they need to manage their mental illnesses while employed, which in turn can positively affect their work-related behaviors.

*Supported employment programs*. Supported employment programs are implemented by government and nonprofit institutions in order to assist individuals with mental illness in obtaining and maintaining employment and its associated benefits. These organizations provide a range of services, including job coaches, transitional employment, career planning help, skill training, and community treatment teams (i.e., multiple coordinated services, including employment assistance, treatment, etc.; Bond, Drake, Mueser, & Becker, 1997).

They are especially important as a result of the high rates of unemployment among individuals with severe mental illnesses (Lehman, 1995). Prior research has demonstrated that supported employment programs are related to return to work and job acquisition behaviors (Elliott & Konet, 2014; McGurk, Mueser, & Pascaris, 2005). For instance, Corbière and colleagues (2011) demonstrated how social support and self-efficacy positively predicted job-search motivation and, subsequently, job acquisition among Canadian individuals involved in a supported employment program. Similarly, return to work self-efficacy significantly predicted partial and full return to work for employees who were on sick leave because of their mental illness (Lagerveld, Blonk, Brenninkmeijer, & Schaufeli, 2010).

*Skill training*. In conjunction with or separate from supportive employment programs, trainings can be administered to help individuals with severe mental illnesses obtain employment. For example, Smith, Fleming, Wright, Roberts, et al. (2015) explored a virtual job training program among job seekers with schizophrenia. The intervention was administered by computer and helped adults to develop their interviewing skills. After 6 months, trainees who had participated in the intervention were more likely to have received job offers and had spent fewer weeks searching for jobs. These results were replicated in a sample of veterans diagnosed with mood disorders or PTSD (Smith, Fleming, Wright, Jordan, et al., 2015).

*Organizational*

Responsibility for minimizing the effects of mental illness on employees' work behaviors does not fall solely on individuals. Rather, there are several organizational factors that can help employees with mental illness to better manage their disorder in the workplace, thereby improving both their job performance and overall work experiences. While some of these factors are legally mandated, such as providing job accommodations, other factors (e.g., supportive climate; employee assistance programs, or EAPs; stigma reduction programs) are voluntary but may yield long-term benefits for both employers and employees. The relevant research findings regarding each of these organizational factors are discussed below.

*Accommodations*. In many countries, including the United States, federal laws prohibit discrimination against employees with mental illness. Furthermore, these laws entitle employees to reasonable accommodations to enable them to fully meet the demands of their job (Nardodkar et al., 2016) and can shape the extent to which employees experience work-related impairments as a result of their mental illness. Despite these legal protections, employees with mental illness may fail to seek or utilize accommodations because of a lack of knowledge regarding their workplace rights. In previous studies, employees with mental illness were not fully aware of the accommodations that were legally available to them (Goldberg, Killeen, & O'Day, 2005) and did not receive the accommodations they needed to perform their job duties (Wang, Patten, Currie, Sareen, & Schmitz, 2011). Regrettably, approximately 20% of employees with severe mental illness believed that receiving accommodations could have prevented their job termination (Mak, Tsang, & Cheung, 2006).

Much of the research on accommodations for employees with mental illness has focused on identifying the types, frequency, and costs of these accommodations. Across studies, job accommodations were frequently implemented to modify workplace processes and structures,

including the adjustment of job tasks, work schedules and time, rules and procedures, social norms, on-site job coaching assistance, and performance expectations (Bolo, Sareen, Patten, Schmitz, Currie, & Wang, 2013; Fabian, Waterworth, & Ripke, 1993; MacDonald-Wilson, Rogers, Massaro, Lyass, & Crean, 2002). In two studies involving employees with mental illnesses enrolled in supportive job programs, the most frequently cited organizational accommodations were on-site job assistance via job coaching, flexible scheduling, training for supervisors, and extended training for employees (Fabian et al., 1993; MacDonald-Wilson et al., 2002).

