Help! I need somebody: Help-seeking among workers with work-related mental disorders

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Abstract

**Purpose:** Worker mental health has emerged as one of the most significant challenges in contemporary workplaces. Knowing what intervention is effective is important to help workers adapt to mental health problems but connecting workers to helpful resources is just as important and perhaps more of a challenge. With the multiple stakeholders involved, mental health problems arising in the workplace poses specific challenges to help-seeking. The present study sought to understand the personal and contextual influences on help-seeking among workers with work-related mental health problems.

**Methods:** A qualitative methodology was employed utilizing purposive sampling to conduct semi-structured interviews with individuals (n=12) from various occupational backgrounds who had experienced a work-related (self-declared) mental health injury. Interpretative phenomenological analysis and thematic content analysis were combined to analyze the data.

**Results:** Three main themes emerged including: 1) self-preservation through injury concealment and distancing themselves from workplace stressors to minimize/avoid internal and external stigma, 2) fatigue relating to complex help-seeking pathways, accumulation of stressors, eroding the worker’s ability to make decisions regarding supports, and 3) (mis)trust in the people and processes involving dual relationships with help providers and the workplace and trust in peer referrals and networks for help.

**Conclusions:** Findings suggest the need to educate workplace parties such as supervisors on mental health and pathways to help, simplifying pathways to service and removing barriers to help seeking including stigmatizing behaviours. Future quantitative and intervention research on workplace mental health should integrate pathways to help into models and frameworks.

**Introduction**

Addressing mental health needs in workers has emerged as one of the most significant challenges in contemporary workplaces. Researchers estimate that two out of nine Canadian workers are affected by mental health issues that are significant enough to impact their productivity [1]. An estimated 500,000 Canadians miss work each day because of some type of mental health issue [2]. More workers are absent from work because of stress and anxiety than from physical illness or injury [3] and absenteeism, resulting from common mental health disorders (i.e., anxiety, depression), has steadily increased for several years [4]. One third of workers attribute chronic work stress as the cause of CMD’s [4].

The economic burden of mental health issues on society is significant. The World Health Organisation predicts that within the next decade common mental health illnesses, such as depression and anxiety, will be the leading cause of disabilities [5]. Further, it is estimated that mental health related issues in the Canadian labour force costs $21 billion (CDN) annually in lost productivity [6]. Globally, mental illnesses are estimated to have cost $1 trillion (USD) in lost productivity in the year 2017 [7].

Modern work and workplaces have increased cognitive and social demands, creating an environment conducive to the development of mental health problems. While primary prevention is the most appealing option to reduce the mental health burden of modern work, providing effective and prompt support is critical to help workers recover and adapt to mental health problems. Cognitive-behavioural interventions have been developed that promote recovery and return to work for workers with common mental disorders, helping to manage the suffering and costs [8]. Interventions that include a work-focused component return workers with common mental disorders to the workplace more expeditiously [9].

Beyond identifying effective treatment, however, getting support in a timely fashion is just as important and may be more of a challenge than developing effective interventions. Many, if not most, individuals with anxiety and depression do not seek help [10, 11]. Those who do may delay seeking treatment and treatment delays have been associated with worse outcomes for individuals with depressive disorders [12]. Delays in treatment can also reduce the likelihood of individuals attending service when it is offered to them [13]. Conversely, recent research indicates that prompt (immediate post traumatic event) behavioural interventions (e.g., exposure therapy) may be effective in reducing posttraumatic stress reactions [14]. Facilitation of clinical service can improve quality of life and help in navigating the disability management system can help improve work functioning in persons sick-listed for common mental disorders or struggling at work [8]. Pathways to support that promote timely access to treatment can promote adherence and work engagement.

Obstacles to engagement in treatment may come at the individual and organisational level. Workers may deny they need support, not feel confident in mental health services, or not know where to go to access support. In individuals with high levels of psychological symptoms, attitudes toward help-seeking, mental health literacy (“knowledge and beliefs about mental disorders which aid their recognition, management or prevention”, [15], and perceived need were shown to be significant predictors of psychotherapy usage [16]. Individuals with high levels of mental health literacy tend to engage in help-seeking for mental health issues more than those with low mental health literacy [17, 18]. Stigma, both internal and treatment-related, has a small to moderate association with reduced help seeking particularly among certain
Interventions to promote help-seeking have primarily focused on individual attitudes and norms and de-stigmatization through developing mental health literacy and provision of information on how to access help. Interestingly, interventions focused on individual level constructs have demonstrated increases in intentions to seek help, but no effect on help seeking [22]. For example, a recently published trial designed to promote help-seeking among fire service workers in Australia demonstrated a limited short-term effect on help seeking with no difference between workers with or without mental disorders [23]. The reasons for these programs not achieving outcomes is unclear, but all are focused on the individual and their beliefs and attitudes towards mental health and knowledge of health services. The potentially critical role of context and how it might affect the translation of intentions towards help-seeking into action has been largely overlooked.

The workplace context may play a significant role in help-seeking behaviours for workplace mental health problems. For workers, disclosing the need for help risks being stigmatized in the workplace, particularly in work cultures that emphasize ‘mental toughness’ (e.g., security occupations and first responders). More than one in three workers still worry about the consequences of reporting a mental health problem [24]. Workers may have limited access to treatment support owing to financial constraints. Help-seeking is also influenced by the addition of multiple stakeholders and power dynamics found in most workplaces. The return-to-work process for mental health disorders is very complex and can include as many as eleven stakeholders, spanning from employer to healthcare worker to insurance stakeholders, each with different roles, actions and agendas [25]. The sheer complexity of the workplace social environment may make it difficult for the worker to know where to go for help. Differing vested interests among actors (e.g., reducing costs versus promoting work involvement), adds tension to balancing health and productivity. The workplace adds stress to an already stressful situation and friction on what support is available and how support is accessed in individuals who are already compromised in terms of the emotional energy required to enact help-seeking behaviours.

Health behaviour theories and frameworks have been applied to help-seeking, focusing on attitudes and beliefs towards help seeking (e.g., Theory of Planned Behaviour [26], illness threat (e.g., Health Belief Model [27], cycles of avoidance [28] and staged processes [29]. Andersen's Emerging Behavioral Model of Health Service use incorporates contextual with personal factors, positing that healthcare-seeking behaviour is a function of perceived need and predisposing individual characteristics as well as enabling resources in the environment couched within the larger healthcare system and socioeconomic environment [30]. Andersen's model does not provide elaboration of specific contexts and is limited in incorporating and specifying relational and contextual factors and is specifically focused on professional care-seeking (versus help-seeking from other sources). We are unaware of any empirical elaboration of models that capture the complex interplay of individual help-seeking and the environment, particularly as it pertains to workplace mental health and help-seeking.

Present Study

Mental health problems and related disabilities arising from work have become a significant challenge for workers and workplaces. Prompt and efficacious treatment is critical in addressing workplace mental health, however workers not only need to be motivated toward but also access such treatment in order for it to be effective. Much research and practice has been directed towards shifting knowledge, attitudes and beliefs, including stigma. Significantly less attention has been paid to context and specifically to the workplace context in understanding the determinants of seeking help for work related mental health problems. Thus, the present study aims to provide insight on the personal and environmental influences on help-seeking behaviour for individuals who have experienced work-related mental health problems through the lived experience of workers seeking help for such problems. Through the insights gained we draw implications for improving programs and pathways to support for workers with mental health problems.

