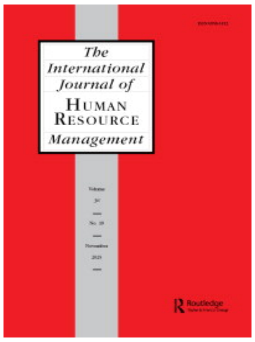

The International Journal of Human Resource Management

Routledge
Taylor & Francis Group

The International Journal of Human Resource Management

ISSN: 0958-5192 (Print) 1466-4399 (Online) Journal homepage: www.tandfonline.com/journals/rijh20

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**To cite this article:** Hadar Elraz & Jen Remnant (07 Jan 2026): Working against the backdrop of extreme marginalisation: stigma and the social relational model for the setting of mental health conditions, The International Journal of Human Resource Management, DOI: 10.1080/09585192.2025.2608825

**To link to this article:** https://doi.org/10.1080/09585192.2025.2608825

THE INTERNATIONAL JOURNAL OF HUMAN RESOURCE MANAGEMENT
https://doi.org/10.1080/09585192.2025.2608825

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# Working against the backdrop of extreme marginalisation: stigma and the social relational model for the setting of mental health conditions

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**ABSTRACT**

This paper investigates how employees with mental health conditions (MHCs) experience and respond to working in the contemporary UK workplace. Employing the Social Relational Model (SRM) of disability, the paper positions stigma as an organising structural force that actively produces Social and Relational disabling barriers – impairment effects, barriers to doing, and barriers to being – that shape the working lives of employees with MHCs. Qualitative data from 42 interviewees working for varied employers – including small, medium and large enterprises, public and private sector – reveals how workplace processes and practices assume norms of the 'ideal worker', a worker characterised by uninterrupted productivity and emotional stability. We explore how these norms contribute to the stigmatisation of workers managing MHCs and how consequently these workers avoid workplace stigmatisation. By explicitly linking understandings of structural stigma to the SRM, we advance understanding of how stigma operates in often indirect and subtle ways to disable employees with MHCs. Conclusions with implications for HRM include the need to confront normative ideals and institutional practices that sustain stigma by advocating for practices that dismantle stigma, challenge ableist constructs, support diverse mental health experiences and, focus on creating ideal workplaces, rather than continuing to valorise the ideal worker.

**KEYWORDS**
Disabilities; mental health conditions; stigma; inclusion; ableism; HRM practices

## Introduction

Mental health conditions (MHCs) encompass a broad spectrum of experiences – including anxiety, depression, OCD, PTSD, schizophrenia, and bipolar disorder – which are all characterised by fluctuating symptoms and diverse trajectories that resist uniform definitions. MHCs are the

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fifth most common reason cited for sickness absence in the UK (Mental Health Foundation, 2024), whilst research suggests that approximately 20% of the UK workforce may be actively managing an MHC (Chen & Wang, 2023). Despite these high numbers, most employees with MHCs do not receive appropriate support within the workplace (Mental Health-OECD, 2021).

Extant research underscores a wide range of negative experiences of employees with MHCs in the labour market, including disproportionate representation within lower status or insecure roles (Mitra & Kruse, 2016; Silla et al., 2005), heightened risks of losing their job (Gunderson & Lee, 2016), and poorer mental health linked to precarious employment. Within organisations, these disadvantages materialise in reduced career progression, increased absence, and even job termination. In the UK, each year up to 300,000 individuals with long-term MHCs lose their jobs due to insufficient workplace adjustments or inadequate support for mental health (Stevenson, 2017). The UK's Health and Safety Executive (2025) estimates that work-related stress, depression, and anxiety resulted in 17.1 million working days being lost in 2022/23. However, these outcomes are not inevitable consequences of individual impairment; but as a result of organisational norms and practices which often fail to accommodate people with fluctuating or invisible[1] conditions, which, in turn, perpetuates environments that actively disadvantage and stigmatise those also manage MHCs (Bam, 2025).

In this paper we understand stigma as a mechanism of social and structural inequality (Kalfa et al., 2021; Tyler, 2020; Zhang et al., 2021) and as an organising force that actively produces Social and Relational disabling barriers. We recognise that people with MHCs face both structural and social barriers at work. Though there are legal entitlements in the UK to request flexible working arrangements, access 'reasonable' workplace accommodations and be protected from discrimination (Equality Act, 2010), these processes put the onus on individual employees to access their entitlements, are inadequately developed in organisational policies (Remnant et al., 2024) and require managerial goodwill for implementation (Foster, 2018) – thus representing a structural barrier. Socially these same workers encounter stereotypes that frame them as unreliable or incompetent, which, in turn, lead to microaggressions, exclusion, and sometimes overt forms of discrimination (Elraz, 2018; Foster, 2018). These stereotypes are developed in opposition to the 'ideal worker' archetype developed by Acker (2006), where employing organisations assume, and reward, workers who are constantly available, do not have caring responsibilities and meet high and consistent levels of productivity; a concept further explored in the following sections.

Seeking to examine the experiences of employees with MHCs this understanding of ideal worker establishes a theoretical bridge between structural stigma and the SRM. Problematising the notion of the ideal worker as a mechanism through which disabling conditions are produced and maintained and how these expectations shape employees' interactions, opportunities, and self-perceptions, the paper illuminates how the 'ideal worker' norm functions as a relational barrier that disables people with MHCs. In doing so, it advances an integrated theoretical account that situates individual experiences of stigma within the broader relational dynamics and institutional arrangements that the SRM foregrounds.

Drawing on qualitative interviews with employees across diverse occupational contexts, we examine how individuals exercise agency in relation weighing up the 'pros and cons' of disclosure (Moloney et al., 2019), performance, and identity management to mitigate the impact of structural stigma in the workplace, and how these practices are shaped by organisational cultures and structures of support (or lack thereof). In doing so, we extend understandings of workplace stigma from a focus on individual pathology or attitudinal bias toward a more situated, relational, and structural account of how stigma is lived and negotiated at work. Detailing the theoretical meeting points of the SRM and stigma and exploring extant HRM literature on mental health, we situate our findings around four key themes, (1) the impact of managing MHCs in the contemporary UK workplace, (2) the use of tactical non/disclosure, (3) the additional labour of employees with MHCs and (4) accessing support outside of work. We conclude the paper with a discussion of these themes, and how they aid develop our understandings of the nuanced and sometimes subtle mechanisms of stigmatisation in the workplace.

## *Stigma in HRM scholarship and the social relational model of disability*

Workplace implications of stigma have been explored in numerous ways in academic literature, including exploration of how some occupations themselves are stigmatised (Ashforth et al, 2017; Ashforth & Kreiner, 1999), identity management for workers with 'invisible' stigmatised elements to their identity such as sexuality (Clair et al., 2005), and more recently, how organisational processes can themselves be stigmatising (Elraz, 2018; Hennekam & Descubes, 2024; Kalfa et al., 2021). Research in this area has produced important work in terms of both identifying stigma as a workplace issue and recognising stigmatising practices by employers, including HR professionals, aimed toward those experiencing obesity (Giel et al., 2012) and chronic health conditions (Bam, 2025) including MHCs (Hastuti & Timming, 2021). Some HRM literature in this area has focused upon processes of devaluation, stigmatised attributes (Jones et al., 1984), stereotyping and individual and interpersonal outcomes, which may have 'restricted us from examining stigmatization (sic) processes' (Zhang et al., 2021, p. 45).

In this paper, we argue that understanding stigma at a structural level can be theoretically aligned with the Social Relational Model (SRM) of disability advocated for by Thomas (1999, 2004). The SRM was developed to enable a deeper examination of how institutional and interpersonal dynamics intersect to produce disabling experiences. Thomas (1999:2004) does not explicitly use the language of stigma in her early writing, yet her theorizing of the SRM advances the interrogation of stigma not as an incidental by-product of individual bias, as it is often framed within HRM and related literature (Zhang et al., 2021), but rather a constitutive element of organisational practices, norms, and cultures that constrain participation and agency for disabled workers. This approach thus allows us to interrogate both the material and psychosocial dimensions of workplace exclusion, underscoring how stigma operates through policies, spatial arrangements, *and* everyday interactions to generate inequality. Despite its explanatory potential, the SRM is largely missing from employment literature, with the notable exception of Sang et al. (2022) who by examining the Higher Education workplace found that HRM practices socially constructed disability. The authors identified how the institutionally embedded sense of the ideal worker – a worker who meets organisational expectations without constraint or interruption – gave rise to barriers to disabled employees *via* its assumption of unreasonably high levels of physical and psychological capabilities. The valued, and assumed notion of this ideal worker, impacted disabled employees' progression and obliged them into negotiation and re-negotiation of workplace supports (Sang et al., 2022).

