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Work focussed psychotherapy, job retention and political literacy

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ABSTRACT: Co-production of a work-focused psychotherapeutic intervention to enhance job retention in service-users revealed a lack of political literacy that should be addressed in the workplace.

KEY WORDS: Depression, capitalism, occupational stress

This article reports on the awakening of my political consciousness which occurred during the process of conducting a mixed methods study undertaken as part of a professional doctorate. My study aimed to design and evaluate a new psychotherapeutic intervention to enhance job retention in service-users of UK Community Mental Health Teams diagnosed with 'depression'. I became interested in this project when working as a psychotherapist in secondary care where about half my caseload were employed, struggling at work and at risk of losing their jobs.

Environmental factors

In recent years, recessionary forces have led many workplaces to see people as 'disposable commodities' and to try and 'squeeze more out of human assets' (Foster & Scott, 2015), with higher expectations that all employees should conform to new norms of productive engagement (Fevre et al., 2013). Staff surveys show that the causes of workplace stress in the UK are 'tight deadlines, too much work or too much pressure or responsibility…a lack of managerial support, organisational changes at work, violence and role uncertainty' (Health & Safety Executive, 2020 p.8).

Modernisation of the workplace and the changing nature of work are shaped by neoliberal ideology with its 'laissez faire' economic principles. Employees have often been subjected to constant change which renders 'the present less stable and predictable' internalised as 'depression' (West et al., 2012 p.203). Burnout in the workplace is a social pathology causally linked to the boundarylessness and unpredictability of modern organisational life (Honneth, 2004). Highly competitive organisational cultures which are 'obsessed with efficiency' to create 'winners and losers' by 'rewarding the best' are not conducive to wellbeing (Mental Health Foundation, 2016). Employees feel oppressed by the infinite 'normative demand for self-realization…in and through work' (Thunman, 2012 p.43). Similarly, not everyone can be the disembodied 'dedicated and reliable' employee envisioned by workplaces because their functioning may be affected by the unpredictable and fluctuating nature of some chronic conditions including 'depression' (van Hal et al., 2013 p.15). New management practices and organisational change often lead to increased chaos, stress, and conflict at work, with workers directing their frustrations not at management but at fellow workers or inward (Crowley et al., 2010). This may account for rising reports of bullying at work (Zapf et al., 2020), and bullying is a risk factor for a diagnosis of 'depression' (Gullander, 2014; Brousse et al., 2008).

Social processes such as ableism, invalidation, and stigmatisation are employed by the dominant majority to label and ostracise an apparent minority of people who cannot 'meet the socialised criteria of normalcy' and are unable to perform the role of 'ideal employee' (Olowookere, 2017 p.167). The construct of 'work' is based on 'non-disabled norms' whereby employees with serious mood disorders do not 'meet the socialised criteria of normalcy' and are therefore seen as 'incapable of work' (p.15). These workers are subject to 'expectations of non-disability…regardless of difference' (p.122) which means they are effectively 'othered' and excluded from the labour market.

The perception of being unable to change the situation contributes to ongoing stress in employees struggling to stay at work when feeling overwhelmed and diagnosed with 'depression'. They develop strategies to 'endure work' and 'take care' of themselves such as managing their feelings and modifying expectations of their future career (Hjarsbech et al., 2015). Ultimately, to cope, 'very engaged employees may eventually leave the workplace or simply distance themselves from work by not being the active and engaged employee any longer' (p.1681).

In parallel, there has been a rise in precarious employment due to over-supply of labour across a wide range of sectors which means humans are a waste product of work (Yates, 2011). The 'erosion in job security, in both manual and professional occupations' (Crowley et al., 2010 p.421) can have a negative effect on employees' mental health (Fløvik et al., 2019).