What constitutes “help” in help-seeking has been debated [31]. Beyond formal treatment, workers may benefit from other supports in and outside of the workplace. In this study, we take a broader view of help-seeking, defining it as any measures taken by individuals who perceive themselves as requiring personal, psychological, emotional, or social support, care or service, with the goal of meeting this need in a positive way (i.e., health practitioners, family, friends, clergy, workplace and institutional supports [31]).

Methods

Design

This study used qualitative methods to provide in-depth, contextualized insight into worker rationale, motivations, emotions, and behaviours when seeking help for work-related mental health injuries through their lived experience. Qualitative methodology is often used to answer questions about experiences and to discern meaning and perspective from the viewpoint of the participant [32] and provide an in-depth
understanding of individuals’ rationale and situational experiences [33]. Ethics approval was received from Trent University’s Research Ethics Board on January 10, 2020 (protocol #26024).

**Theoretical Orientation**

This research takes a critical theory approach to identify and highlight the systems, processes, stigma, and power imbalances individuals experience when seeking help for workplace mental health injuries. Critical theory challenges the status quo and strives for equality in society [34]. Critical theory can be defined as aiming “to seek human emancipation to liberate human beings from the circumstances that enslave them.” [35]. Critical theory concerns itself with the imbalance of societal power. Adequate critical theory follows three criteria: 1) it must explain the current state of societal inequities, 2) it must discern what action is required to change it, and 3) it must include an understanding of the status quo to be able to critique and inform change. As such, a critical theory approach was taken to give a voice for those that have, or will, experience the difficulties with the current system and processes so that existing standards, mindsets, and policies are challenged with the goal of inducing positive change.

**Context**

The study was performed in Ontario, Canada. More recently, this jurisdiction has workers’ compensation legislation providing workers with income replacement and health care support for work-related mental health problems arising as a result of acute or chronic workplace exposures. Gaining access to such support is limited as the vast majority of such claims are denied by the workers’ compensation system [36,37]. Employers may also provide short and long-term disability support for workers affected by mental health problems. Workers also have access to sickness absence benefits through federal Employment Insurance and welfare support for disability through the provincial government.

Publicly funded mental health services have traditionally been limited. Supports have been available through community agencies and, more recently, individuals have been able to access mental health services through family health teams and community clinics. Some employers provide Employee Assistance Programs (EAP’s) that include counseling services, and some provide extended health benefits that include mental health services. These systems lack any form of coordination in providing support to affected individuals.

**Sampling And Recruitment**

Purposive sampling focused on gaining a naturalistic sample of participants having sustained a self-declared WHMI, who had or were currently seeking treatment for their problem. Owing to ethical considerations, the present study relied upon self-identification of WMHI; no verification of the injury, diagnosis, or workplace relatedness was sought by the researchers from healthcare providers. Furthermore, participants were eligible regardless of whether their experiences were within benefit systems like workers’ compensation or if any or all help-seeking activities were self-funded. Participants’ employment status was also not considered as an eliminating factor for participation in this study. Participants were excluded if the mental health problem was a result of a workplace physical injury or if they did not judge their mental illnesses to not have originated in the workplace.

Social media (i.e., LinkedIn and Facebook) and posters in local businesses and mental health practices were used to recruit participants. Snowball sampling (generating participants through referrals from previous participants) was employed as some participants forwarded the social media link to friends that they believed may be interested and eligible to participate. Potential participants contacted the research team if they wished to participate in the study.

**Data Collection**

Data was collected between January 15, 2020, and April 6, 2020, and included both the initial interview and a four-week follow-up interview. Meetings were scheduled at the participants’ convenience in a private, confidential environment (n = 10) or virtually through online video conferencing software (n = 2). Participants were first screened to determine whether they meet inclusion criteria and written, informed consent was obtained from all participants. A gift card of $25 was provided as an incentive.

A guide (see supplementary material) was used to support the interviews. The interview protocol took an exploratory and semi-structured approach to attain a holistic view including the workplace experience leading up to the mental health problem, the problem itself, the help-seeking process, remedies or mitigation and interactions with insurance, workplace and healthcare actors. The interview protocol evolved throughout the data collection process to include the individual’s understanding of their injury and perception of recovery. Initial interviews
ranged from 42 to 93 minutes, depending on the participants’ availability and experiences. Follow-up interviews were conducted approximately four weeks later, either in person (n = 1) or over the telephone (n = 10), to confirm impressions from the initial interview (i.e., member checking) and for any updates regarding the participants’ circumstances with their work-related mental health problem. Participant 2 was unable to complete the follow-up interview owing to COVID-19 pandemic issues. Follow-up interviews ranged from 14 to 58 minutes.

A short questionnaire was used to collect demographic information (age range, gender, and level of education, employment status, current occupation). The questionnaire also asked about their diagnosed mental health disorder and any treatments received (current or past). The 21-item Depression, Anxiety, and Stress Scale (DASS-21) (Appendix B) was used to normatively describe the sample. DASS-21 has been found to be reliable in assessing depression, anxiety, and stress with internal consistency reliability \( \alpha = .91, .80, \text{ and } .84 \), respectively [38]. The questionnaire was provided to the participant after obtaining consent and prior to the start of the initial interview.

**Data Analysis**

Recorded interviews were transcribed verbatim and reviewed for accuracy. The analysis combined elements of interpretative phenomenology and thematic content analysis. Interpretative phenomenological analysis provided a flexible framework to deeply understand the lived experiences of the participants [39]. Thematic content analysis ensured systematic organization of emergent patterns that emerge from the data [40]. Transcripts were coded line-by-line using ATLAS.ti 9 Windows software (Berlin, Germany). Multiple reads using progressive coding (open, axial and selective) was used to code the data [41,42]1. The result was an organized and detailed thematic grouping of the data, which provided a meaningful view of participants’ thoughts, emotions, and behavioural processes for help-seeking after experiencing a work-related mental health injury.

Sociograms [43] were constructed for each of the cases to depict the actors from four work disability systems [44] personal, workplace, healthcare, insurance - involved in the participant’s story, the perceived level of support provided and how the actors were connected. Help-seeking pathways were constructed from the interview narratives to depict the sequence of supports and consequent changes to the participant’s situation.

**Results**

A summary of participant demographics can be found in Table 1. A total of 12 participants participated in this study with women making up two thirds of the sample. Age spanned the range of working age (21 to 60 years). Six of the participants worked in the education, law and social, community and government services (including social work, police officers, and educational assistants), four worked in business, finance, and administration, one in management and one in health. Most participants had post-secondary education.

Self-reported mental health disorders included depression, anxiety, and PTSD. Consistent with the diagnostic criteria for these disorders, participants (n = 12) described emotional and physical fatigue that were often not recognized by those around them. The majority of participants had a familial history of mental health disorders; however, most participants did not report mental health conditions prior to the WMHI. Most participants had experienced their WMHI longer than 1 year ago and only one participant sustained the WMHI within recent months. At the time of the interviews nine participants had left their employer where they sustained their WMHI while three participants had stayed with their employer.

According to participant responses to the pre-interview questionnaire, participants identified their WMHI when it reached the extent that they had to take sickness absence or leave work. Participants’ WMHI’s were a result of cumulative stressors and/or direct or vicarious traumatic exposure. Participants may have sought treatment prior to declaring that there was a WMHI, mainly owing to lack of recognition or acceptance of a problem or a critical incident that resulted in a crisis in coping and declaration of the need to take time off.