There has also been research examining the accommodations employees with mental illness found to be most useful. Wang and colleagues (2011) conducted phone interviews with 784 employed Canadian adults who were eligible for workplace accommodations as a result of having a mental illness. When asked about the accommodations they needed to successfully perform their job duties, participants most frequently cited the need for weekly meetings with their supervisors, exchanging work tasks with others, and quieter workplaces. Individuals who experienced a mental illness in the last 12 months were more likely to cite the need for EAPs, a change in jobs, and reduced work hours as compared to individuals who had experienced a mental disorder in their lifetime (but not in the last 12 months).

Finally, these studies imply that providing necessary workplace accommodations is both reasonable for organizations and helps employees to perform to their full capabilities. One study exemplified how accommodations for employees with mental illness most often involved reallocation of time or job tasks and did not contribute to significant direct expenditures (MacDonald et al., 2002). The longitudinal findings provided by Bolo and colleagues (2013) showed that for employees who required but did not receive workplace accommodations, 31% had a mood or anxiety disorder at the 1-year follow-up, while employees who did receive accommodations had a lowered risk of mental illness. Finally, accommodations have been shown to relate to increases in employees' job tenure (Fabian et al., 1993).

*Supportive organizational climate*. Beyond efficacy beliefs, organizational factors may also help employees with mental illness to successfully return to the workplace after taking a sick leave due to mental illness. Across focus groups with union representatives and peer support specialists, Corbière and colleagues (2015) identified individual elements that affected return to work among employees with depression, including personal life factors, attitudes towards the workplace, and emotional reactions to returning to work (e.g., shame, fear). However, several factors were perceived as essential for building an organizational culture supportive of successful return to work. These included the presence of supportive colleagues, peer support networks, increased communication between the union and employees, and continuous contact between employees and their organizations during sick leave. Together, participation in supportive work programs can help employees with severe mental illness to obtain access to quality employment opportunities and maintain high levels of work functioning.

*EAPs*. Finally, there were several studies that explored the effects of interventions designed to help employees manage their mental illness, including EAPs as well as other options that would likely enhance EAPs, such as treatment-based programs and skill training. EAPs provide "confidential assessment, counseling, and therapeutic services" for

employees experiencing personal, emotional, or psychological problems (Arthur, 2000: 550). These programs allow employees to acquire needed psychological or medical services related to their mental illness, which may otherwise go unrecognized or untreated. Employees who took advantage of EAPs (e.g., short-term counseling, screening, awareness tools) were found to show improvements in depression, anxiety, and alcohol abuse symptoms after 5 months in comparison to those who did not use EAPs (Richmond, Pampel, Wood, & Nunes, 2016). Similarly, EAP use among male Japanese employees was related to decreased suicidal thoughts, agitation, psychomotor issues, guilt, and depressed mood (Nakao, Nishikitani, Shima, & Yano, 2007).

Specific treatment interventions have also been examined among employees with mental illness. Furukawa and colleagues (2012), for instance, explored the effects of using only an EAP versus participating in an EAP and a telephone-based cognitive behavioral therapy (CBT) program on employees' presenteeism levels. Although there were no significant differences in presenteeism among participants in the two conditions, those who received both the therapy and the EAP reported reduced depressive symptoms and more satisfaction with their services. Furthermore, Noordik, van der Klink, Klingen, Nieuwenhuijsen, and van Dijk (2010) conducted a literature review on the effectiveness of exposure in vivo, a part of CBT that focuses on changing behavior and gradually making it easier for treatment recipients to deal with situations at work that would produce stress and anxiety. On the basis of the seven studies that met their inclusion criteria, they concluded that exposure in vivo was useful in improving productivity outcomes among employees with OCD and PTSD in comparison to other treatments.

There have also been studies that have explored the effects of trainings on health and work outcomes among employees with mental illness, yielding mixed results with regard to changes in work behavior. Hees, de Vries, Koeter, and Schene (2013) tested the effectiveness of an occupational therapy intervention designed to improve coping skills among employees with depression. The results demonstrated that there was no statistically significant difference in workforce participation between the occupational therapy and standard treatment conditions, but there was an increase in recovery from depression as well as a higher probability of returning to work among participants who received the occupational therapy intervention. Although the results of these studies generally suggested that these interventions were effective in decreasing mental illness symptoms, both positive and null effects on the work outcomes of interest were demonstrated. Additional research is needed in order to refine these interventions so that employees with mental illness can be supported and experience positive work experiences.