Employees fear being 'cast off' by the organisation as a 'waste product' and to avoid dismissal many employees 'suffer in silence' by concealing their true identity (Leifson,

2015). Furthermore, the 'employer-dominated approach towards managing disability and long-term ill-health' in UK workplaces has led to 'individualised, fragmented, uncoordinated, deinstitutionalised' care (Foster & Scott, 2015 p.17).

One feminist critique of coping with 'depression' in neoliberal workplaces explored the experience of young middle-class professional women (Chowdhury, 2020). This study discusses the 'adverse effects of patriarchal capitalism, and particularly workplace sexism' and how the psychological survival strategies that female employees use such as 'putting on a brave face' and 'ploughing through' in order to 'prove one's worth' may implicitly reinforce gendered social relations, which perpetuates a toxic organisational culture (p.137).

'Depression' is experienced by employees in four narrative stages (West et al., 2012): 1) internalizing e.g., taking on the 'the instability and incoherence of the workplace itself'; 2) somatizing e.g., affective states being projected into the body; 3) medicalising e.g., seeking professional medical help; and 4) pharmacologizing e.g., 'taking up of medically supervised treatment options' (p.203-204). Another study found that in communities that score high on indices of urban or rural deprivation, residents who present to their GP in distress are often diagnosed with 'depression' and prescribed medication or referred for 'talking therapies' because their distress is medicalised and attributed to 'depression' rather than to the 'injustices caused by on-going economic, social and health inequalities' (DeStress Project 2019 p.4).

For some people work has a negative effect on their mental health and sometimes being unemployed is better (Chandola & Zhang, 2018; Butterworth et al., 2011). However, once unemployed, 'people have not 'just' lost their jobs: their history, skills, confidence, and experience also tend to disappear, at least temporarily' (Bodman et al., 2003 p.39), they also disappear into the 'Bermuda Triangle of illness', wanting to work but unable to (Shapiro et al., 2010 p.43). They often end up claiming long-term sickness and disability benefits which provide only a subsistence level income. Return-to-work is unlikely because after two years on Incapacity Benefit, claimants are 'more likely to retire or die than return to work' (Beatty et al., 2007 p.21) meaning they are trapped in poverty.

Policy context

Current reforms have been shaped by the 'austerity' agenda with cuts to welfare and tightening up of eligibility criteria for sickness and disability benefits. The process of claiming is characterised by multiple 'belittlements' and 'demonizations' (Stewart, 2019). In tandem, there is the drive for self-management of chronic illness, which transfers responsibility from the State to the individual through a process of 'moralisation' and 'delegitimisation' of mental distress (Greener & Moth, 2020). Norms and expectations shaped by this agenda are based on principles of patient activation, independence, self-management, recovery, and 'responsibilisation' with new forms of deviance defined by

'tendencies to construct distress in terms of individual moral failure or motivational inadequacy' (p.15).

Recent actions undertaken by the Coalition and Conservative governments are regressive (Equality & Human Rights Commission, 2016) and have set back the realisation of international human rights and equality enshrined in the International Covenant on Economic, Social and Cultural Rights, and Article 27 of United Nations Convention on the Rights of Persons with Disabilities. This would have given people in England 'the right to work and to just and favourable conditions of work' (p.7).

Method

Stakeholder consultation was undertaken both pre and post intervention with the intention of finding out what might be helpful in the design of a new psychotherapeutic intervention to enhance job retention in employees with moderate-severe 'depression'. Perhaps unsurprisingly, whilst I attempted to direct the discussion to address specific pre-determined questions, participants talked at great length about their experiences in the workplace and volunteered a lot of information about potentially disabling workplace contexts. Their descriptions, which were heartfelt and rich in detail, allowed me to expand the scope of the research and to ask two parallel questions:

1. What contributes to stress / doesn't help?
2. What contributes to mental wellbeing / does help?

Focus groups

Focus groups were used as a data collection method because conversation with others allows for greater disclosure of personal and sensitive information (Guest et al., 2017), and for interesting and unexpected ideas to emerge (Liamputtong, 2011) by which researchers can gain a more in-depth and wide-ranging understanding of the question/s. There were ten focus groups of 1-3 hours, and participants were 13 former service-users and 15 frontline practitioners (including occupational therapists, occupational health nurses, clinical psychologists and psychotherapists), and managers, most of whom had received or provided group-CBT in secondary mental healthcare or job retention interventions within the last two years.