At the time of the first interview, DASS-21 scores indicated that most participants (n=9) had at least one of depressive, anxious or stress scores in the severe range [45] and elevated in comparison to normative samples [38]. We considered the sample high functioning but distressed and most participants were still actively receiving help for their WMHIs at the time of the interviews.

Resources were categorized into workplace resources, healthcare resources, institutional resources, and personal resources according to the Work Disability Paradigm [46]. Patterns of resource access are described in sociograms [46] in the supplementary materials. Resource access varied considerably among participants as did the degree of support perceived by participants from the various sources. Trajectories of resource access are likewise described in the supplementary materials.
<table>
<thead>
<tr>
<th>ID</th>
<th>Gender</th>
<th>Age</th>
<th>Education</th>
<th>NOCC</th>
<th>Pre-existing MHIs</th>
<th>Family history of MHIs</th>
<th>Causal Incidents</th>
<th>WMHIs Sustained</th>
<th>Time Since WMHIs</th>
<th>Occupational Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Male</td>
<td>41–50</td>
<td>Not reported</td>
<td>Business, finance, and administration</td>
<td>Bipolar</td>
<td>Bipolar</td>
<td>Depression, anxiety, mania</td>
<td>1 year</td>
<td>Different job, different employer</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Female</td>
<td>51–60</td>
<td>College diploma</td>
<td>Business, finance, and administration</td>
<td>No</td>
<td>Depression, anxiety</td>
<td>Anxiety, PTSD, insomnia</td>
<td>1 year</td>
<td>Different job, different employer</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Female</td>
<td>41–50</td>
<td>College diploma</td>
<td>Education, law and social, community and government services</td>
<td>No</td>
<td>Depression, anxiety</td>
<td>Depression, anxiety</td>
<td>2 months</td>
<td>Same job, but looking for different employer</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Male</td>
<td>41–50</td>
<td>Master's</td>
<td>Management</td>
<td>PTSD</td>
<td>Bipolar, depression</td>
<td>Depression, anxiety, insomnia, NSSRD</td>
<td>1 year</td>
<td>Same job, different employer</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Female</td>
<td>41–50</td>
<td>College diploma</td>
<td>Education, law and social, community and government services</td>
<td>No</td>
<td>Obsessive compulsive disorder</td>
<td>Depression, anxiety, PTSD</td>
<td>12 years</td>
<td>Retrained in new occupation, currently unemployed</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Male</td>
<td>31–40</td>
<td>College diploma</td>
<td>Education, law and social, community and government services</td>
<td>No</td>
<td>No</td>
<td>Depression, PTSD, insomnia</td>
<td>4 years</td>
<td>Currently training in new occupation</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Female</td>
<td>51–60</td>
<td>College diploma</td>
<td>Education, law and social, community and government services</td>
<td>No</td>
<td>No</td>
<td>PTSD</td>
<td>1 year</td>
<td>Left employer, looking for alternate occupation</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Female</td>
<td>21–30</td>
<td>College diploma</td>
<td>Education, law and social, community and government services</td>
<td>Yes – not specified</td>
<td>Depression, anxiety</td>
<td>Anxiety, NSSRD</td>
<td>3 years</td>
<td>Same job, different employer</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Female</td>
<td>41–50</td>
<td>Bachelor's degree</td>
<td>Business, finance, and administration</td>
<td>No</td>
<td>No</td>
<td>Depression, anxiety, PTSD, insomnia</td>
<td>6 years</td>
<td>Different job, same employer</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Male</td>
<td>41–50</td>
<td>College diploma</td>
<td>Education, law and social, community and government services</td>
<td>No</td>
<td>No</td>
<td>Depression, anxiety, PTSD, insomnia</td>
<td>9 years</td>
<td>Different job, same employer</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Female</td>
<td>31–40</td>
<td>Bachelor's degree</td>
<td>Business, finance, and administration</td>
<td>Depression, anxiety</td>
<td>Depression, anxiety</td>
<td>Depression, anxiety, insomnia</td>
<td>2 years</td>
<td>Same job, different employer</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Female</td>
<td>41–50</td>
<td>College diploma</td>
<td>Health</td>
<td>Not reported</td>
<td>Not reported</td>
<td>PTSD</td>
<td>5 years</td>
<td>Same job and employer, with accommodations</td>
<td></td>
</tr>
</tbody>
</table>
Note. ID = Participant Number, NOCC = National Occupational Classification Category, WMHIs = workplace mental health injuries, PTSD = post-traumatic stress disorder, NSSRD = non-specific stress related disorder, MHIs = mental health illnesses

*Occupations were classified using the Canadian National Occupational Classification system.

**Participants were asked to self-report mental health conditions as diagnosed by their healthcare practitioner, e.g., physician, psychologist and number of mental health injuries they sustained.

***Causal incidents are participant perceived number of incidents relating to their WMHIs.
Table 2
Summary of Participant DASS-21 Scores and Utilized Supports

<table>
<thead>
<tr>
<th>ID</th>
<th>Depression</th>
<th>Anxiety</th>
<th>Stress</th>
<th>Receiving Treatment</th>
<th>Workplace Resources</th>
<th>Healthcare Resources</th>
<th>Institutional Resources</th>
<th>Personal Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Severe (0.77)</td>
<td>Moderate (0.32)</td>
<td>Extremely Severe (1.43)</td>
<td>Yes</td>
<td>PCP, psychiatrist, hospital, counsellor, crisis support group,</td>
<td>Community services</td>
<td>Partner, family, friends</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Moderate (0.28)</td>
<td>Severe (0.80)</td>
<td>Severe (0.90)</td>
<td>No</td>
<td>Human resources</td>
<td>PCP, psychiatrist, psychologist, occupational therapist</td>
<td>Workplace insurance &amp; benefits</td>
<td>Partner, family, friends, clergy</td>
</tr>
<tr>
<td>3</td>
<td>Severe (0.65)</td>
<td>Extremely Severe (1.60)</td>
<td>Extremely Severe (1.17)</td>
<td>Yes</td>
<td>Supervisor, EAP</td>
<td>PCP, EAP</td>
<td>Workplace insurance &amp; benefits</td>
<td>Family</td>
</tr>
<tr>
<td>4</td>
<td>Extremely Severe (1.26)</td>
<td>Normal (-0.16)</td>
<td>Mild (-0.02)</td>
<td>No</td>
<td>Human resources</td>
<td>PCP, psychiatrist, psychologist</td>
<td>Workplace insurance &amp; benefits</td>
<td>Friends</td>
</tr>
<tr>
<td>5</td>
<td>Severe (0.77)</td>
<td>Extremely Severe (2.55)</td>
<td>Severe (1.03)</td>
<td>Yes</td>
<td>Colleagues, manager, superintendent, union</td>
<td>PCP, psychiatrist, group therapy, hospital</td>
<td>Ontario Disability Support Program</td>
<td>Partner, family</td>
</tr>
<tr>
<td>6</td>
<td>Normal (-0.21)</td>
<td>Severe (0.80)</td>
<td>Moderate (0.25)</td>
<td>Yes</td>
<td>Manager, colleagues, EAP, Critical Incident Stress Management</td>
<td>Psychiatrist, psychologist</td>
<td>WSIB</td>
<td>Partner, family, friends</td>
</tr>
<tr>
<td>7</td>
<td>Moderate (0.52)</td>
<td>Moderate (0.48)</td>
<td>Extremely Severe (1.17)</td>
<td>Yes</td>
<td>Colleagues</td>
<td>PCP, psychiatrist, group therapy</td>
<td>Spousal work insurance, community resources</td>
<td>Partner, friends</td>
</tr>
<tr>
<td>8</td>
<td>Normal (-0.21)</td>
<td>Normal (-0.16)</td>
<td>Moderate (0.51)</td>
<td>No</td>
<td>Colleagues, workplace group therapy</td>
<td>PCP, psychiatrist, group therapy</td>
<td>Employment insurance</td>
<td>Family, friends</td>
</tr>
<tr>
<td>9</td>
<td>Normal (-0.45)</td>
<td>Normal (-0.64)</td>
<td>Mild (-0.15)</td>
<td>No</td>
<td>Colleagues, EAP, union</td>
<td>PCP, human resources</td>
<td>Workplace insurance &amp; benefits</td>
<td>Friends</td>
</tr>
<tr>
<td>10</td>
<td>Severe (0.89)</td>
<td>Normal (-0.16)</td>
<td>Mild (-0.02)</td>
<td>No</td>
<td>Colleagues, workplace mental health, human resources, unspecified mental health professional</td>
<td>Psychologist</td>
<td>Workplace insurance &amp; benefits</td>
<td>Friends</td>
</tr>
<tr>
<td>11</td>
<td>Extremely Severe (1.74)</td>
<td>Extremely Severe (1.92)</td>
<td>Severe (0.77)</td>
<td>Yes</td>
<td>Colleagues</td>
<td>PCP, psychologist</td>
<td>None</td>
<td>Partner, family, friends</td>
</tr>
<tr>
<td>12</td>
<td>Severe (0.65)</td>
<td>Extremely Severe (1.12)</td>
<td>Extremely Severe (1.17)</td>
<td>Yes</td>
<td>Human resources</td>
<td>PCP, hospital physician, psychiatrist, psychologist, occupational therapist, social worker, group therapy</td>
<td>WSIB, in-patient program, work transition specialist, caseworkers, nurse consultants,</td>
<td>Partner</td>
</tr>
</tbody>
</table>