The SRM conceptualises disablement as arising from three interconnected dimensions: (1) impairment effects, which refer to the lived experience of managing symptoms; (2) barriers to doing, which capture structural obstacles to participation, such as, for example, rigid workloads and inflexible expectations; and (3) barriers to being, which involve attacks upon identity and self-worth (Sang et al., 2022). In this paper, we build on this conceptualisation by combining the SRM with processes of stigma and exclusion (Cologon & Thomas, 2014), which we argue is vital to understand individual experiences while advancing theoretical insight.

This integrated framework, then, of stigma *and* SRM-enables to understand the experiences of employees with MHCs as being socially produced, rather than being the consequence of individual health conditions. In this respect, the SRM stresses the need to understand in what ways disabled people navigate these specific barriers. However, the barriers experienced by employees with MHCs have only been explored in a handful of HRM studies (Hennekam et al., 2021)

### *HRM and mental health conditions*

Within HRM and organisational research, the focus has predominantly been on common MHCs, such as depression and anxiety, which are often treated as stable, individualised problems (Fryers et al., 2005; Irvine, 2011). This approach overlooks the dynamic and episodic nature of many MHCs (Park & Kim, 2020) and neglects how structural and organisational contexts shape whether and how these conditions become disabling. Persistent stereotypes of permanence also contribute to structural stigma by restricting opportunities based on perceived enduring incapacity (Kalfa et al., 2021).

HRM systems often reproduce stigma by reflecting outdated assumptions grounded in the medical model of disability (Bunbury, 2019). For example, the UK Equality Act (2010) protects employees with disabilities or health conditions but tends to emphasise recruitment over retention or in-work support (Tomas et al., 2022). Limited mental health literacy and the invisibility of many MHCs exacerbate disbelief, under-disclosure, and emotional strain (Elraz, 2018). Societal attitudes further compound these challenges: assumptions about stability and competence shape career trajectories (Brouwers, 2020; Mitra & Kruse, 2016), and public opinion can be ambivalent about the employment rights of people with MHCs (Fevre et al., 2013). Together, these organisational and societal factors create workplaces that often fail to accommodate, and may even worsen, the conditions they overlook (Giorgi et al., 2020; Hastuti & Timming, 2021).

Given the pervasiveness of workplace stigma and the limited effectiveness of current HRM practices (Kalfa et al., 2021; Remnant et al., 2024), it is vital to understand how employees with MHCs navigate these challenges. Disclosure of an MHC, particularly for invisible conditions, is critical for accessing legal protections under the Equality Act (2010) but simultaneously exposes employees to stigma, stereotyping, and labelling (Lyons et al., 2017; McKinney & Swartz, 2021; Toth et al., 2022). Employees often expend significant effort to appear non-disabled, balancing disclosure, symptom management, and workplace expectations (Irvine, 2011; Moloney et al., 2019; Quinane et al., 2021).

The understanding of stigma as structural and relational, embedded in organisational systems, policies, and broader societal norms (Lempert & Monsma, 1994; Link & Phelan, 2001; Loyd & Bonds, 2018; Pryor & Reeder, 2011), enables understanding the relationship between stigma and individual understanding of themselves as well how interactions, and opportunities are self-perpetuated through hierarchies, exclusionary practices, and ableist expectations (Doyle & Barreto, 2024; Sheehan et al., 2017; Tyler, 2020; Zhang et al., 2021). In the workplace, these dynamics intersect with HRM practices, producing barriers that go beyond individual behaviour to limit meaningful participation.

Societal and organisational expectations of the ideal worker – a fully available, productive, emotionally stable employee, unencumbered by external responsibilities – can contrast sharply with the realities of employees with MHCs (Mescher et al., 2010; Scholz & Ingold, 2021). This, combined with structural stigmatisation and reinforced by neoliberal and ableist ideals, shapes both in-work experiences and employability trajectories (Acker, 2006; Scholz & Ingold, 2021) for employees with MHCs while also contributing to their exclusion and marginalisation. As they are perceived to be failing to meet these norms (Tew, 2005; Williams, 2000).

Contemporary HRM research has begun exploring disclosure dilemmas, accommodation gaps, and personal strategies for managing MHCs (Hastuti & Timming, 2021; Hennekam et al., 2021; Quinane et al., 2021). However, few studies situate stigma as a structural, oppressive mechanism, and fewer explore how employees actively navigate these processes in daily work life (Hastuti & Timming, 2021; Shann et al., 2019). Similarly, few HRM studies draw on the SRM, which is particularly suited to understanding 'invisible disabilities' by highlighting relational and structural barriers, including navigating disbelief and disclosure concerns (Brouwers, 2020; Hennekam et al., 2021).

This paper addresses these gaps by applying the SRM to examine how employees with MHCs negotiate workplace expectations and structures. Specifically, it investigates how UK-based employees, protected under the Equality Act (2010), navigate the workplace through additional labour, non-disclosure, and seeking support outside formal channels. It addresses the following research questions:

1. How do employees with MHCs experience and respond to contemporary workplace expectations?
2. How do organisational structures and expectations shape the experiences of employees with MHCs?
3. What are the implications for understanding the SRM in the context of MHCs?

## Methods

Data was collected through interviews with the first author (researcher) that formed part of a larger project funded by the UK's Economic and Social Research Council. The broader project investigated the experiences of people with MHCs in the workplace. Interviews were adopted because they constitute a relatively natural setting through which to study how participants engage with sensitive issues related to their understanding of themselves and their work, which is predicated on the notion that they are experts over their own experience (Blaike, 1993; Shakespeare, 2013). The interviews facilitated sensemaking through the process of reflection and evaluation of current and/or past work experiences (Boud Keogh & Walker, 2013) with some emotional distance from experiences which may have caused upset in the past (Giæver, 2009). The focus here was to gain an 'insider' perspective, which, in turn, would allow understanding their social world and workplace experiences.

Participants were recruited *via* several avenues, including mental health support groups and mental health organisations. All the participants have been diagnosed with MHCs. While both the self-selection and call for participants may have skewed the sample, insofar as all of them were interested in discussing MHCs in the workplace, it is instructive to note that not everyone with an MHC shares the same sentiment or employs similar ideas or strategies to those outlined here.

Ethical considerations were addressed from the review process and throughout the research. All participants were informed both verbally and in writing about the study and signed inform consent, being fully aware that they can withdraw at any time. On top, the researcher sought to establish a trustworthy relationship with the participants, providing them with access to a helpline for mental health support, and routinely reiterating that they were not obliged to answer all the questions and could stop the interview at any time. Secondly, the researcher shared details from her own background in researching MHCs so that her orientation to the study topic both was known to the participants. This facilitated the establishment of a report and provided the participants with a sense of trust and reassurance (Dianiska et al., 2021).

The analysis is based on 42 interviews with employees with MHCs (30 with males[2] and 12 with females), aged 31–65. Their occupations, skills and qualifications were diverse, comprising accounting professionals (10%) insurance advisors (10%) engineers (15%) architects (5%), scientists (10%), health services employees (10%), semi-skilled/unskilled production workers (10%), teachers (5%), lecturers (5%), administrators (5%), business consultants (5%), business directors and senior managers (10%). All the participants have been diagnosed with a MHC (depression 30%; bipolar 35%; anxiety disorders 20%; OCD 10%; and psychosis 5%) but there was not any selection criteria focused on a specific MHC however, the ratio of the various MHCs encountered in the research was in accordance with prior research which found that mood and anxiety disorders are the most common MHCs in the workplace (Fryers et al., 2005). Semi-structured interviews lasted around one hour and were audio recorded and then transcribed verbatim. The following topics were discussed: participants' reflections on their work experiences related to their MHCs; how they dealt with workplace expectations; how they managed their MHCs.

Data analysis was conducted with an emphasis on the value of problematising current understanding of the studied phenomenon (Alvesson

& Kärreman, 2007). This approach facilitates the identification of novel insights within the data and supports the expansion of theory (Bergström & Knights, 2006). The analysis was carried out in multiple stages.

The initial stage began during the interviews, involving notetaking and familiarisation with the broad experiences shared by participants. Following this, the transcripts were anonymised, and the first two phases of theme development: initialisation and construction took place (Vaismoradi & Snelgrove, 2019). This process involved initial coding by identifying abstractions in participants' accounts and writing reflective notes, followed by classification, comparison, and labelling of the data.

The subsequent phases, rectification and finalisation, were conducted collaboratively by both authors. These stages involved distancing ourselves from the data and relating initial themes to existing literature (Nowell et al., 2017), before re-engaging with the data to allow themes to stabilise through discussions and continued drafting and revisions of the manuscript. This iterative approach enabled a maturation of the analysis and consensus on final themes (Vaismoradi & Snelgrove, 2019).