*Stigma reduction*. There have also been attempts to reduce mental illness stigma in the workplace. To illustrate, Hamann, Mendel, Reichhart, Rummel-Kluge, and Kissling (2016) explored the effectiveness of a workshop designed to reduce managers' stigma of mental illness. In the workshops (limited to 12 people each), participants learned information about mental disorders, how they could be effective in supporting employees with mental illness, how to detect and support employees who are stressed, finding solutions when difficult situations occur, and how to prevent mental health problems in the workplace. Although the participants in this study showed lower baseline scores compared to the general population, the workshop still resulted in decreases in stigma and negative attitudes towards employees with mental illness.

*Effects on organizational outcomes*. Given the significant costs associated with employees with mental illness, organizations are likely to benefit from implementing interventions aimed to reduce mental illness and related impairments. Iijima, Yokoyama, Kitamura, Fukuda, and Inaba (2013), for instance, examined a mental health prevention program among 11 Japanese organizations and found that a majority of the programs demonstrated a return on investment. As another example, after an organization minimized employees' mental health coverage to reduce costs, the savings the organization obtained by reducing coverage were offset by increases in non–mental health service use as well as increased sick days related to mental health (Rosenheck, Druss, Stolar, Leslie, & Sledge, 1999). Several studies have yielded similar findings where employees who have access to treatment and psychological services experience increased well-being and work productivity (Mechanic & Olfson, 2016). This all suggests that it is in an organization's best interest to provide employees with resources that make the attainment of such services possible.

*Summary*

The systematic review aimed to synthesize the research on employees with mental illness as a way to provide a holistic understanding of their work experiences, including the factors that exacerbate or attenuate the relationship between mental illness and important work outcomes. Together, the research stemming from individual, other, and organizational perspectives helps to more fully elucidate how employees with mental illness experience the workplace. Building on this, we highlight several avenues for future research that can meaningfully improve our understanding of employees with mental illness.

## Mental Illness in the Workplace: A Future Research Agenda

Even though more than 100 studies across various fields have addressed employees with mental illness, there is still much we do not know about the work experiences of these individuals. In light of this review, it is now possible to identify ways in which organizational researchers can contribute to the conceptualization and measurement of work-related phenomenon among employees with mental illness. As more attention is paid to this unique employee population, we identify some of the existing theoretical and methodological limitations observed from the systematic review and provide suggestions that can help facilitate rigorous future research.

### *Theoretical and Methodological Limitations*

First, missing from many of the studies was a strong theoretical rationale to guide the research questions and hypotheses, which restricts our understanding of employees with mental illness. While this may be due, in part, to different normative standards for research across fields of study, it is nonetheless a serious omission. Organizational scholars are encouraged to extend existing theories related to identity management (e.g., Jones & King, 2014; Ragins, 2008), disability (e.g., Colella, 2001), help seeking (e.g., F. Lee, 1997), emotion regulation (e.g., Grandey, 2000), and stress and coping (e.g., Tetrick & Winslow, 2015) to the study of employees with mental illness. Through improved theoretical foundations, organizational scholars can move beyond surface-level descriptions of mental illness to more

robust studies of the processes and boundary conditions surrounding individual, other, and organizational perspectives.

For instance, while symptomatology was frequently included in the review articles, few studies provided a theoretical rationale for why it might affect employees' behaviors and attitudes. Here, conservation of resources (Hobfoll, 1989) or cognitive load (Paas & van Merriënboer, 1994) theories could be useful in developing interventions that mitigate the effect of cognitive symptoms on job performance and engagement. Similarly, existing theories of emotion regulation (Grandey, 2000) may be useful in examining the strategies individuals employ to manage their emotional symptoms as well as the effectiveness of such strategies. Furthermore, models from clinical psychology that explore factors underlying symptoms of several mental illnesses could also be useful in this effort (e.g., Krueger, Caspi, Moffitt, & Silva, 1998).