*Note. ID = Participant number, DASS-21 = Depression, Anxiety, and Stress Scale, 21-point, EAP = Employee Assistance Program, PCP = Primary Care Physician, WSIB = Workplace Safety and Insurance Board*

*Categorized according to the DASS-21 scoring scheme as developed by Lovibond and Lovibond [49] and evaluated on a normal adult sample (N = 717) [47].*
Individual Z-scores are bracketed in corresponding categories of Depression, Anxiety, and Stress according to the DASS-21 point scale and were calculated using Sinclair et al. (2011) mean and standard deviation of a non-clinical U.S. adult sample.

Workplace resources were defined as individuals within the workplace who may provide guidance in WMHI recovery. Healthcare resources included formal supports for mental health recovery. Institutional resources included financial support to aid in mental health recovery. Personal resources were participant's personal networks which were utilized during their help-seeking journey.

**Thematic Analysis**

Three main themes - self-preservation, fatigue, and trust - that were composed of seven subthemes were derived from the data. In Table 3 we summarise the themes, subthemes and prevalence among participants. Figure 1 illustrates the inter-related nature of these determinants on help-seeking for WMHIs and are presented in detail in turn.
Workers concealed injuries and distanced themselves from stressors as a means of self-help and self-preservation.

Participants in non-supportive and stigmatizing environments experienced the need to look internally to find strength and strategies in an effort to persevere and overcome the WMHIs and associated hardships.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Subthemes</th>
<th>Description</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workers concealed WMHIs as a means of self-help and self-preservation</td>
<td>Workers concealed WMHIs while attempting to regain coping capacity to preserve self-image during recovery.</td>
<td>Individuals used time-off work under the guise of a physical ailment or vacation to regain mental health coping capacity to avoid acceptance of or the label of a person with a mental health issue.</td>
<td>P2, P3, P4, P5, P9, P10, P11</td>
</tr>
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<td></td>
<td>Workers were reluctant to disclose mental health problems and access support because of fear of being demoted and/or facing harassment and/or losing their jobs</td>
<td>Experiencing or seeing negative consequences of disclosure made workers reluctant to disclose problems and seek help.</td>
<td>P3, P4, P11, P12</td>
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<td></td>
<td>Workers decided to change occupations or employers to distance themselves from the workplace situation or environment which caused or continued to cause WMHIs.</td>
<td>Individuals that decided to change occupations either had previous education allowing them to move to a different occupational field or decided to be retrained in an effort to leave their current occupational field. Other workers decided to leave their employer while remaining in the same occupational field. Individuals felt this was required for mental health recovery.</td>
<td>P1, P2, P3, P4, P5, P7, P8, P9, P10, P11</td>
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Complex help-seeking pathways and accumulated stressors caused fatigue leading to reduced independence in decision-making.

Participants experienced mental and physical feelings of exhaustion as a result of the complexity of obtaining resources and accumulated workplace stressors. This feeling of fatigue resulted in individuals deferring decisions regarding their help-seeking journey.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Description</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complex help-seeking pathways and accumulated stressors caused fatigue leading to reduced independence in decision-making</td>
<td>Workers experienced complex routes in obtaining resource supports for WMHIs recovery.</td>
<td>P1, P2, P4, P5, P7, P10, P11, P12</td>
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<tr>
<td></td>
<td>Due to a lack of a prescribed path to resource supports, participants were required to expend significant effort identifying and pursuing resources they felt would help in their recovery.</td>
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<td>Workers experienced an accumulation of emotional distress until coping capability was depleted.</td>
<td>All participants</td>
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<tr>
<td></td>
<td>An on-going experience of compounding workplace stressors caused diminished coping capabilities resulting in the individual’s WMHI.</td>
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<td>Workers experienced a decreased ability to make decisions regarding their own WMHIs help-seeking trajectory.</td>
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<td></td>
<td>Workers experienced a reduced capacity to act independently in mental health recovery decision-making.</td>
<td>P2, P3, P5, P6, P12</td>
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<td></td>
<td>Individuals that felt this was required for mental health recovery.</td>
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Trust contributed to resources accessed.

Participants felt that reliable and trustworthy resources were best found through individuals who could relate to their occupation. Alternatively, participants experienced a reciprocal mistrust between themselves and stakeholders when trying to access resource supports.

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<thead>
<tr>
<th>Theme</th>
<th>Description</th>
<th>Participants</th>
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<tbody>
<tr>
<td>Trust contributed to resources accessed.</td>
<td>Workers trusted WMHI resources referred from within their group and not under the perceived influence of employers.</td>
<td>P6, P7, P10, P11, P12</td>
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<td></td>
<td>Individuals felt confident in a referee’s guidance for mental health resource supports as a result of perceived feelings of relatedness to their job. Participants expressed a lack of trust in the motives of the employer and the employer provided mental health resources due to a perceived conflict of interest. This led to decreased trust, efficacy, and uptake of offered treatments.</td>
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<td></td>
<td>Workers felt the need to convince stakeholders of what they felt was an invisible illness.</td>
<td>P4, P10, P12</td>
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<td></td>
<td>Participants expressed feeling distrusted because of the continual need convince stakeholders of the legitimacy and severity of their mental health injury for the purpose of obtaining access to treatments, workplace accommodations, and financial support.</td>
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Workers Concealed WMHIs And Distanced Themselves From Stressors As A Means Of Self-help And Self-preservation

The help-seeking narrative of participants began with reluctance to acknowledge and/or disclose their mental health struggles. The primary response of most participants (11 of 12) to WMHIs was self-preservation by minimising, concealing and subsequently leaving their work or workplace. Fear of reprisal was a strong motivating factor. Nonetheless, these strategies had their limit and as participants continued at work, all eventually made changes to their work situation to distance themself from work stressors.