Service-user involvement

Involving service-users in this study was a decision based on a critical approach that aims to reduce the alienation of this group, and to question some of the social and economic structures that contribute to their oppression and exclusion, which may be a causative factor in recurrent 'depression'. Whilst the National Institute of Health Research (Bagley et al., 2016), the Mental Health Research Network (National Institute for Mental Health, 2013; Staley, 2012) and the National Institute for Health & Care Excellence (Barham,

2011) call for public and patient involvement in research and review, it is vital to guard against 'pseudo participation' (Goeke & Kubanski, 2012) or tokenism (Beresford et al., 2005). The Service-User Research Group for England (SURGE) outlines three different levels of involvement (Morgan, 2006): consultation (service-users' views are sought but they do not have a role in decision-making), collaboration (genuine sharing of power and cooperative working) and control (service-user led research). The function of the focus groups in this study was mainly consultation, with some elements of collaboration (Shippee et al., 2015), but they were not 'maximally empowered to make decisions at every stage of the mixed research process' as Onwuegbuzie & Frels, (2015) describe as a 'critical dialectical pluralist focus group discussion', although this will be considered in future research. The Mental Health Research Network has developed a menu of service-user involvement which provides a framework to identify the knowledge, skills, experience and training needed at different degrees and stages of the research process (National Institute for Health Research, 2013).

Morgan (2006) proposes three key principles which researchers should uphold when involving service-users:

- Clarity and transparency: The involvement of service-users as co-researchers should be founded on open and honest discussions which outline the expectations and obligations of all concerned.
- Accessibility: All service-users regardless of their disabilities and needs should be able to contribute to research. Resources in terms of appropriate accommodation, expenses, jargon-free materials and support should be available to ensure as wide participation as possible.
- Diversity: Recruitment should reflect the demographic range of the study population. It should aim to engage members of under-represented groups taking into account age, ethnicity, gender, sexuality, social class and diagnosis for example.

Servicer-users may require emotional and practical support as well as adequate training in order for their involvement to be meaningful.

Mental healthcare practice has been criticised as oppressive and often leads to the perpetuation of stigma and social exclusion (Porter, 2002). Survivors of mental health problems are a marginalised group and collaborative research is one way for service-users to have a voice. It is vital that 'above all multi-perspectivity and multivocality must be preserved in representation of the results' (Bergold & Thomas, 2012 p.13) in participatory research. However participatory research could be misused as a way to gain access to service-users and to influence their choices (Hagey, 1997). There is also an increased risk of boundary transgression due to role confusion between researcher-participant, leaving both parties vulnerable to abuse. Strier (2007, p.3) warns that 'any intervention or research

project, regardless of the benevolent and progressive nature of its goals and intentions, may replicate the structural conditions' that perpetuate oppression.

The true role of the researcher in participatory research is 'an ally, an advisor, an enabler, and maybe a partner' (Evans & Jones, 2004 p.9). I hoped to be able to really listen to service-users' perspectives so that my research is based on a better understanding of their lived experience. As well as being the moderator of the focus group, I was also a member. In order to enter the world of an employee with mental health problems, some degree of self-disclosure was appropriate. Under supervision I acknowledged my own difficulties encountered at work when 'depressed'.