For example, codes related to disclosure and additional labour, involved categorising and labelling data regarding evidencing work ethic, productivity, and masking. These themes were refined through author discussions, which eventually centred on how participants aligned themselves with neoliberal ideals of high performance, where their desire to meet ableist expectations sometimes compromised their own wellbeing. We coded this as additional labour. This thematic development is visually represented in Table 1.

## Findings

Drawing upon the rich qualitative data gathered from the interviews, our analysis revealed four interconnected strategies that participants employed to navigate their workplaces. These strategies were not isolated coping mechanisms but rather relational responses to the systemic stigma and ableist job demand norms that pervade contemporary work environments – sometimes subtly – as illuminated by the Social Relational Model (SRM) (Thomas, 1999, 2004, 2012) and theorisation of stigma (Kalfa et al., 2021; Tyler, 2020; Zhang et al., 2021).

The iterative process of analysing the interviews quotes anecdotes' themes emerged (Vaismoradi & Snelgrove, 2019) provided the complexity needed to explore interrelation of themes (Coffee & Atkinson, 1996) which included linking key findings to literature. This allowed us to make connection and go back and forth between findings and theory. This also provided nuanced insights into how individuals with MHCs actively shape their experiences in the workplace, often in ways that

**Table 1.** 4 Findings strands in relation to the understanding stigma and the SRM.

| Theme | Exemplifying quote | Social relational model | Structural stigma |
|---|---|---|---|
| *Work is good for you until it isn't* | *I have enjoyed the work and find it meaningful, but the amount of stress can be quite harmful"* | *Barries to doing:* common job demands are challenging for individuals with MHCs; ableist norms assume absence of MHCs. | MHCs are not viewed the same as physical health conditions – the process of stigma is reinforced through perceived prejudices and ableist norms resulting in "special" stigma treatment. |
| Non-disclosure as practice of inclusion | *"I didn't want to compromise my employment chances by declaring my mental health condition so did not declare it to my employer"* | *Barriers to being:* MHCs are linked with stigma reflecting personal experiences and perceptions of research participants. | Reinforced through non-disclosure |
| Additional labour as coping mechanisms at work | *"Many times, I have to work additional hours, unpaid, to make up for times where I am unwell"* | *Barrier to being and barriers to doing:* Unable to work in workspaces without the additional labour; less time to relax also means the participants are more prone to become unwell | Reinforced through the excess work as means of attaining ideal worker norms |
| Outside help as form of self-management | *"I often attend peer support groups to help with the management of my mental health and where I don't feel judged or penalised"* | *Temporary removal of barriers to being only outside of the workplace:* having to access specific spaces outside of work where lived experience is actively valued and it is safer to disclose the MHC and feel supported | Reinforced through ideal worker norms and the invisibility/inaccessibility of workplace support |

reflect both resistance and conformity to prevailing norms, allowed to move beyond surface-level interpretations and identify the deeper structural forces shaping these experiences. The findings underscore how participants often internalised neoliberal ideals of personal responsibility, reflecting an alignment with ableist worker norms, even when doing so conflicted with their own health needs.

Table 1 shows the relationship between our four thematic strands, stigma and the SRM.

In the below, we have included indicative quotes, fieldwork notes and analytical notes to illustrate how the themes were developed.

## *Work is good for you, until it isn't*

A clear finding from this data set is that working individuals with MHCs value paid employment, beyond its role of generating income. Participants articulated in both subtle and more explicit ways that being in work was preferable to being out of work. In most of interviews participants did not engage explicitly in discussions of the stigmatised position of being unemployed or without work, but instead gently distanced themselves from that identity through valorising work as a way of being an active, and productive citizen. They alluded to the stigmatised nature of being out of work by situating paid work as being vital to develop self-respect and to gaining the respect of others. This sentiment aligns with broader societal beliefs about the value of work and its connection to identity and self-worth (Saunders, & Nedelec, 2014). Our findings suggest that this ideal is particularly salient for individuals with MHCs, who may experience additional pressure to demonstrate their value and counteract negative stereotypes.

For example, Eleanor,[3] a lecturer in her mid-forties, diagnosed with bipolar disorder, was clear that to not be in work was '*not good for your self-esteem or your confidence*', but perhaps most tellingly, would make you '*feel like you are not getting anywhere*'. This last phrase relates to productivity and purpose, a notion which was present to lesser and greater extents across all the study interviews and implicitly recognises the stigma associated with being a non-productive member of society.

Most participants also shared perspectives that echo more widely held beliefs about the benefits of paid employment. These included the social nature of work, as well the benefits of routine:

> [Work] gives me an agenda and structure for my week, and it is a very sociable experience [Edwin, anxiety and psychosis, gardener, late thirties]

However, despite sharing the view that being in paid work, in more general terms, was a good thing, participants were also able to identify how the contemporary workplace created challenges for them especially in relations to exceeding performance demands:

> There are less [sic] people in organisations … I do not mind a certain amount of pressure – it is when it is an excessive amount of pressure that it becomes a problem. [Stuart, bipolar, insurance advisor, early-forties]

Stuart, above, provides an example of how participants simultaneously framed work as essential while also struggling with the conditions required to meet normative expectations for example. He acknowledges that he is capable of managing some pressure, aligning with ideal worker assumptions, but also highlighted a tipping point where pressure triggered his MHC. This illustrates the SRM's 'barriers to doing' and how ideal worker norms reinforce exclusion by setting unrealistic standards for those managing fluctuating MHCs.

This reflects findings in wider literature that have shown that workplace pressures not only negatively impact the general health and wellbeing of people with MHCs (Woods et al., 2019), but also that common job demands are found to be challenging for employees with MHCs due to ableist norms which potentially trigger a decline in their mental health (Ahmad et al., 2025; Hennekam, & Descubes, 2024). Participants shared experiences of work intensification, work overload (Giorgi et al., 2020), and in some roles, customer abuse. All issues that are widespread throughout much of the labour market but are known to disproportionately impact disabled individuals (Fevre et al., 2013). From the SRM perspective this is indicative of the 'barriers to doing' part of the SRM. We can see an illustration of the oppression through the disabling nature of many workplaces characterised by excessive work pressures (Liao et al., 2025) and responsibilities which has a disproportionate impact on employees also managing MHCs (Tran et al., 2020).

Alongside the more subtle barriers to doing inherent in pressured workplaces, participants shared more explicit barriers they experienced at work as people with MHCs. Referring to the Equality Act (2010), they reported that '*despite legislation being in place, there is a certain level of stigma attached to mental health*' (Clive, bipolar disorder, radio engineer, mid-fifties) and were able to explain how they experienced that stigma. Specifically, participants felt that their conditions were not acknowledged in their workplaces highlighting the fact that their MHCs are not being visible disabilities. This invisibility was largely evidenced through the contrast that participants felt existed between the support offered to physically disabled people, and people with MHCs. Participants drew on examples, including the presence of stair lifts and ramps for wheelchair users. One participant discussed employees with diabetes, speculating that they would be allowed '*to go to the toilet every five minutes, or inject*', and that employers would '*accept that*' (Martha, bipolar disorder, music teacher, early-fifties). This comment is interesting, because diabetes is not necessarily a visible health condition, and so this participant was implying a more complex division than just in/visibility for managing workplace health conditions, that is specific to people with MHCs. This may suggest a non-monolithic (Beatty et al., 2019) typology of stigma for different conditions (see also Kalfa et al., 2021).

This notion of difference was repeated across the data, with many participants sharing the sentiment of Colin, a charity lead and business partner with depression in his early fifties who said '*…physical illness is seen differently to mental illness*', due to what many participants suggested was a lingering societal ignorance about the experiences and challenges of people with MHCs. This suggest that mental health stigma may be more disruptive than other stigma related health conditions. Consequently, this increases possibilities for worsen experiences of discrimination (Zhang et al., 2021).

Perceived ignorance and stigmatisation towards MHCs formed a significant part of the participants' accounts of their workplace experiences, thus underscoring how the type of disability one has is associated with the organisational response one receives (Toth et al., 2022). This nuanced relationship between *barriers to being* (i.e. mental health stigma), and *barriers to doing* (i.e. lack of workplace inclusion for MHCs) indicates a lack of visible representation or accommodations for employees with MHCs and represents the complex issues they need to navigate to retain in paid employment. The following sections explore the strategies deployed for this navigation.