WMHIs were concealed in order to preserve self-image and regain coping capacity
For many participants the initial response to their emerging WMHI was not to seek help, but to deny or minimise their injury in an effort to avoid personal acknowledgement of “weakness” and/or being labelled as having a mental health condition. For example, in discussing his WMHI, Participant 4 admitted to his own internalised stigma, namely his thoughts that having a mental health injury meant he was mentally weak.

I guess I also have a bit of a stigma towards mental health because I certainly feel weaker, having had it ... so it kind of again why I drove myself not to take it [time off], I was just trying to get through the next year to get the vacation up not to admit to myself I needed a break, not to admit to myself I was having a problem that I could fix it myself, um ... yeah that's a blow to the ego for sure. Participant 10 used a physical issue, for which he was accommodated with time off work, to try and recover from his WMHI. As a police officer, this participant was conscious of the potential repercussions of disclosing a mental health problem including the loss of professional identity.

...but we as an industry, we have a big hesitation with any conversation around that because of the self-image and you identify yourself as a cop and if you lose access to your gun...so I think a lot of guys and girls will avoid that conversation and that was the same for me...

Initially participants believed that, if given some time to recover, they would be able to regain coping capacity and avoid labels of a WMHI from themselves and their employer and colleagues. Participants preferred to use their sick time or vacation time or a physical injury to conceal their mental health problem in the workplace. For the participants that discussed concealing their WMHI to gain pockets of time for recovery, this was largely unsuccessful and, as a result, they needed to employ increasingly drastic self-preservation tactics.

Workers were reluctant to disclose mental health problems and access support because of fear of being demoted and/or facing harassment and/or losing their jobs.

Consistent with much previous research [48, 49], participants expressed concerns about the social and economic consequences of disclosing mental health problems with a particular focus on work and the workplace - i.e., losing out on promotions, being demoted, being assigned to undesirable modified duties and losing their jobs. These concerns were not unfounded as Participant 5 described how she was let go by her employer after taking time off work for her WMHIs:

So, they didn't want to hire me full time, so they basically said there was no position for me. And they tried to make me feel guilty by saying, you know, there's other people that come to work every day and they deserve the rollover [conversion to full-time employment] more than you and so you know, you shouldn't fight it and let them have it ...they sent me a letter saying that I was a good employee and, but they had to, but they were saying goodbye, in a way that made it look like I wasn't being fired.

Participant 4 highlighted the insidious stress of working with a WMHI label when he stated “...you are always worried about your job, what is being said and will they [the employer] in fact find wiggle room to fire you because they're worried you'll take more time off ...”.

Even actions taken by employers with the intent of protecting the employee from harm, could still be a deterrent to employees in accessing appropriate support. As a police officer, Participant 10 explained that he was reluctant to step forward for fear of being stuck on a desk job and so chose to suffer in silence rather than come forward. Participants did not need to experience these outcomes directly; they were well-aware of other workers experiencing similar problems who suffered similar consequences. Fear of scenarios such as these deterred participants from disclosing mental health problems and accessing appropriate mental health supports.

Workers changed occupations or employers to distance themselves from the workplace situation or environment that caused WMHIs

Ultimately, most participants (n = 9) switched employers or occupations. Two participants felt that changing jobs but remaining with the same employer was sufficient to aid in their recovery from their WMHI. For some, walking away from their jobs resulted in a decrease or loss of income, but that was considered more psychologically acceptable than further mental stress, complete job loss, or possible permanent disability leave. Participant 4, for example, felt the only way to recover was to simply leave the job; “In my case it [WMHI] went away cause I switched jobs, I think I'd probably be back off again at some point if I was still working there.” Participant 7 firmly asserted that she would not return to her field (human services) owing to its triggering nature. “Like the bad memories and the nightmares and everything like that. Um, so I’m going to look at going into something else.” (P7)

Some participants self-advocated for workplace accommodations in an attempt to stay at work and access treatment support with limited success. Participant 4 received accommodation support from his psychologist to change his work schedule to reduce travel and be able to attend appointments, but this was not supported at the workplace. Consequently, P4 was unable to consistently attend treatment and subsequently left the job and workplace. P12 had similar problems with accommodations recommended by their psychologist denied by WSIB and the workplace.
Participants 9 and 10 managed to obtain ‘back door’ accommodations at the same employer. P9 requested a transfer to a different unit, which was denied but managed to bid into a different position through seniority provisions in the collective agreement. Participant 10 strategically initiated a change in positions due to a physical health issue, wherein he moved to a more administrative role with reduced work-related mental stress. Participant 12 was unique in obtaining permanent workplace accommodations which entailed moving her from rural work to urban work, where she felt better supported by other first responders and less likely to experience the same type of events which caused her WHMI.

Interestingly, even with the change of employer, occupational fields, or jobs, the resulting impact of the initial WMHI continued to follow participants into their new jobs as they still felt the need to protect themselves through concealment. Participant 11 discussed what it is like for her in her new job with a new employer:

It’s good yeah, I like this, the new job yeah it’s a lot of the energy is going towards again looking healthy to seem more healthy than I actually am. ...I haven’t disclosed at work that I’m unwell and I’m quite afraid that it might backfire but for as long as I can keep going without disclosing that I’m, I’m going to do that.

**Complex help-seeking pathways compounded stress and fatigue and lead to reduced independence in decision-making for help-seeking**

This theme reflected the combined effort required to navigate complicated pathways to support compounding already present fatigue. Consequently, participants deferred decision-making for help-seeking to others, sometimes to their detriment.

**Workers Experienced Complex Routes In Obtaining Resource Supports For WMHIs Recovery**

Sociograms depict the complex pathways participants encountered in accessing workplace resources, healthcare resources, institutional resources and personal resources. Sociograms indicated that participants accessed between 4 (P3) and 16 (P12) workplace, healthcare, institutional, and personal resources. Sociograms also revealed the complex and varied nature of referral and access patterns for participants.

A few (P3, P4, P9) were relatively simple, including 4 or 5 supports and direct pathways of referral and access. Others (e.g., P10, P12) were extremely complex with multiple direct and indirect pathways to help and with the participant being bounced back and forth between supports (e.g., P11).

Resource pools varied as well. Some participants had rich pools of personal resources (e.g., P2), while others were modest (e.g., P10, P12). The use of institutional resources was absent in six participants (P1, P3, P4, P7, P9, P11) who dealt with their WMHI without accessing any form of insurance or system support. Some made extensive use of workplace resources and found them helpful (P10, 4), while others made little use (P2, P4) and found any they used unhelpful. All accessed healthcare supports to varying degrees with varying degrees of helpfulness. For some, the Primary Care Physician provided the sole (P3, P8, P9) and most helpful source of healthcare support, while others had a rich network of healthcare support (P12). For those participants that experienced more straightforward paths, such as Participants 3, 4, 8, and 9, significant effort was still required for them to obtain help as was evidenced by their narratives.

The narrative trajectories shown in the supplementary material present a sequential overview of participant-accessed resources and the outcome from help-seeking. Help-seeking trajectories, when viewed together, highlighted that there was no singular or prescribed pathway to treat WMHIs. Most participants reported an arduous and complex help-seeking journey and sometimes the paths selected were unhelpful and the participant had to step back and try another route. Even those that had few points on the trajectory reported difficulty finding or accessing services or healthcare practitioners.