A second limitation of the existing research is related to the methodologies used to study employees with mental illness (e.g., cross-sectional, small-sample qualitative studies). Using rigorous research methods can aid in capturing the complex and nuanced nature of mental illness. Longitudinal and experience sampling methods, for example, would be useful in identifying how fluctuations in symptomatology across time influence work-related outcomes. In a similar vein, the predominant method for investigating others' beliefs was through vignette-based studies where individuals responded to hypothetical scenarios depicting individuals with mental illness. Going forward, it would be useful to utilize field studies to investigate the experiences of current employees and supervisors who work alongside individuals with mental illness, while the use of paired samples involving an employee with mental illness and his or her coworker could be useful in investigating disclosure decisions and outcomes. As organizations grapple with creating inclusive work environments, increased intervention-based research designs are also needed to identify how to best train employees about mental illness.

Finally, rigorous qualitative methods can provide a foundation for gathering information on employees' lived experiences with mental illness, including the ways in which it disrupts, modifies, or enhances their job. Recent explorations of specific mental illnesses, such as depression (Follmer & Jones, 2017a), eating disorders (Siegel & Sawyer, 2017), and autism (Johnson & Joshi, 2016), have been useful in revealing specific strategies that individuals and organizations can use to better manage these conditions.

In our review, we postulated that a holistic understanding of the work experiences of employees with mental illness was possible to obtain by considering individual, other, and organizational perspectives. With these unique perspectives, researchers can better understand what it means to have a mental illness, how mental illness is perceived by others, and the challenges and opportunities experienced by organizations who employ persons with mental illness. Below, we complete our discussion with general recommendations for advancing the research related to employees with mental illness, taking the theoretical and methodological recommendations mentioned above into account.

## *General Recommendations for Research*

### *Individual Perspectives*

Employees with mental illness face many obstacles in the workplace resulting from symptomatology, stigmatizing self-perceptions, and misunderstanding by others about the

nature of mental illness. While the majority of studies were guided by individual perspectives on mental illness, these have only begun to scratch the surface of fully understanding what it is like to experience and manage a serious psychological disorder at work.

A great deal of research demonstrated that mental illness negatively affected work performance and job attitudes. However, many of these studies were limited in their measurement of work-related constructs; organizational scholars are needed to ensure that workplace outcomes are measured with reliable and valid scales. Furthermore, shifting the conversation from identifying the consequences or costs associated with employing these individuals to identifying the ways in which they positively contribute to their organizations would be useful and consistent with person-centered work psychology (Weiss & Rupp, 2011). Thus, organizational scholars are encouraged to examine how employees with mental illness behave in counterstereotypic ways (e.g., being engaged) as well as how having a mental illness helps them to thrive (e.g., creativity, empathy) at work.

Several studies demonstrated that both treatment and accommodations assist employees with managing their disorders in the workplace. Much of this work was descriptive in nature, describing the types of treatment or accommodations individuals received, while little work has investigated how employees gain access to them. The findings from this review showed that a lack of knowledge regarding accommodation rights created a barrier for employees, suggesting that more research is needed to understand how and where employees gain knowledge about accommodations. Baldridge and Veiga (2001) presented a theoretical model suggesting that attributes of the workplace, required accommodation, and the requester influence how personal costs, benefits, and appropriateness judgments about the accommodations are made, which ultimately affects the likelihood of the request being approved. In addition to knowledge, these additional factors should be explored regarding mental illness accommodation requests (Baldridge & Veiga, 2006).