## Tactical non/disclosure

A primary strategy used by participants was carefully controlling if, when, and how they disclosed their MHC at work. Being a calculated response to workplace environments structured by stigma and dominated by an ableism ideal worker norms ethos that demands consistent reliability, emotional stability, and uninterrupted productivity. Aligning with this ableist agenda especially in the light of increasing austerity (Bailey, 2024; Lewis et al., 2017) participants described non-disclosure protective act. Greg, an engineer in his mid forties, who manages depression, stated:

> I lied on the health questionnaire… because if I had disclosed, it could have prejudiced my position. In this industry, people don't want to take the risk.

Greg's narrative highlights how individuals are able to engage in HRM processes in such a way as to avoid disclosure, and in that, how stigma operates at a structural level: even before organisational relationships are formed, disclosure is anticipated to trigger disadvantage (Toth et al., 2022) due to shared assumptions that employees with MHCs might fail to meet the ableist ideal type ethos (Hennekam & Descubes, 2024). In SRM terms, this reflects a barrier to being – an organisational climate that signals some identities are less welcome or legitimate.

Other participants revealed their condition only to carefully selected individuals. Jamie (Scientist in his early fifties, depression) explained:

> I don't mention it to colleagues generally, but there are one or two I trust. I just don't think people would understand the up and down… they might question if I can handle the workload.

Drawing on 'the "othering" of employees with MHCs, skepticism about the veracity of MHCs' (Kalfa et al., 2021, p.3207), Rick, 30-year-old admin personnel (depression) explains:

> There is so much misunderstanding around depression and of course it is invisible if I discuss this at work, I may be taking unnecessary risk, so I try to keep this to myself and just take it one day at a time…

Here, non-disclosure emerges as a relational tactic to preserve a professional identity aligned with the ableist ideal type ethos. By masking the episodic nature of their condition, participants sought to shield themselves from the moralised judgement that associates fluctuating capacity with irresponsibility or incompetence (Elraz, 2018) or the violation of ableist workplace expectations (Scholz & Ingold, 2021).

Yet this strategy also placed significant emotional labour on individuals. Choosing non-disclosure required constant vigilance, managing signs of distress or scheduling medical appointments around work to avoid exposure (Jones and King, 2014). As Link and Phelan (2001) argue, stigma does not simply manifest as overt discrimination but compels self-regulation in anticipation of judgement – an insight that Tyler (2020) deepens by framing this as a structural systematic process that organises social hierarchies. Viewed through the lens of the SRM, these accounts reveal how workplace environments construct disability through social and institutional barriers rather than individual impairments (Thomas, 2004).

This concealment functioned both as resistance to workplace exclusion and compliance with normative ableist ideal worker expectations. While non-disclosure enabled continued employment and deflected attention from participants' MHCs, it also reinforced the structures that demand silence and uninterrupted output. Aligning with 'transactional HRM approaches' which 'are characterized by limited disclosure' (Kalfa et al., 2021, p. 3200), avoiding stigmatisation, necessitates further alignment with exclusionary norms. Paradoxically, this demonstrates how participants can be directed toward a narrow repertoire of coping strategies that ultimately reproduce the conditions they seek to escape.

## *Engaging in additional labour: compensating to approximate ableist assumptions*

Participants consistently reported undertaking additional labour to manage both their MHCs, and the stigma associated with them in the workplace, reflecting on the various sacrifices they make to maintaining workplace performance. This labour was emotional, cognitive, and physical and often stemmed from the choice not to disclose their condition, and experience the heightened stigma attached to MHCs relative to many physical health conditions. For example, Samantha (depression, business administration, early-sixties) noted, '*Recently, when I was diagnosed, I didn't tell my boss… it was quite difficult to go to work with all the medication*'.

Heavily relying on individual expertise and accumulated work skills, Adrian (OCD, charity manager, early-forties) reflected, *'I try not to let any outside thoughts interfere with what I am doing'*.

In addition, participants frequently reported working beyond contracted hours. This pattern of overwork was motivated by a perceived need to match the output of ableist workplace expectations and colleagues not managing MHCs.

Jeramy, IT consultant managing anxiety, captured this dynamic:

> I work longer hours than most of my team. I don't want anyone to think I can't cope or I'm a burden. So, I stay late, make sure my figures are always ahead of target.

Our findings support previous research suggesting that disabled employees often work longer hours to pre-empt any possible performance concerns (see also Colella & Bruyère, 2011)- this aligns with the 'prejudicial HRM approaches' which 'are relatively unconcerned with performance effects of MHCs, borne of a broad rejection for responsibility for MHCs and the anticipation that any adverse impacts of MHCs on work performance will be addressed by employees themselves' (Kalfa et al., 2021, p. 3207).

Here, additional work functioned as a compensatory performance. It was not simply about meeting job requirements but about exceeding them to avoid confirming stigmatised stereotypes of employees with MHCs as fragile or erratic – directly reflecting how the ableist ideal worker norm shapes what employees feel compelled to prove.

Similarly, Brian (Senior manager, depression, mid- thirties) noted:

> … I'm still pulling my weight, I don't want my mental health to suggest I am unreliable but to be working very, very long days and working in the night does put my mental health at risk so I need to be careful with that

Importantly, participants articulated that this additional labour frequently diverted energy and focus away from their core responsibilities. This suggests that stigma management itself constitutes a workplace burden for the individual employee, reinforcing inequality and undermining long-term sustainability of employment. While inclusive HRM policies may exist on paper (Sayce, 2003), they remain inaccessible to those unwilling or unable to disclose. As a result, the organisational conditions that necessitate such concealment go unchallenged and structural stigma is reinforced.

From an SRM perspective, these accounts underscore how disabling environments are shaped not by individual impairments, but by the institutional and social norms that compel silence and conformity. Consequently, this then suggests that organisational barriers to doing are not always about explicit denial of participation but about the unspoken, intensified demands placed on those whose identities do not align with the presumed norm. Stigma thus operates to structure not only what work is done but how much, and by whom.

This strategy also intersected with the uptake of individual responsibility to make up for their stigmatised, MHCs. By absorbing the responsibility to overperform, participants often reinforced the ableist assumptions underpinning the ideal worker – implicitly accepting that it was their burden to adapt, not the organisation's role to accommodate. This also reaffirm the stigma derived from HRM approaches to MHCs (Kalfa et al., 2021). As Tyler (2020) suggests, this is precisely how stigma maintains systemic inequality: it naturalises expectations that those marked as 'other' must do more to earn the same belonging.

### *Seeking support outside organisational structures: negotiating barriers to doing and being*

While participants often felt that disclosing their MHCs within work jeopardized their employment chances and intensifies structural stigma, they equally felt that disclosure in non-judgmental environments outside workplace was beneficial to them.

Unlike the management of MHCs at work, which involved aligning their outputs to their peers, hiding, masking or mitigating their symptoms, these spaces allowed individuals to be their full selves, inclusive of their MHC. For example, Phil, who has bipolar and worked as a telecommunication engineer prior to taking early retirement and working part-time at a local hospital, explained the disclosure process in a support group:

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

Not only did these spaces enable individuals to be honest about their MHCs, but they also allowed them to use their lived experience to benefit others, which was largely only an aspirational concept in the workplace. Neil, late thirties who has OCD and works in Academia and facilitates a self-help group, explained:

> You feel as if you have helped people when they go to the meetings and they say that it was beneficial. So, you feel that you have helped a little bit… so there are a lot of people out there who need help.

These sentiments illustrate the therapeutic benefits of disclosing MHCs in non-work settings, something that may in turn help the participants cope with work. Although these experiences of disclosure primarily occurred outside the workplace, the participants also emphasise the importance of disclosure in the workplace to enable support. For example, Ria argued:

> If people are aware they probably treat you better. (Ria, depression, social worker, mid-thirties)

A key issue with this sentiment, as evidenced in the literature and findings, is that we know disclosure does not always result in improved management, despite legal requirements under the Equality Act (2010). Furthermore, disclosure requires even more labour from employees with MHCs, in addition to the work they are obliged to undertake to pass as non-disabled, perform adequately in competitive pressurised neoliberal environments, manage their symptoms and access (or facilitative) appropriate support in their unpaid time.

These accounts illustrate how external support networks served as vital counter-spaces where participants could resist the organisational imperative to embody the ideal worker. They provided environments that affirmed participants' identities and allowed open discussion of impairment effects without fear of professional penalty – addressing barriers to being that were otherwise unacknowledged or exacerbated by employers. At the same time, the very reliance on external rather than internal resources underscore how stigma shapes organisational responsibilities. By avoiding workplace channels – often perceived as risky or inadequate – participants implicitly shouldered the work of managing their health outside formal systems. This reflects the individualisation of responsibility for health conditions/disabilities that is prevalent in many HRM approaches.