In addition to experiencing difficulty in finding help, participants also experienced difficulty accessing the available and suggested treatments. Participant 4, 10, and 11 discussed difficulties in accessing resources because of the times these were offered. For example, Participant 10 discussed how mental health supports in the workplace were scheduled around times that were only beneficial to office administrators, and as a result many of the individuals that worked in the field were not able to access these workplace resources. For Participant 11, some treatments prescribed by primary physicians were only available during regular work hours, thus making it difficult to attend. Participant 3 reported difficulty getting appointments with their family physician - a significant barrier, as most participants sought out guidance from their primary physician for treatment or referrals.

Systemic barriers proved to be another obstacle to help-seeking. When deciding which mental health supports were a good fit, some participants found themselves on the wrong side of the eligibility requirements. Participant 10, for example, was denied access to a counselling program supported by workers’ compensation, which resulted in anger and disengagement from help-seeking despite worsening WMHI symptoms. Others described that support programs sponsored by workplaces required formal diagnoses of conditions, like PTSD, that were hard to obtain in the first place and therefore left many workers not eligible for the program. Where benefit coverage was available to
receive psychological services for a diagnosis, the number of sessions covered was limited resulting in large out-of-pocket expenses for the worker.

The challenge of accessing certain systems was also a barrier to help-seeking. The significant amount of time taken to process claims through the workers’ compensation system resulted in either delays in treatment or significant out of pocket expenses for participants should they decide to cover treatment costs. In some cases, these hassles resulted in participants opting out of that system. For example, Participant 8 had previous experience making a workers’ compensation claim for a physical injury and, as a result, decided to pursue an employment insurance claim for their WMHI to avoid what they considered to be persistent, invasive, and repetitive questioning by compensation caseworkers which they previously experienced during their physical injury claim. Although Participant 8 felt that EI was not an ideal system because it provided less financial and mental health service support, its simplicity was less emotionally taxing therefore more appealing.

Other participants did access support through workers’ compensation, with variable experiences, seemingly due to changes in claims adjudication. Submitting a claim prior to a change in legislation (2016) that de facto recognized compensation entitlement for psychological injuries in first responders, Participant 12 faced delays in accessing treatment due to the timeliness of the workers’ compensation claims adjudication process. As a result, P12 had to pay out of pocket for psychological services to receive a diagnosis that enabled their entitlement to benefits - a seemingly Kafkaesque situation. Applying after this change in legislation, Participant 6’s claim was accepted without question. While Participant 6 agreed that workers’ compensation required significant detail for claim acceptance, he felt that the experience of the caseworker that was assigned to him allowed them to discuss some of the more specific stressors because the caseworker already had a good understanding of the participant’s work environment and the common WMHIs in that occupation.

Despite further changes in legislation in Ontario to increase workers’ compensation entitlement for WMHI’s many participants remained uncertain about which avenue to pursue. For example, when Participant 7 was asked why she did not pursue a WSIB claim after legislation had passed in 2018 for chronic mental stress in the workplace, she replied that it had not occurred to her that she might be entitled to support owing to her problems being psychological rather than physical.

All these experiences provide evidence that help-seeking is a complex process requiring much energy, thought, and action. Help-seeking occurred at a time of reduced energy, decreased self-agency, and high stress. This affected the agency of some participants in accessing mental health supports.

As a result of complexity and fatigue, some workers deferred decisions regarding help-seeking to others, with positive and negative results. Some participants (n = 5), including those with a straight-forward path to accessing help, still felt a sense of reduced capacity in decision-making and thus deferred decision making to others. For example, when asked about taking alternatives to treatment options dictated by workers’ compensation, Participant 6 responded “I kind I let them dictate how that was going to go.” adding “… basically whatever WSIB said I had to do, I did…”

Deferring decisions was not necessarily negative for the worker. Participant 5 related the support of their manager in accessing treatment support.

...one day I got to work and I freaked out, like I couldn't go in the gate, I just freaked out in the parking lot and another officer was there and she went and got my manager, my manager said the psychiatrist is in today, I want you to go see him. So, I went and saw the psychiatrist and he became my psychiatrist and he put me in the hospital at one point and that's when I got diagnosed.

Participant 12 enlisted the aid of her spouse who recognized that she was not coping well and insisted that she seek treatment. Also, a first responder, her husband recognized her symptoms of PTSD and understood the type of help needed.

Nonetheless, deferring decision-making to others had its risks. This was evident in the data from P5 whose manager advised against filing a workers’ compensation claim, despite the apparent material relationship between work conditions and the WMHI. Going along with this suggestion precluded P# from income replacement and treatment support afforded through the workers’ compensation system.

(Mis)trust Contributed To Resources Accessed And The Perceived Value Of Those Resources

Although not as prevalent as the first two themes, two facets of trust emerged that influenced participant help-seeking - trust in the source of help and feeling mistrusted by others in seeking help.

Workers trusted WMHI resources referred from within their group and not under the perceived influence of employers...
Participants, and in particular first responders, in the sample placed a high degree of trust in resources that were recommended by colleagues and other first responders owing to their shared experiences in the field. As P7 related:

... so the officers and fire guys and EMS, we all, we all kind of talk and say hey, have you tried so and so or hey, I'm seeing so and so, this is what they do and it's really working or it's not really working. ...I know a lot of the guys and myself included, like, that's your first go to is your, you know, your fellow workers,”

Participant 10 also discussed how, when they were at the point of needing time off work for mental health recovery, they sought out a colleague who experienced a similar situation and had also sustained a WMHI and sought help. Participant 10 said “I think the first time I went for a note for work would’ve been with the woman that my other deployed friend referred me to.”

Conversely, some participants (n = 3) viewed employer-supported resources with skepticism related to the motivation to provide support resources and the dual allegiances of employer-sponsored providers. Some participants felt employer provided resources were a band aid for poster over the problems in the workplace rather than a meaningful attempt to solve the workplace mental health problems. Participant 4 talked about their human resource department and their role in providing mental health resource supports:

...they would do a typical poster you'd see at work, ya know here's an employer, I think it was called EAP, employer-employee assistance program and there's mental health in it and they would say ya know “take a walk at lunch time for mental health” so on and so forth ... it was a poster of points every couple of months from HR, it was kinda an afterthought, certainly with physical stuff [i.e., physical injuries] was more important...
Not only did participants have concerns around how attuned their employer was with their needs for mental health supports, but participants also had doubts around confidentiality of the supports being provided by employers. Participant 4 expressed this concern when stating:

...part of me also thinks, the company pays for it, maybe it's not as confidential as going some of the other routes, more regulated, like the psychiatrist with the patient doctor confidentiality and the psychologist was paid for by me so there's no obligation to come back or write anything to the employer.

Participant 10 echoed this mistrust when contrasting reaching out to colleagues for help versus accessing workplace support.

... it's a lot easier if you're ya know speaking to your colleagues about versus reaching out and do what the company's offering cause there's that mistrust, the suspicion, ya know if I tell them this, am I gonna get burned on that ya know that sorta thing.

In a similar vein, P2 described how being mandated to attend a psychotherapist of the insurer's choosing affected their response to the intervention.

They were helpful but again, that's like, it can only be as helpful as you allow it to be, right, you know, if somebody, if somebody says the insurance company says I have to do this so I am sitting here and I'll just, we can just sit and stare at each other for 10 sessions, for 10 hours, whatever but that's the thing right.