Data analysis

Critical realism is recommended as an approach to understanding the social origins of mental distress and disability (Brunner, 2019; Karadzhov, 2019). Therefore, I used a realist evaluation approach to analyse the data. The critical realist philosophy of science (Bhaskar, 2008) proposes a layered ontology whereby reality is 'stratified' such that there are three overlapping domains of reality: not just the 'empirical' level of reality (i.e. what can be observed or experienced), but also the 'actual' level (i.e. what is known but cannot always be seen or felt), and the 'real' level (i.e. what is hidden in terms of deep social structures). The different levels of reality interact interdependently, and thus reality is 'emergent' from and 'rooted' in other levels (p.102). Some aspects of reality possess attributes of 'materiality' such as the workplace, and some do not but are nonetheless real such as stigma and social exclusion. In this way the whole is more than the sum of its parts, and reality is irreducible to biological, psychological, or social processes.

Critical realists also emphasise the interdependence of structure and agency, with social structures providing resources and limits, and individuals creatively responding to those circumstances over time. Human agency is always enabled or disabled by social structures such as patriarchy, gender relations, class dynamics, or neoliberalism, but also by other factors such as biology, evolution, ecology, geography and genetics (Carolan & Clark, 2005).

I also considered the question of determinism versus voluntarism (Porter, 2015), i.e. whether employees' actions are caused by institutional structures and social relations in the workplace and in the community, or whether their actions are caused by individual volition, arising out of their ability to reason and choose. A non-reductionist approach probably better represents why things happen. It is not a case of either determinism or voluntarism. The free will of individuals is necessarily enabled or disabled by contextual factors or 'pre-existing conditions' (Pawson, 2006 p.25). However, what people do, say, think and feel is not simply determined by indoctrination or internalisation of the prevailing social structure. If humans are relegated 'to the role of robot without capacity for deliberation' (Morselli, 2014 p.13), then there can be no individual freedom. Rather,

seeing human agency and social structure as two distinct things creates a 'false dichotomy' (Morselli, 2014). Thus, a dualism of agency / structure in a relationship of mutual interdependence allows people to change society, institutions, and organisations and vice versa. Occupational stress, 'depression' and sickness absence are likely to have multi-determinations.

Porter (2015) advises that it is important to differentiate 'contextual mechanisms' that might cause 'depression' in employees such as the experience of loss for example, and 'programme mechanisms' that might be activated to produce the desired outcomes such as acquisition of interpersonal skills for example. Realist analysis of the data from the focus groups elucidated 'a range of mechanisms which sustained the original problem' (Pawson & Tilley, 1997 p.75) in terms of barriers to job retention in 'depression', as well as enabling and disabling contexts in which the hypothesised mechanisms might be activated or not (Pilgrim, 2019).

For critical realists there are many valid ways of exploring social phenomena, including observational, experimental, participatory, or evaluative forms of enquiry. Data analysis requires a combination of deductive, inductive, abductive and retroductive reasoning to reveal plausible generative mechanisms which could best account for the observed phenomena (Danermark et al., 2019). Reasoning strategies include visual displays, counterfactual thinking, and thought experiments.

Findings

The data collected were extraordinarily detailed, with many insightful and thought-provoking contributions from the participants. In line with critical realist methods, the data were analysed to identify participants' attributions about the cause of their distress which were subsequently framed as potentially disabling contexts. The findings are presented using the different levels of reality. For more details, contact the author.

Empirical level of reality

Participants frequently reported their own experiences and others' behaviours at the *empirical level* of reality (i.e. what can be observed or experienced) as causing stress and not helping them to remain in employment.

Actual level of reality

Participants occasionally reported events and effects such as the organisational culture at the *actual level* of reality (i.e. what is known but cannot always be seen or felt) as causing stress and not helping them to remain in employment.

Real level of reality

Participants rarely reported underlying structural mechanisms such as capitalism,

patriarchy, social exclusion, or ableism at the real level of reality (i.e. what is hidden in terms of deep social structures) as causing stress and not helping them to remain in employment.

Discussion

This study was part of a larger study which aimed to design a new psychotherapeutic intervention to enhance job retention in 'depression' using a critical realist approach. A work-focused relational Group-CBT programme was piloted in a community setting with eight women and the feasibility of implementation and evaluation is reported elsewhere.