## Discussion

This research has addressed three interrelated gaps within HRM research by addressing limited qualitative insight into the experiences of people with MHCs in the workplace, underscoring that stigma operates structurally to shape the experiences of individuals with MHCs at work, and the application of the SRM within the context of managing MHCs at work.

The analysis of the findings reveals that employees with MHCs experience work expectations through a lens of pervasive stigma, ableist norms and prevailing ideal worker expectations. The findings identified how non-disclosure combined with various forms of overworking counteracted concerns over workplace stigma/discrimination arising from these abovementioned working cultures. By making these links explicit, these findings underscore that the disadvantages faced by employees with MHCs are not solely the result of their symptoms or choices but rather are actively structured by organisational environments that both normalise and reward particular ways of being and working. Consequently, these insights address an additional gap within extant literature, by calling to 'decompose the stigmatization process' (Zhang et al., 2021, p. 191).

While disclosing an MHC can facilitate access to legal protections or accommodations, it simultaneously exposes employees to stigma, judgement, and inequitable treatment (Lyons et al., 2017; McKinney & Swartz, 2021). Importantly, under the Equality Act (2010), disclosure is not required for legal protection, yet participants reported feeling compelled to reveal aspects of their MHC to navigate organisational expectations or access support, highlighting a gap between legal rights and workplace reality. Navigating these expectations through a variety of mechanisms, including tactical non-disclosure and additional labour, the analysis highlighted how employees compensate for perceived deficiencies. While taking an active role in shaping their workplace experiences, it also showed how participants deliberately use of HR policies to enable non-disclosure. However, disclosure remains a complex and ambivalent tool.

By explicitly exploring individual responses to structural stigma, unpacking how stigmatisation emerges from the discrepancies between capacities or circumstances of individuals with health conditions/disabilities and the expectations embodied in the ideal worker (Foster & Wass, 2013; Remnant, 2025), this paper underscores how stigma operates not merely as a form of individual bias but rather as a societal barrier. This extends existing critiques of the ideal worker norm (Scholz & Ingold, 2021), demonstrating how expectations of continuous productivity, constant availability, and emotional steadiness especially disadvantage those who must manage fluctuating or invisible MHCs and directly linking ableist work organisational standards to processes of stigmatisation.

Implicit and internalised assumptions about workers being constantly available, productive, and emotionally neutral (Doll et al., 2022; Irvine, 2011) create a yardstick against which employees are measured, perceive themselves to be measured and measure themselves. By linking tactical non-disclosure and compensatory labour to systemic ableist norms, these findings underscore that disadvantages faced by employees with MHCs are not solely the result of individual symptoms or choices but are actively structured by organisational environments.

This supports the work of both Scholz and Ingold (2021) and Hennekam and Descubes (2024), arguing that ableist assumptions underpin the 'ideal worker' and 'ideal jobseeker' assumptions, which, in turn, create barriers for individuals with MHCs. For example, common workplace demands are often characterised by high work expectations which generate excess stress without any consideration for the symptoms of MHCs. While employees exercise agency through strategies such as disclosure management, overwork, and peer support, stigma operates as an organisational and systemic force. Managerial expectations, HR policies, and societal norms that valorise the able-bodied, constantly available ideal worker (Doll et al., 2022; Scholz & Ingold, 2021), insufficiently address these structural barriers.

The analysis demonstrates that there remains significant ground to be covered with regard to improving workplace experiences for those with MHCs, in order to eradicate these assumptions and, in so doing, create space for employee diversity. As highlighted by Mescher et al. (2010), these work related barries directly impact the work-life balance of employees with MHCs or access to workplace support. Indeed, research participants sought support outside of organisational structures, as articulated by Neil (who facilitates a self-help group)-organisational cultures often fall short in providing safe spaces for both disclosure and support.

The organising logic that makes inclusion structurally unattainable unless ableist norms and the ideal worker construct are dismantled is illustrated through the findings and suggests that employees experiences and actions should be understood as relational responses to systemic stigma embedded within organisational life. When ableist job demands (Hennekam & Descubes, 2024) and 'ingrained beliefs' are 'the largest barrier to the inclusion of disabled people in employment' (Olsen, 2024, p. 794), we come to see how stigma operates through the very design and culture of workplaces themselve and sustained *via* the persistent myth of the ideal worker. These insights offer new directions for both HRM policy and practice, arguing that meaningful inclusion requires fundamentally challenging the normative ideals that both continue to marginalise employees with MHCs and impede the achievement of genuine workplace equality.

The analysis put forward has articulated various work barriers to doing and being that are experienced by employees with MHCs, who are also having to manage their MHCs within the workplace. Employing the SRM for the setting of MHCs (Mulvany, 2000) advances theory by explicitly incorporating a conceptualisation of stigma that frames it as a mechanism of systemic inequality not only within society broadly (Tyler, 2020) but specifically at work (Zhang et al., 2021). This expands upon previous research exploring how 'historically subordinated social groups' (Jammaers et al., 2016, p. 1380) negotiate work organisations while applying the SRM for understanding MHCs.

By 'developing a more critical research agenda and building capacities for wider contestation against ableism' (Kumar et al., 2012, p.1), this paper has made visible how the oppression and marginalisation of people with disabilities is the product of social relationships rather than solely being a product of a dichotomy between dis/ability (Sang et al., 2022).

The nuanced understanding gained through the analysis of the findings illuminates the 'web of power that weaves and un-weaves stigma' (Meisenbach & Hutchins, 2020, p. 38). While ableist working cultures discriminate against employees with MHCs, disclosure expectations also function as a possibly discriminatory HRM practice which may disadvantage these employees even further.

While evidencing the forms of agency performed by workers when entering tactical non-disclosure arrangements, the analysis also unpacks the barriers to being and doing that the participants face. If employees feel they must disguise their condition to enter the labour market and/or remain in employment, then organisations are both compromising productivity and failing to fulfil their duty of care to the health, safety and wellbeing of their employees (Kalfa et al., 2021). This also means that mental health stigma is not being challenged, which, in turn, hinders ongoing attempts to normalise MHCs within the workplace. Consequently, this can result in a vicious cycle which ultimately serves to hinder the legitimatisation of MHCs and, in turn, further reduce the likelihood of removing barriers to both being and doing. Problematically, this may also undermine governmental and policy agendas that seek to prioritise health, not only in terms of an act of equality and inclusion but also on the grounds of its notable impact upon work productivity (Health and Safety Executive, 2025; Stevenson, 2017).

The pressure to exceed work expectations can jeopardise employees' with MHCs health, in as far as they have to work longer hours to maintain adequate levels of productivity, access emotional and social support through peer networks outside of work, and deal with disclosure tactics at work—leading to psychological strain and emotional stress (Smart & Wegner, 1999) as well as compromised performance compensation and promotion decisions (Jones & King, 2014). Supporting an alternative notion of 'ideal workplaces' that are inclusive for all employees (Kumar et al., 2012, see also Hastuti & Timming, 2021; Senarathne Tennakoon, 2020; Wang et al., 2022), the move away from 'ideal worker' assumptions, enables focus upon how to enable inclusion and normalise MHCs within the workplace. To do this, organisations must address the structural barriers faced by employees with MHCs.

If work organisations were designed from the ground up with diverse needs in mind, including those of employees with MHCs, then these individuals would be able to thrive and contribute more fully to their organisations, therefore both reducing stigma and increasing the diversity of the workforce. By wholly rethinking work norms (Meisenbach & Hutchins, 2020), rather than merely shaping individuals to fit the ideal worker mould, organisations could move towards creating ideal workplaces and inclusive environments that are designed to support diverse needs (Denissen, 2010; Senarathne Tennakoon, 2020). Designing work environments with diverse capacities in mind – irrespective of the perceived demand – could help to challenge stigma and promote inclusion. Ultimately, this study contributes to a growing body of research framing inclusion as an organisational imperative. By recognising structural and cultural barriers and valuing employees with MHCs, HRM can meaningfully advance equity, wellbeing, and workplace participation.

## Conclusions

This paper underscores the fundamental role of stigma and ableist work norms in perpetuating a cycle of marginalisation. It does so by qualitatively exploring responses to increasing work demands, stress, and structural stigma for MHCs in the workplace. By so doing, this exploration expands existing theoretical perspectives to make sense of their workplace experiences to 'contribute to continued theory refinement' (Hennekam et al., 2021, p. 3143).