**Workers felt the need to convince stakeholders of what they felt was an invisible illness**

While participants felt that they may not always be able to trust stakeholders they also felt that they, themselves, were not trusted throughout the process. To obtain help they felt the need to constantly convince others of what seemed to be an invisible illness to the outside world.

When Participant 12 experienced a WMHI and sought help through workplace resources, she felt she had to go through the incident meticulously and justify it was severe enough to cause injury just to receive support.

I really forensically went through the call too, so then I could take it to them because at that point it became me having to justify why I was having the reaction that I was having so I had to like explain whether it was scary enough to be able to be approved [for treatment support] and, and that's what has happened every uh, recurrence since, is it has to be scary enough to have brought my PTSD symptoms back.

Some participants (n = 4) discussed the invisibility of mental health injuries and the perceived workplace attitudinal differences between mental health and physical injuries. Participant 8 stated “I'm sure if I had broken my leg or my arm ya know what I mean in a cast it would have been a lot different because there was something physical instead of me just being off work for mental health.”

In addition to workplace parties, sometimes health care professionals needed to be convinced of their invisible illness. Participant 11, for example, had a difficult time in convincing her doctor that she had sustained a WMHI and the severity of her injury. The time spent trying to convince her primary physician resulted in additional delays in obtaining care by a psychiatrist. Having to participate in independent medical examinations was also a sign to workers that they were not to be trusted despite the gravity of the circumstances leading to the problem. In
convincing others about the severity of their problem, participants discussed how having to retell stories again and again resulted in retraumatization.

**Discussion**

We examined help-seeking for work-related mental health problems using qualitative interviews with 12 workers. Results demonstrated how participants engaged in self-preservation as a means of coping through concealing their WMHI as well as distancing themselves from the work environment where the incident occurred. Both internalized and externalized aspects of stigma were reasons workers concealed their injuries. All participants described complexity of obtaining resource supports contributing to fatigue and deferring decisions to others. Trust impacted participants’ decisions for which resources they chose to access. Participants felt a reciprocal distrust between themselves and stakeholders as, on one hand, they described a lack of trust in resource supports provided by employers and, on the other hand, felt the need to continually legitimise their condition and its effects to mistrusting employers. Importantly, the results demonstrated how getting help for WMHI's is a product of the interaction between the individual and the workplace environment, with both personal and contextual influences contributing to help-seeking.

Previous research has found limited effects of interventions designed to promote help-seeking on help-seeking behaviour for persons with depression, anxiety and other mental health problems [50] despite positive effects on intentions towards help-seeking. All of our participants silently struggled with mental health problems, some for long periods of time, before seeking help. The gap between intention and action is where behaviour change interventions often break down [51]. Our results help us to understand why these interventions may be coming up short at individual, relational and organisation/system levels.

Interventions typically target individual knowledge and motivation through mental health literacy interventions rather than facilitating action. While attitudes reported following a help-seeking intervention indicate a more positive orientation towards help-seeking, conflicting motivations can still be present. Our results demonstrated that internalised stigma was a significant deterrent to disclosure of mental health problems and help-seeking. Internalised stigma is the negative emotions, beliefs, and behaviours towards oneself because of a mental illness [52]. Previous metanalysis of the effect of stigma on help seeking across mental health conditions identified internalised stigma as having the most consistent negative effect on help-seeking and shame/embarrassment was endorsed by a median 22 percent of participants in the studies examined [53]. Disclosure concerns were rated as the most significant barrier to help, endorsed by a median 32 percent of participants. Participants were reluctant to acknowledge to themselves that mental health problems were present, feeling that acknowledging these issues would be a negative reflection on themself as a “weak” or damaged person who cannot be relied on. This personal evaluation posed a threat to both the individual's feelings of competence and their social identity thus motivated them to try to conceal and cope along in the hopes that things would improve.

At a relational level, external stigma also played a role through a reluctance on the part of participants to disclose to workplace parties for fear of being othered and experiencing employment repercussions (which were real). The general effects of stigma on help-seeking are well documented in deterring help-seeking, albeit with small overall effects [53]. Research demonstrates the strongest effect of disclosure concerns in stigma-based evaluations [53] and the default position of workers with mental health problems can be that of non-disclosure owing to stigma concerns [53, 54]. This is understandable through cognitive theories of risk that demonstrate that individuals are predominantly loss-averse (versus gain approaching) and thus reluctant to expose themselves to situations that would result in a loss of status [55]. Owing to the power imbalances present and high stakes, the workplace context amplifies the effects of stigma on help-seeking behaviour. Stigma, particularly in workplace settings where performance and competence are highly valued, may exert greater negative effects on help-seeking behaviours despite the worker's best intentions to seek help. Indeed, employment-related discrimination is one of the primary barriers to help-seeking identified in a previous metanalyses [53].

The effects of stigma can be understood through the lens of Social Identity Theory, which posits that persons possess both individual and group identities and choose if and when to acknowledge and deploy aspects of identity in social settings like workplaces to manage their impression of others [56]. How we relate to and deploy our identity can be complex and varies according to a number of factors internal and external to the individual including the contextual aspects of risk/reward. Strong and rigid ties to a self-concept focused on the worker role can make it more difficult for individuals to carry thoughts about themselves as anything less than a reliable and competent worker, leading to avoidance of acknowledging the gravity of mental health problems through distracting thoughts such as ‘if I can make it to my holidays and get a break, I will be ok’. At a relational level we strive towards inclusion in groups. Disclosure of perceived undesirable qualities to other members of the group, particularly those with power and influence, elicits fear and anxiety about being cast out or losing status. Both mechanisms make denial and concealment understandable in the context of help-seeking behaviours.

A related dimension - trust - emerged as a factor influencing help-seeking. Personal disclosure of mental health problems can make people feel vulnerable, and therefore, is perceived to be emotionally risky. In an ideal interdependent relationship, trust is an acceptance of
vulnerability and a confident expectation that another other party will act in good faith and not take advantage of a situation [57]. In help-seeking, trust allows individuals to disclose vulnerabilities while feeling secure that the help-giver will take care of their best interests. Trust is an important factor in general help-seeking in workplaces [58]. Similar to other studies on workplace mental health [59], the participants' experiences indicated that, when seeking help and advice, participants trusted those who would not only take a non-judgmental stance, but also those who could most relate to their experiences including coworkers who had similar mental health experiences and shared the same work culture. Intentions towards help seeking may be negatively affected by a relational environment where trust is lacking, for example where gossip is common and individuals with similar concerns have received adverse treatment (e.g., being fired) or by demonstrations of mistrust (e.g., questioning the legitimacy of mental health problems) on the part of workplace actors. This may be particularly relevant in security occupations, such as law enforcement, with "suck it up cultures" and where help-seeking might result in removal from duty.

At an organisational and systemic level our findings point to the variable value of workplace and healthcare supports and the exhausting process through which individuals with mental health problems (who are already fatigued) may pass to access help. Similar to previous research, normative aspects of personal disclosure and how workplaces handle mental health issues including threats to job security and status were important aspects of help-seeking [60]. This research elucidated just how complex pathways and systemic barriers resulted in many of our participants abandoning or simply not enacting plans for help-seeking. This is not unique to the experience of these individuals. Research in mental health service delivery depicts an often unknown and/or inaccessible fragmented collection of services [61]. Primary care physicians remain the main point of initial contact and site of service delivery, yet physicians and mental health care operate in different spheres. Thus, individuals who have solid intentions towards seeking help find themselves having to put forth so much effort to access resources that the immediate costs outweigh potential benefits. Related to trust, confidentiality concerns may also impact on help-seeking.