Overall, the findings of this study confirm the findings from other qualitative studies which explore how people with 'depression' cope in the workplace, and what they find helpful and unhelpful (Brohan et al., 2012; Bertilsson et al., 2013; Goodley, 2005; Mental Health Foundation, 2016; Foster & Scott, 2015; Richards et al., 2016; Morgan, 2017; Thisted et al., 2020; Corbière et al., 2016; Meunier et al., 2019; Fevre et al., 2013; Joosen et al., 2017; Danielsson et al., 2017; Danielsson et al., 2019).

However, this study also reveals a new finding in that one of these contextual mechanisms may be a low level of political literacy. This mechanism was revealed by considering what was not said as much as what was said. Employees' causal attributions regarding what contributes to stress in the workplace (Olsen et al., 2015) and does not help them to maintain employment tended to be mainly at the empirical and actual levels of reality. Nobody indicated a cause arising from the real level of reality, although two people mentioned 'austerity' as a factor in causing occupational stress. Participants were either providers or consumers of mental health services, so it is perhaps unsurprising that they demonstrated a high level of psychological literacy in how they talked about the phenomenon of 'depression' as a subjective experience with a psychological cause. They may have been unwittingly indoctrinated to interpret events rather uncritically through the lens of psychology rather than through a socio-political lens.

This new finding stimulated a more questioning attitude towards the role of psychotherapy when addressing issues such as job retention. I became aware of critical disability studies which opened up a new channel for understanding the phenomenon of 'depression' as due to social processes in the workplace 'arising directly from socio-historic material conditions embedded in capitalism' (Foster, 2018 p.191). Wellbeing initiatives are often focused on the individual rather than collective causes of mental distress (p.188).

Likewise, psychotherapy emphasises internal rather than external change which ignores the socio-economic conditions of people living in areas of relative deprivation (Moloney & Kelly, 2004). A realist multilevel situational analysis of maternal 'depression' found that the cause was related to structures such as the global economy, occupational role, organisational culture, team climate, ethnicity, and neighbourhood social capital for example (Eastwood et al, 2016). When psychotherapists are 'forgetful of society' and

reinterpret employees' subjective experiences as evidence of an internal pathological process, it leads to a 'normalization of overburdening demands at work' and a 'de-thematization of social factors' (p.4). Understanding 'depression' as 'social suffering' caused by structural conditions such as power differentials in workplace hierarchies (Flick, 2016) casts doubts on what, if anything, psychotherapy focused on 'the exploration of putative internal psychological spaces' (Moloney & Kelly, 2004 p.4) can actually do to help. Trying to design a work-focused psychotherapeutic intervention now seems perverse because psychotherapists have 'no direct therapeutic means at their disposal to change concrete structures of work' (Flick, 2016, p.4).

Moreover, critical psychotherapists have highlighted how the profession endorses the idea that 'depression' is located within an individual thereby deflecting attention away from the material, cultural, and environmental determinants of their distress (Nightingale & Cromby, 2001), and responsibility for the self-management of 'depression' (using CBT and other psychological or pharmacological treatments) is placed on individuals (Esposito & Perez, 2014). Once diagnosed with 'depression', individuals are both labelled, problematized, and isolated which affords psychotherapists a legitimate role in treating them (Flick, 2016).

CBT, as practised in 'Improving Access to Psychological Therapies' (IAPT) with its institutional ethos informed by neoliberalism (Loewenthal, 2018), is particularly criticised for being 'technical and treatment oriented' (Moloney & Kelly, 2004 p.7). Furthermore, CBT invests therapists with considerable 'authority to enforce the norms established by CBT' (Proctor, 2008 p.237). If 'depression' is caused by a sense of powerlessness and oppression, then the CBT approach is arguably iatrogenic (Proctor, 2008). When psychotherapy creates 'a context for surveillance and disciplinary techniques of the self', there is a risk that CBT abuses its power by becoming a form of 'social control' (p.235). However, one of the key principles of CBT is 'collaborative empiricism' whereby client and therapist share the power. If clients are experiencing CBT as oppressive, then there should be more emphasis on developing therapists' competence in relational processes (Kazantzis et al., 2018).