The findings empirically contribute to 'the question of where stigma comes from and how stigmatization emerges' (Zhang et al., 2021, p. 206). The proactive attempts of research participants in managing their conditions and negotiating workplace expectations through engaging in tactical non-disclosure, seeking external support, and engaging in additional labour, often operate to covertly counteract structural stigma. Nonetheless by conforming to ableist and ideal worker norms, the analysis equally reveals the pervasive influence of organisational structures and practices which reinforce them—thus illminating the 'cycle, where higher levels of stigma discouraged disclosure…has wide reaching consequences beyond the individual employee's experiences' (Kalfa et al., 2021, p. 3210).

The reliance on tactical non-disclosure; the calculated choices individuals make to protect their professional identities in environments where disclosure could lead to disadvantage illuminate how how this cycle manifest itself in employees working lives. Similarly, the willingness to engage in additional labour underscores the pressure employees with MHCs face to both compensate for perceived deficiencies and demonstrate their value to their organisation, without fully considering the long-term consequences of these actions. Similarly, while external support networks offer a valuable alternative space for honest self-expression and affirmation, their existence points towards the shortcomings of organisational cultures or adequate support and understanding.

Ultimately, this study demonstrates the systemic nature of the challenges faced by employees with MHCs. The SRM serves as a useful lens through which to understand how societal attitudes, organisational policies, and interpersonal dynamics coalesce to create disabling barriers, which, in turn, hinder meaningful inclusion and, ultimately, undermine both the well-being and performance potential of employees with MHCs. This has demonstrated how participants' experiences were shaped not only by their individual conditions but also by the organisational norms, policies, and practices that perpetuate stigma and ableism. Engaging with policymakers to explore the effectiveness of the Equality Act (2010) across the employment cycle including recruitment and employment to eliminate 'prejudicial HRM approaches' would increase ethical practices and HRM processes to ideally minimize these 'employees' exit from organizations' (Kalfa et al., 2021, p. 3209).

Future research could seek to further unpack how underlying structural factors create disabling workplace environments and the coping mechanisms utilised by employees with MHCs. Different contexts across professions and industries, within both public and private and charitable organisations, as well as in different sizes of organisations (small, medium and large) as well as the intersection between individual, organisational, societal and legal factors. Fully unpacking these intersections will then provide a fuller insight into the experiences of employees with MHCs (Fried & Robinaugh, 2020).

## Recommendations for HRM practice

Re-evaluate Performance Management Systems: employees with MHCs engage in additional labour to compensate for perceived deficiencies, driven by a fear of being judged for inconsistent performance due to their MHC. This could be addressed by implementing performance evaluation criteria that both acknowledges the fluctuating nature of health conditions and de-emphasises metrics that privilege consistent availability and output. The focus could instead shift to evaluating the quality of work, contributions to teamwork, and progress towards individual goals, and providing flexibility in terms of deadlines and workload assignments where appropriate.

Enhance both the Transparency and Accessibility of Support Resources: employees with MHCs often seek support outside of the workplace, which is indicative of either a lack of trust in, or awareness of, available organisational resources. This could be addressed by proactively communicating about available (mental) health and anti-stigma resources *via* multiple channels (intranet, training sessions, onboarding materials). Ensure clear, confidential procedures for accessing these resources, whilst, simultaneously, reassuring employees that this would not impact upon their performance in any way.

Provide organisational context-specific stigmatisation campaigns to fit particular organisational conditions, whilst, simultaneously, educating employers and employees *via* the use of case studies (Szeto & Dobson, 2010) about the length to which employees with MHCs go to conceal their condition by providing real life examples and exemplary research findings. Remind managers and employees that stigma is context bound (Crocker et al., 1998) and, as such, can be alleviated. Engage in honest campaigns and communication which go beyond the legal obligations of the Equality Act (2010) and positively promote the workplace contributions of employees with MHCs while overlooking possible disruptiveness resulting from MHCs (Beatty et al., 2019) to alleviate structural stigma.

Foster Inclusive Leadership Development: Employees with MHCs have reported concerns over both stigma and a lack of understanding from colleagues and managers, which, in turn, leads to non-disclosure and increased labour. To address this, mental health awareness and sensitivity training could be built into leadership development programs, emphasising the importance of empathy, active listening, and creating a supportive work environment which challenges ableist/ideal worker norms or ways of working.

## Notes

1. It is important to note that we recognise that the concept of ‘invisibility’ is complicated insofar as it oversimplifies the complex nature of health and overlooks how many conditions have both visible and invisible components that can be context-dependent (Ropski, 2023). For example. Individuals with MHCs may not exhibit visible symptoms most of the time, and it is only when experiencing crises, or extreme symptoms, that their condition becomes very ‘visible’ to those around them. We adopt the categorisation of MHCs as ‘invisible’ conditions in this paper to both reflect the perspectives of our participants and recognise their ability to choose whether to disclose their conditions to their employers in efforts to avoid stigmatisation.
2. Whilst the self-selective nature may have skewed the sample’s gender divide, we are equally aware that there is less research on the experiences of men with MHCs when compared to women. The insights discussed in this paper therefore provide an important gaze on the experiences of this hard-to-reach population.
3. Pseudonyms are used for readability throughout the findings section.

## Disclosure statement

The authors have no relevant financial or non-financial competing interests to report.

## Funding

This study was supported by the UK Economic and Social Research Council [under grant number I902023].

## References

Acker, J. (2006). Inequality regimes: Gender, class, and race in organizations. *Gender & Society*, *20*(4), 441–464. https://doi.org/10.1177/0891243206289499

Ahmad, N. R., Ullah, I., Aziz, M. U., & Iqbal, F. (2025). Investigating stress, burnout, and organizational factors contributing to psychological well-being at work. *Review of Education, Administration & Law*, *8*(1), 29–40. https://doi.org/10.47067/real.v8i1.401

Alvesson, M., & Kärreman, D. (2007). Constructing mystery: Empirical matters in theory development. *Academy of Management Review*, *32*(4), 1265–1281. https://doi.org/10.5465/amr.2007.26586822

Ashforth, B. E., & Kreiner, G. E. (1999). "How can you do it?": Dirty work and the challenge of constructing a positive identity. *The Academy of Management Review*, *24*(3), 413–434. https://doi.org/10.2307/259134

Ashforth, B. E., Kreiner, G. E., Clark, M. A., & Fugate, M. (2017). Congruence work in stigmatized occupations: A managerial lens on employee fit with dirty work. *Journal of Organizational Behavior*, *38*(8), 1260–1279. https://doi.org/10.1002/job.2201

Bailey, D. J. (2024). Worker-led dissent in the age of austerity: Comparing the conditions of success. *Work, Employment and Society*, *38*(4), 1041–1061. https://doi.org/10.1177/09500170231169675

Bam, A. (2025). Invisibility, stigma and workplace support: Experiences of individuals with chronic disorders. *SA Journal of Human Resource Management*, *23*(0), 2859. https://doi.org/10.4102/sajhrm.v23i0.2859

Beatty, J. E., Baldridge, D. C., Boehm, S. A., Kulkarni, M., & Colella, A. J. (2019). On the treatment of persons with disabilities in organizations: A review and research agenda. *Human Resource Management*, *58*(2), 119–137. https://doi.org/10.1002/hrm.21940

Bergström, O., & Knights, D. (2006). Organizational discourse and subjectivity: Subjectification during processes of recruitment. *Human Relations*, *59*(3), 351–377. https://doi.org/10.1177/0018726706064179

Blaikie, N. (1993). *Approaches to social enquiry*. Polity Press.

Boud, D., Keogh, R., & Walker, D. (2013). *Reflection: Turning experience into learning*. Routledge.

Brouwers, E. P. (2020). Social stigma is an underestimated contributing factor to unemployment in people with mental illness or mental health issues: Position paper and future directions. *BMC Psychology*, *8*(1), 36. https://doi.org/10.1186/s40359-020-00399-0

Bunbury, S. (2019). Unconscious bias and the medical model: How the social model may hold the key to transformative thinking about disability discrimination. *International Journal of Discrimination and the Law* , *19*(1), 26–47. https://doi.org/10.1177/1358229118820742

Clair, A., Beatty, J. E., & Maclean, T. L. (2005). Out of sight but not out of mind: Managing invisible social identities in the workplace. *Academy of Management Review*, *30*(1), 78–95. https://doi.org/10.5465/amr.2005.15281431

Coffee, A., & Atkinson, P. (1996). *Making sense of qualitative data*. SAGE.

Colella, A. J., & Bruyère, S. M. (2011). Disability and employment: New directions for industrial and organizational psychology. In S. Zedeck (Ed.), *APA handbook of industrial and organizational psychology, Vol. 1. Building and developing the organization* (pp. 473–503). American Psychological Association.

Cologon, K., & Thomas, C. (2014). Ableism, disablism and the early years. In *Inclusive education in the early years: Right from the start* (pp. 27–48). Oxford University Press.