Integrating organizational and systemic factors into a theory base could help to advance help-seeking research and practice. Social ecological models such as the IGLOO (Individual, Group, Leadership, Organization, Outside Influences) framework [62] and Work Disability Paradigm [46] have been proposed as models that incorporate key features of the environment in and outside of the workplace that help to understand the role of context in workplace health and disability. For example, at the leadership level direct supervisors need to have refined communication skills and sensitivity around information management when dealing with the personal disclosure of mental health problems. Health care providers need to consider the worker's personal and workplace context when helping them reintegrate to work following a period of sickness absence. Our research supports this contention, pointing to the importance of integrating mental health services into primary care pathways and developing an organizational culture conducive to help-seeking.

**Implications**

Our findings speak to the need to consider help-seeking as highly contextualized behaviour. Interventions for help-seeking that are focused on the individual are missing key environmental and systemic influences in the process. Again, we can consider the individual, relational and organizational levels in supporting help seeking.

At an individual level, the observation that many workers continue to conceal and carry mental health challenges with them into new work settings causes concern. First, in changing jobs and/or employment settings, workers are not guaranteed they will not encounter similar and new stressors in a new work environment, along with having to develop relationships and elicit social support in a new environment. Workers considering such moves should seek counsel and those working with such workers should prompt discussion with them in considering changes in employment. Workers considering job change should also explore workplace supports in alternative employment situations, such as inquiring about benefit coverage and workplace programs aimed at employee wellness, so that they can be more selective in finding workplaces that embrace and meaningfully support total employee well-being. In addition, in changing the environment the worker may be bypassing important shifts in personal coping style that could help them lead a healthier work life. Again, this should be part of discussions with mental health clinicians with a focus on building adaptive coping strategies whether the worker decides to stay at the current employment setting or move on.

While perceived need is perhaps a necessary condition for help-seeking, it is not sufficient. Workers need to feel safe internally and externally in disclosing information around mental health problems to seek help. Workplace practices that normalize mental health issues as a potential consequence of work (like it is done with back pain) can help to reduce personal feelings of personal inadequacy that might arise in the context of mental health struggles. Including mental health in health and safety discussions and having periodic check-ins targeting mental well-being help to make mental health a common part of the workplace discussion. Workplaces that develop an organisational culture that promotes fairness and transparency in dealing with issues of accommodation and considers investment in a happier, healthier work environment for workers are more likely to encourage help-seeking [63]. One off training interventions (e.g., Mental Health First Aid) are unlikely to be effective unless there is ongoing conversation about mental health in the workplace.
Likewise, fair, consistent, and transparent practices regarding how mental health issues are discussed and dealt with in workplaces can help to reduce the threat posed by external stigma for workers to enact help-seeking behaviours. Despite the best of intentions, programs like EAP that are administered solely by employers or rehabilitation interventions that are funded by employers may elicit feelings of threat and suspicion among workers, particularly where other signs (i.e., colleagues being dismissed) point to bad outcomes for disclosing mental health problems. Jointly developed supports may be an alternative where employer/worker committees develop practices for assistance/rehabilitation programs that help assure workers of the integrity of such programs. This needs to take place in a context where workers are not punished through dismissal or other punitive measures for disclosing mental health problems.

Actively strengthening social cohesion and relationships in workplaces and among work teams may also help to encourage help-seeking. Managers play a critical role in developing cohesive work teams and settings and set the tone in terms of what is and is not appropriate in discussion [64, 65]. In order to be comfortable discussing mental health issues, workers need to trust that, in exposing their vulnerability, their interests will be looked after. Developing trust requires a mutual history of exchange, hence a management style that includes the development of authentic relationships with workers will help to develop trust on the part of workers. The power differentials inherent in supervisor-subordinate relationships complicates this, requiring that managers be skilled social actors, with the ability to set appropriate boundaries while establishing these relationships.

Trust is reciprocal as demonstrated by participant concerns about not being trusted by other actors. It is said that if you want to be trusted, you need to give trust. In the case of WMHI, workers are in a vulnerable position and in a state of uncertainty. To foster disclosure and help-seeking in the workplace, trust needs to start with action on the part of managers and human resource professionals towards workers disclosing issues. As previous research has noted, the default position of those in positions of authority needs to shift towards acceptance and willingness to work with workers to prevent and manage mental health issues [62].

At a system level, providing clear pathways for workers to access support in a timely fashion is essential to reduce chronic exposure and promote positive outcomes for those with WMHI's. In the jurisdiction of the study (Ontario) Family Health Teams and Community Clinics now integrate mental health clinicians alongside physicians into primary care service. This can result in better access to mental health care, although it was not evident that any of our participants accessed such service. Research on such service delivery models supports this team approach, both in terms of patient satisfaction and outcome [66].

**Strengths And Limitations**

This study's strengths lie in the diversity of the sample (i.e., the range of occupations, age, gender), the lived experiences of the participants, and the exploratory qualitative approach and rigorous approach to data collection and analysis. This diverse sample of age, gender, occupations, resources utilized, and injuries experienced, creates a foundation by collecting a broad range of observations on WMHI help-seeking behaviours, which will enable future researchers to build upon to better understand any nuances between occupational classes or workplace environments. Further, the granular and detailed analysis contributes to our understanding of the complexities of seeking help for WMHI's and the internal and procedural barriers individuals often encounter as they attempt to navigate their return to well-being. At the same time these purposively sampled participants may not reflect the generalized experiences of workers seeking help for WMHI. Historical effects may also be present as more recent changes to workers' compensation legislation has included workplace stress as a compensable injury, although only under certain conditions. Early data following this change also indicates that the vast majority of claims for WMHI's are denied. The present study relied on self-reporting of the WMHI and subsequent diagnosis of the injury as access to this information for verification would be difficult to obtain both ethically and logistically, and, as such, was unable to confirm participant diagnosis or verify the mental health issue was solely a result of workplace incident or workplace environmental factors.

**Conclusions**

Helping interventions are only effective if the people needing them enact help-seeking behaviours. Our findings provide insight into the help-seeking process among individuals with work-related mental health injuries. While personal factors such as internalised stigma did play a role in help-seeking, interpersonal (stigma and trust) and contextual factors (system complexity) are key influences on help-seeking. A detailed understanding of context is important to advance research and practice in the area. Interventions that target relational and organizational/systemic factors are likely to enable the transition from help-seeking intentions to action among workers currently suffering silently with mental health difficulties.

**Declarations**

Funding - This study was not externally funded.
Conlicts of interest/competing interests - The authors declare no conlicts of interest.

Compliance with Ethical Standards - All procedures followed were in accordance with the ethical standards of the responsible committee on human experimentation (institutional and national) and with the Helsinki Declaration of 1975, as revised in 2000 (5). Informed consent was obtained from all participants for being included in the study. The Trent University Research Ethics Board approved this study (protocol #26024).

Author Contributions - All authors contributed to the study conception and design. Material preparation, data collection and analysis were performed by Kara Rutherford and Fergal O'Hagan. The first draft of the manuscript was written by Fergal O'Hagan and all authors commented on previous versions of the manuscript. All authors read and approved the nal manuscript.

References


Figures

Interconnectedness of Help-Seeking Determinants for Workers with Workplace Mental Health Injuries

Note. WMHIs = workplace mental health injuries

Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- SupplementaryMaterial1interviewguide.pdf
- SupplementaryMaterial2sociograms.pdf
• SupplementaryMaterial3trajectories.pdf