As with other types of disabilities, employees with mental illness who require accommodations must first disclose their mental illness at work, thereby exposing themselves to the risk of stigmatization and discriminatory treatment (Brohan, Evans-Lacko, Henderson, Murray, Slade, & Thornicroft, 2014; Paetzold, Garcia, Ren, del Carmen Triana, & Ziebro, 2008). To this end, more research is needed to understand the individual (e.g., nonwork support, self-stigma) and organizational (e.g., diversity climate, leadership) factors that motivate individuals to disclose their mental illness to others. For instance, both between-person (Clair, Beatty, & MacLean, 2005) and within-person (Jones & King, 2014) models of disclosure of concealable stigma would be helpful in understanding how and why people with mental illness engage in specific identity management strategies.

A final recommendation for the study of employees with mental illness is the need for increased consideration of intersectionality (Weaver, Crayne, & Jones, 2016). An individual's experience of having mental illness likely intersects with other identities he or she holds. For example, social class can influence the extent to which individuals have access to resources to manage their mental illness (e.g., treatment options, flexibility to leave work), while help seeking may be influenced by race-based differences in attitudes regarding mental illness. The intersectional perspective goes beyond differences in diagnoses that may occur across gender, race/ethnicity, and other categories to identify how these multiple identities uniquely affect important work experiences and outcomes.

*Other Perspectives*

The systematic review revealed persistent negative stereotypes of employees with mental illness. Indeed, these negative stereotypes are found in the general public as well as among employees and supervisors, suggesting that the stigma associated with mental illness remains a significant workplace barrier. One limitation in the study of others' perspectives is that they did not directly address strategies for reducing stigmatizing beliefs. A fruitful avenue for future research, therefore, is to create and measure the effectiveness of training programs aimed at educating employees across organizational levels about mental illness (e.g., increasing general knowledge about mental illness to correct stereotypes; Corrigan & Gelb, 2006). Although the literature pertaining to diversity training is already rich (Roberson, Kulik, & Tan, 2013), the unique stigma of mental illness necessitates additional research to explore ways to reduce both subtle and overt discrimination. An important perspective not fully represented in other-based research was that of organizational leaders. More research regarding how leaders obtain procedural knowledge of managing employees with mental illness (e.g., sensitively discussing issues, monitoring workplace behavior; Martin, Woods, & Dawkins, 2015) is warranted.

While much of the extant literature has focused on employees who hold negative views of persons with mental illness, one population of employees has been overlooked: mental illness allies. Employees without mental illness can help foster an inclusive workplace by supporting those who do have a mental illness. Allies demonstrate help for stigmatized individuals by offering emotional support, speaking up when injustices occur, and actively contributing to social change efforts. Understanding how allies develop as well as the effect they have on the work experiences of employees with mental illness is greatly needed (Wessel, 2017).

*Organizational Perspectives*

Studies that assumed an organizational perspective overwhelmingly focused on the costs associated with employing persons with mental illness. Although these studies helped to identify mental illness as a critical concern for employers, additional work is needed to understand how organizational factors can promote or hinder the work experiences of those with mental illness. It is known that receiving treatment can help minimize the negative effects of mental illness on work performance; however, less is known about the effectiveness of organizational support systems (e.g., EAPs). One future avenue for research, then, includes increased examination of organizational resources and policies geared toward assisting employees with mental illness. Furthermore, research on how the composition of the top management team (Carpenter, Geletkanycz, & Sanders, 2004) effects implementation of organizational interventions would be useful.

In addition to providing employees with resources, it is important that organizations continue to work on identifying strategies for building inclusive climates for mental illness that are reflected at individual, team, and organizational levels. Much of the existing literature on diversity climate has focused on visible identities (Nishii, 2013) or diversity broadly (Dwertmann, Nishii, & van Knippenberg, 2016) with few considerations given to creating inclusive environments for those with concealable identities. Such efforts can help increase the amount of social support available to employees with mental illness, which can have implications for disclosure, accommodation requests, and help-seeking behaviors.

Although interventions that specifically target employees with mental illness are important, organizations may also benefit from paying increased attention to the overall mental

health and well-being of their employees. These efforts can inform employees about the risk factors associated with the onset of mental illness as well as increase recognition of early indicators in the self and others. To this end, a supportive and inclusive organizational culture aims not only to minimize the losses associated with employing individuals with mental illness but also to improve the quality of work life for those employees.

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