Detractors have complained that psychology does not offer 'a cogent critique of capitalism' (Holmes & Newnes, 2004 p2), and that most psychotherapeutic interventions have little or no impact on low wages or poor working conditions. Instead of offering psychotherapy: '*They might be better off setting up businesses that pay people a decent wage (rather than the poverty-inducing minimum wage) and give them control over their work as well as providing a supportive network*' (p.4). This has led psychotherapists to seek a coherent and ethical justification for the development of psychotherapeutic interventions with a work-focus. Wesson & Gould (2010) claim that having return-to-work (or stay-at-work) on the CBT agenda, need not jeopardize the client-therapist relationship if 'work issues are embedded within the formulation' and the treatment plan (p.27). However, the formulation needs

to include environmental factors such as the organisational culture and the current policy context. Clearly, psychotherapy cannot directly address structural factors, complex social problems, personal vulnerabilities, and other contributory factors that are not under the client's control. Therefore, a radical, integrated, multi-level approach removing 'institutional, political, ideological, organisational…inequality-generating mechanisms' is needed to promote recovery from so-called serious mental illness (Karadzhov, 2019 p.18) and to help people maintain their employment (MacEachen, 2018).

An example of such an approach to practice is 'social action psychotherapy' (Holland, 1992) which is based on the idea that the root cause of emotional distress is not individual psychopathology but arises from 'past and present personal, social, and political obstacles to mental health' especially in contexts where people are economically disadvantaged, marginalized and oppressed. Holland (1992) designed and evaluated a model of intervention to alleviate 'depression' based on a pathway with 4 steps corresponding to Burrell & Morgan's 'social theory' (1979): step one: 'patient on pills'; step two: 'person-to-person psychotherapy'; step three: 'talking in groups'; and step four: 'taking action'. The steps move from expert-led, client-led, peer-led to social action. The principles of social action psychotherapy were taken up and further developed by critical psychologists to create community based groupwork (Holmes, 2010).

Another example is the model of political practice which has been proposed for Occupational Therapists (PPOT) (Pollard & Kronenberg, 2008). Work is seen an opportunity for 'doing, being, becoming and belonging' that many people with mental and physical disabilities are denied, and addresses inequalities that 'arise from the injustices that surround the conditions of human occupation' (p.3). This has led to debates about how to promote activism in Occupational Therapy research and education (Bryant et al, 2019).

Limitations

The main limitation which undermines the claims made in this study is that participants were not asked directly about political explanations for their distress. This may have generated a completely different discussion. However, despite this weakness it is striking that without prompting, participants did not attribute their suffering to structural causes.

Conclusion

In conclusion, the main finding of this study suggests that to help people maintain their employment, it is necessary to promote a sense of agency and empowerment through improving their level of political literacy. Where mental health literacy is currently being promoted in workplaces, the erosion of workplace collectives such as Trade Unions may mean that political literacy has declined. Evidence from the focus groups suggests that employees may benefit from coming together as a group to share experiences and to develop understanding about how external pressures on them as individuals affect their

health.

One implication of this finding is that CBT training should equip therapists with an understanding of micro-, mezzo-, and macro-level causes of suffering and distress rather than relying on categorical definitions of 'depression'. Another implication is that whilst Trade Unions can play a role in tackling psychosocial hazards in the workplace (Edelson, 2016), the 'trade union effect' has only been reported in terms of physical health and safety whereby unionised workplaces report fewer accidents, injuries and physical illness (Walters, 2006). Therefore, more research is needed to demonstrate that Trade Union membership might have a positive impact on mental well-being as well.

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