Chen, S., & Wang, Y. (2023). Industry-specific prevalence and gender disparity of common mental health problems in the UK: A national repetitive cross-sectional study. *Frontiers in Public Health*, *11*, 1054964. https://doi.org/10.3389/fpubh.2023.1054964

Crocker, J., Major, B., & Steele, C. (1998). Social stigma. In D. T. Gilbert, S. T. Fiske, & G. Lindzey (Eds.), *The handbook of social psychology* (4th ed., Vol. 2, pp. 504–553). McGraw-Hill.

Dianiska, R. E., Swanner, J. K., Brimbal, L., & Meissner, C. A. (2021). Using disclosure, common ground, and verification to build rapport and elicit information. *Psychology, Public Policy, and Law*, *27*(3), 341–353. https://doi.org/10.1037/law0000313

Denissen, A. M. (2010). The right tools for the job: Constructing gender meanings and identities in the male-dominated building trades. *Human Relations*, *63*(7), 1051–1069. https://doi.org/10.1177/0018726709349922

Doll, C. M., Michel, C., Betz, L. T., Schimmelmann, B. G., & Schultze-Lutter, F. (2022). The important role of stereotypes in the relation between mental health literacy and stigmatization of depression and psychosis in the community. *Community Mental Health Journal*, *58*(3), 474–486. https://doi.org/10.1007/s10597-021-00842-5

Doyle, D. M., & Barreto, M. (2024). Stigma salience increases loneliness among ethnic minorities. *The British Journal of Social Psychology*, *63*(4), 1625–1639. https://doi.org/10.1111/bjso.12742

Elraz, H. (2018). Identity, mental health and work: How employees with mental health conditions recount stigma and the pejorative discourse of mental illness. *Human Relations*, *71*(5), 722–741. https://doi.org/10.1177/0018726717716752

Equality Act. (2010). *Socio-economic inequalities*. https://www.equalityhumanrights.com/en/equality-act-2010/what-equality-act

Fevre, R., Robinson, A., Lewis, D., & Jones, T. (2013). The ill-treatment of employees with disabilities in British workplaces. *Work, Employment and Society*, *27*(2), 288–307. https://doi.org/10.1177/0950017012460311

Foster, D. (2018). The health and well-being at work agenda: Good news for (disabled) workers or just a capital idea? *Work, Employment and Society*, *32*(1), 186–197. https://doi.org/10.1177/0950017016682458

Foster, D., & Wass, V. (2013). Disability in the labour market: An exploration of concepts of the ideal worker and organisational fit that disadvantage employees with impairments. *Sociology*, *47*(4), 705–721. https://doi.org/10.1177/0038038512454245

Fried, E. I., & Robinaugh, D. J. (2020). Systems all the way down: Embracing complexity in mental health research. *BMC Medicine*, *18*(1), 205. https://doi.org/10.1186/s12916-020-01668-w

Fryers, T., Melzer, D., Jenkins, R., & Brugha, T. (2005). The distribution of the common mental disorders: Social inequalities in Europe. *Clinical Practice and Epidemiology in Mental Health: CP & EMH*, *1*(1), 14. https://doi.org/10.1186/1745-0179-1-14

Giæver, F. (2009). Looking forwards and back: Exploring anticipative versus retrospective emotional change-experiences. *Journal of Change Management*, *9*(4), 419–434. https://doi.org/10.1080/14697010903360616

Giel, K. E., Zipfel, S., Alizadeh, M., Schäffeler, N., Zahn, C., Wessel, D., Hesse, F. W., Thiel, S., & Thiel, A. (2012). Stigmatization of obese individuals by human resource professionals: An experimental study. *BMC Public Health*, *12*(1), 525. https://doi.org/10.1186/1471-2458-12-525

Giorgi, G., Lecca, L. I., Alessio, F., Finstad, G. L., Bondanini, G., Lulli, L. G., Arcangeli, G., & Mucci, N. (2020). COVID-19-related mental health effects in the workplace: A narrative review. *International Journal of Environmental Research and Public Health*, *17*(21), 7857. https://doi.org/10.3390/ijerph17217857

Gunderson, M., & Lee, B. Y. (2016). Pay discrimination against persons with disabilities: Canadian evidence from PALS. *The International Journal of Human Resource Management*, *27*(14), 1531–1549. https://doi.org/10.1080/09585192.2015.1072106

Hastuti, R., & Timming, A. R. (2021). An inter-disciplinary review of the literature on mental illness disclosure in the workplace: Implications for human resource management. *The International Journal of Human Resource Management*, *32*(15), 3302–3338. https://doi.org/10.1080/09585192.2021.1875494

Hennekam, S., & Descubes, I. (2024). Why common job demands are challenging for individuals with mental illness: The interaction of personal vulnerability factors and ableist norms. *Equality, Diversity and Inclusion: An International Journal*, *43*(1), 72–92. https://doi.org/10.1108/EDI-12-2022-0341

Hennekam, S., Follmer, K., & Beatty, J. (2021). Exploring mental illness in the workplace: The role of HR professionals and processes. *The International Journal of Human Resource Management*, *32*(15), 3135–3156. https://doi.org/10.1080/09585192.2021.1960751

Health and Safety Executive. (2025). *Work related stress, depression and anxiety*. https://www.hse.gov.uk/statistics/assets/docs/stress.pdf

Irvine, A. (2011). Something to declare? The disclosure of common mental health problems at work. *Disability & Society*, *26*(2), 179–192. https://doi.org/10.1080/09687599.2011.544058

Jammaers, E., Zanoni, P., & Hardonk, S. (2016). Constructing positive identities in ableist workplaces: Disabled employees' discursive practices engaging with the discourse of lower productivity. *Human Relations*, *69*(6), 1365–1386. https://doi.org/10.1177/0018726715612901

Jones, E. E., Farina, A., Hastorf, A. H., Markus, H., Miller, D. T., & Scott, R. A. (1984). *Social stigma: The psychology of marked relationships*. Freeman.

Jones, K. P., & King, E. B. (2014). Managing concealable stigmas at work: A review and multilevel model. *Journal of Management*, *40*(5), 1466–1494. https://doi.org/10.1177/0149206313515518

Kalfa, S., Branicki, L., & Brammer, S. (2021). Organizational accommodation of employee mental health conditions and unintended stigma. *The International Journal of Human Resource Management*, *32*(15), 3190–3217. https://doi.org/10.1080/09585192.2021.1910536

Kumar, A., Sonpal, D., & Hiranandani, V. (2012). Trapped between ableism and neoliberalism: Critical reflections on disability and employment in India. *Disability Studies Quarterly*, *32*(3). https://doi.org/10.18061/dsq.v32i3.3235

Lewis, S., Anderson, D., Lyonette, C., Payne, N., & Wood, S. (2017). Public sector austerity cuts in Britain and the changing discourse of work–life balance. *Work, Employment and Society*, *31*(4), 586–604. https://doi.org/10.1177/0950017016638994

Lempert, R., & Monsma, K. (1994). Cultural differences and discrimination: Samoans before a public housing eviction board. *American Sociological Review*, *59*(6), 890–910. https://doi.org/10.2307/2096374

Liao, Q., Zhang, J., Li, F., Yang, S., Li, Z., Yue, L., & Dou, C. (2025). "Rat race" or "lying flat"? The influence of performance pressure on employees' work behavior. *Frontiers in Psychology*, *16*, 1466463. https://doi.org/10.3389/fpsyg.2025.1466463

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology*, *27*(1), 363–385. https://doi.org/10.1146/annurev.soc.27.1.363

Loyd, J. M., & Bonds, A. (2018). Where do Black lives matter? Race, stigma, and place in Milwaukee, Wisconsin. *The Sociological Review*, *66*(4), 898–918. https://doi.org/10.1177/0038026118778175

Lyons, B. J., Pek, S., & Wessel, J. L. (2017). Toward a "sunlit path": Stigma identity management as a source of localized social change through interaction. *Academy of Management Review*, *42*(4), 618–636. https://doi.org/10.5465/amr.2015.0189

McKinney, E. L., & Swartz, L. (2021). Employment integration barriers: Experiences of people with disabilities. *The International Journal of Human Resource Management*, *32*(10), 2298–2320. https://doi.org/10.1080/09585192.2019.1579749

Mental Health-OECD. (2021). *Mental health*. https://www.oecd.org/els/health-systems/mental-health.htm

Mental Health Foundation. (2024). *Mental health at work: Statistics*. https://www.mentalhealth.org.uk/explore-mental-health/statistics/mental-health-work-statistics

Mescher, S., Benschop, Y., & Doorewaard, H. (2010). Representations of work—life balance support. *Human Relations*, *63*(1), 21–39. https://doi.org/10.1177/0018726709349197

Meisenbach, R. J., & Hutchins, D. (2020). Stigma communication and power: Managing inclusion and exclusion in the workplace. In M. L. Doerfel & J. L. Gibbs (Eds.), *Organizing inclusion: Moving diversity from demographics to communication processes* (pp. 25–42). Routledge.

Mitra, S., & Kruse, D. (2016). Are workers with disabilities more likely to be displaced? *The International Journal of Human Resource Management*, *27*(14), 1550–1579. https://doi.org/10.1080/09585192.2015.1137616

Moloney, M. E., Brown, R. L., Ciciurkaite, G., & Foley, S. M. (2019). "Going the extra mile": Disclosure, accommodation, and stigma management among working women with disabilities. *Deviant Behavior*, *40*(8), 942–956. https://doi.org/10.1080/01639625.2018.1445445

Mulvany, J. (2000). Disability, impairment or illness? The relevance of the social model of disability to the study of mental disorder. *Sociology of Health & Illness*, *22*(5), 582–601. https://doi.org/10.1111/1467-9566.00221

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods*, *16*(1), 1609406917733847. https://doi.org/10.1177/1609406917733847

Olsen, J. (2024). Employers: Influencing disabled people's employment through responses to reasonable adjustments. *Disability & Society*, *39*(3), 791–810. https://doi.org/10.1080/09687599.2022.2099251

Park, S. C., & Kim, D. (2020). The centrality of depression and anxiety symptoms in major depressive disorder determined using a network analysis. *Journal of Affective Disorders*, *271*, 19–26. https://doi.org/10.1016/j.jad.2020.03.078

Pryor, J. B., & Reeder, G. D. (2011). HIV-related stigma. In *HIV/AIDS in the post-HAART era: Manifestations, treatment, and epidemiology* (pp. 790–806). People's Medical Publishing House.

Quinane, E., Bardoel, E. A., & Pervan, S. (2021). CEOs, leaders and managing mental health: A tension-centered approach. *The International Journal of Human Resource Management*, *32*(15), 3157–3189. https://doi.org/10.1080/09585192.2021.1925325

Remnant, J., Sang, K., Calvard, T., Richards, J., & Babajide, O. (2024). Exclusionary logics: Constructing disability and disadvantaging disabled academics in the neoliberal university. *Sociology*, *58*(1), 23–44. https://doi.org/10.1177/00380385231162570

Remnant, J. (2025). Notes on a spoiled working identity: Stigma, illness and disability in the contemporary [western] workplace. In G. Thomas, O. Williams, T. Spratt, & A. Chandler (Eds.), *Recalibrating stigma: Sociologies of health and illness*. Bristol University Press.

Ropski, S. S. (2023). *"But you don't look sick…": Shedding light on the socially constructed problems of invisible chronic illness and the benefits of shifting to a dynamic illness framework* [Master's thesis]. Loyola University Chicago.

Sang, K., Calvard, T., & Remnant, J. (2022). Disability and academic careers: Using the social relational model to reveal the role of human resource management practices in creating disability. *Work, Employment and Society*, *36*(4), 722–740. https://doi.org/10.1177/0950017021993737

Sayce, L. I. Z. (2003). Beyond good intentions. Making anti-discrimination strategies work. *Disability & Society*, *18*(5), 625–642. https://doi.org/10.1080/0968759032000097852

Saunders, S. L., & Nedelec, B. (2014). What work means to people with work disability: A scoping review. *Journal of Occupational Rehabilitation*, *24*(1), 100–110. https://doi.org/10.1007/s10926-013-9436-y

Scholz, F., & Ingold, J. (2021). Activating the 'ideal jobseeker': Experiences of individuals with mental health conditions on the UK Work Programme. *Human Relations*, *74*(10), 1604–1627. https://doi.org/10.1177/0018726720934848

Senarathne Tennakoon, U. (2020). Ideal organizations for the new ideal workers: Exploring the role of life-friendly work practices. In M. L. H. Maestro, M. N. C. Albiol, & M. Grau (Eds.), *The new ideal worker: Organizations between work-life balance, gender and leadership* (pp. 73–91). Springer. https://doi.org/10.1007/978-3-030-12477-9_5

Shakespeare, T. (2013). *Disability rights and wrongs revisited*. Routledge.

Shann, C., Martin, A., Chester, A., & Ruddock, S. (2019). Effectiveness and application of an online leadership intervention to promote mental health and reduce depression-related stigma in organizations. *Journal of Occupational Health Psychology*, *24*(1), 20–35. https://doi.org/10.1037/ocp0000110

Sheehan, L., Dubke, R., & Corrigan, P. W. (2017). The specificity of public stigma: A comparison of suicide and depression-related stigma. *Psychiatry Research*, *256*, 40–45. https://doi.org/10.1016/j.psychres.2017.06.015

Silla, I., Gracia, F. J., & Peiró, J. M. (2005). Job insecurity and health-related outcomes among different types of temporary workers. *Economic and Industrial Democracy*, *26*(1), 89–117. https://doi.org/10.1177/0143831X05049404

Smart, L., & Wegner, D. M. (1999). Covering up what can't be seen: Concealable stigma and mental control. *Journal of Personality and Social Psychology*, *77*(3), 474–486. https://doi.org/10.1037/0022-3514.77.3.474

Stevenson, D. (2017). *Thriving at work: The Stevenson/Farmer review of mental health and employers*. Department for Work and Pensions and Department of Health.

Szeto, A. C., & Dobson, K. S. (2010). Reducing the stigma of mental disorders at work: A review of current workplace anti-stigma intervention programs. *Applied and Preventive Psychology*, *14*(1–4), 41–56. https://doi.org/10.1016/j.appsy.2011.11.002

Tew, J. (2005). *Social perspectives in mental health: Developing social models to understand and work with mental distress*. Jessica Kingsley Publishers.

Thomas, C. (1999). *Female forms: Experiencing and understanding disability*. McGraw-Hill Education.

Thomas, C. (2004). Rescuing a social relational understanding of disability. *Scandinavian Journal of Disability Research*, *6*(1), 22–36. https://doi.org/10.1080/15017410409512637

Thomas, C. (2012). Theorising disability and chronic illness: Where next for perspectives in medical sociology? *Social Theory & Health*, *10*(3), 209–228.

Tomas, V., Ahmed, H., & Lindsay, S. (2022). Unravelling the complexities of workplace disclosure among persons with non-visible disabilities and illnesses: A qualitative meta-ethnography. *Journal of Occupational Rehabilitation*, *32*(3), 538–563. https://doi.org/10.1007/s10926-022-10023-0

Toth, K. E., Yvon, F., Villotti, P., Lecomte, T., Lachance, J. P., Kirsh, B., Stuart, H., Berbiche, D., & Corbière, M. (2022). Disclosure dilemmas: How people with a mental health condition perceive and manage disclosure at work. *Disability and Rehabilitation*, *44*(25), 7791–7801. https://doi.org/10.1080/09638288.2021.1998667

Tran, C. T., Tran, H. T., Nguyen, H. T., Mach, D. N., Phan, H. S., & Mujtaba, B. G. (2020). Stress management in the modern workplace and the role of human resource professionals. *Business Ethics and Leadership*, *4*(2), 26–40. https://doi.org/10.21272/bel.4(2).26-40.2020

Tyler, I. (2020). *Stigma*. Bloomsbury Publishing.

Vaismoradi, M., & Snelgrove, S. (2019). Theme in qualitative content analysis and thematic analysis. *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research*, *20*(3), 23. https://doi.org/10.17169/fqs-20.3.3376

Wang, Y., Byrne, L., Bartram, T., & Chapman, M. (2023). Developing inclusive and healthy organizations by employing designated lived experience roles: Learning from human resource management innovations in the mental health sector. *The International Journal of Human Resource Management*, *34*(10), 1973–2001. https://doi.org/10.1080/09585192.2022.2054287

Williams, S. (2000). Chronic illness as biographical disruption or biographical disruption as chronic illness? Reflections on a core concept. *Sociology of Health & Illness*, *22*(1), 40–67. https://doi.org/10.1111/1467-9566.00191

Woods, M., Macklin, R., Dawkins, S., & Martin, A. (2019). Mental illness, social suffering and structural antagonism in the labour process. *Work, Employment and Society*, *33*(6), 948–965. https://doi.org/10.1177/0950017019866650

Zhang, R., Wang, M. S., Toubiana, M., & Greenwood, R. (2021). Stigma beyond levels: Advancing research on stigmatization. *Academy of Management Annals*, *15*(1), 188–222. https://doi.org/10.5465/annals.2019.0031