AN EXPLORATION OF JOB ACCOMMODATIONS FOR EMPLOYEES WITH DEPRESSION

by

DOUGLAS BRIAN HANSON

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ABSTRACT

Depression is an international problem for individuals, corporations and governments. It is estimated to affect 5 to 10% of the workforce at any one time (Olsheski, Rosenthal, & Hamilton, 2002). In the 2001 World Health Report released by the World Health Organization (WHO), mental disorders were projected to account, by 2020, for 15% of disability internationally and depression as the second highest burden of disease (Murray & Lopez, 1996; Simon, 2003). The costs to Canadian employers in lost productivity from presenteeism, absenteeism and mortality is in the billions of dollars per year (Stephens & Joubert, 2001). Depression is accompanied by discrimination and stigma resulting in employers being uncertain of how to accommodate their depressed employees in returning to work. Research on mental disability management, including return-to-work processes, to inform practice is inadequate (Goldner, Bilsker, Gilbert, Myette, Corbiere, & Dewa, 2004).

This study used qualitative methods to understand how job accommodations for depression are actually practiced in the field. This is an important contribution because although accommodations are seen as one of the most important strategies for promoting employment of the disabled, there has been little direct work to study how accommodations are actually evolving in the field for individuals with depression. This study identified and critically reviewed job accommodation processes that support the inclusion and retention of persons with depression in the workforce. This involved the identification of employment-based barriers (i.e. attitudes, lack of knowledge, finances and system support), and approaches to job accommodation for workers with depression. Interviews were conducted with 21 participants (experts) who have recognized training...
and experience in the treatment, rehabilitation and job accommodation of workers with depression.

This study offers recommendations for job accommodations that will assist employers and rehabilitation professionals in facilitating the employment of workers with depression. The long-term intention of this study is to enhance the treatment and vocational rehabilitation of employees with depression.
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CHAPTER I
INTRODUCTION

Statement of the Problem

Ten percent of the workforce suffers from depression (Olsheski, Rosenthal, & Hamilton, 2002). Depression (major depressive disorder) is predicted to become the second most common type of disability in the world by 2020 (Goldberg & Steven, 2001). Currently the incidence of claims for mental illness including depression approximates 30% of total disability insurance claims and “70% of the total costs-$15 to $33 billion annually” (Dewa, 2004, p. 22). An estimated 8% of Canadians will suffer from this disorder during their lifetime. Fifty to eighty percent of these individuals will experience more than one episode, reflecting the chronic cyclical nature of the disease (Health Canada, 2002, p. 38; Davison & Neale 2001, p. 243). Hergenrather and Rhodes (2004) report that with each recurrence there is a coinciding increase in severity. Fifty percent of individuals with depression are employed and of these 75% will remain employed (p. 86). Stewart, Ricci, Chee, Hahn and Morganstein (2003) estimated that the prevalence of depression in the US working age population as ranging from 6.5% to 11.1%. They also reported that presenteeism, defined as lost productivity due to depression while working, accounts for 81% of total economic losses attributed to low work performance. Presenteeism is synonymous with debilitating depressive symptoms such as difficulties with concentration, social interactions, energy, motivation, judgment and intellectual functioning.

It is of economic and humanitarian necessity that workplace initiatives be implemented to reduce the incidence and facilitate the rehabilitation of those employees
disabled by depression. Workplace prevention, education, intervention and supportive accommodation incorporate the main themes inherent in a proactive rehabilitation paradigm. Goldner, Bilsker, Gilbert, Myette, Corbiere and Dewa (2004) reported that there was limited adequate research to guide disability management practices for mental illnesses such as depression. There is not adequate research to understand the treatment and rehabilitation process as it incorporates the work environment and the individual’s disability related accommodation needs.

Employers, insurers and service providers need to develop interventions and accommodations that will minimize the risk of future exacerbations and reduce the duration of each subsequent recurrence of depression.

**Purpose of the Study**

The purpose of this study is to obtain the perspective of renowned experts in the treatment, rehabilitation and accommodation of workers with depression. The individuals with depression of interest to this study are those who continue to manifest functional limitations due to ongoing symptomatology. This study will explore, with the experts, the issues of barriers to accommodations, solutions to these barriers and the issues of current and recommended practices in the job accommodation of individuals with depression. The long-term intent of this study is to support the removal of employment-based barriers (i.e. attitudes, lack of knowledge, finances, and system support) and the promotion of approaches to job accommodations for individuals with depression.

**Perspective**

We have taken for granted that “job accommodation” means a material or behavioural change in job requirements, but this operational definition is not referenced
in the psychological, social-psychological, occupational therapy, testing, business or human resources literature. In seeking the causal relationship between accommodations and successful employment integration, have we identified the correct variables (i.e. not requiring a depressed worker to initially meet with customers)? If we were to conduct a quantitative study of the success of such an accommodation and found significant variance in the results, might we say that some other variable must be involved in the successful accommodation? Might it be that the operational definition of "accommodation" is actually the "employer/employee relationship" and/or the "level of communication" between the two? If this was inferred from such a study, then would it not seem reasonable to focus our rehabilitation resources on facilitating the improvement of the employer/employee relationship and their communication? Would this not facilitate the likelihood that the two individuals might ultimately figure out what material/behavioural changes might be necessary for the employee's successful return to work? In essence, is it possible that by focusing on the material/behavioural definition of accommodations it removes the employer and employee from facing the real issue: the human relationship?

In the absence of empirical evidence to the contrary, in this current study, a pragmatic definition of “accommodation” has been accepted to mean the removal of barriers to employment for an individual with a disability. In this way the individual’s disability does not pose as a handicap to employment. Since 1973 “reasonable accommodations” have been an inherent component in the rehabilitation of individuals with disabilities. This term was defined legally by the American Rehabilitation Act 1973 (Sahi & Kleiner, 2001; Light, 2001) and has also been incorporated into Canadian Human
Rights legislation (Canadian Human Rights Commission, 2005). Numerous quantitative and qualitative studies have assessed the benefits of “accommodations.” Studies have measured technical accommodations, such as material modifications in the work environment, and relationship accommodations including those involving supervisors and coworkers.

Significance of the Study

This study involves semi-structured interviews with recognized experts in the professions providing treatment, rehabilitation and initiating job accommodations for employees disabled with depression. Although accommodations are seen as one of the most important strategies for promoting employment of individuals disabled with depression, there has been little direct work to study how job accommodations are actually evolving in the field with this population. This study identifies barriers which many employees with depression experience. There are recommendations for resolving the barriers and the identification of accommodations that will be of benefit to all stakeholders. As a qualitative study, the results establish directions for further research concerning the process of accommodating depressed workers. The conclusions of this study will be of benefit to policy makers, researchers, practitioners, employers and individuals disabled from depression.

Currently, the Global Roundtable on Addiction and Mental Health, the Canadian Senate Standing Committee on Social Affairs, Science and Technology, and the BC Business and Economic Roundtable on Mental Health are in the process of establishing recommended practices for the treatment and job accommodation of individuals disabled
with depression and other mental illnesses. This study will be made available to these groups with the hope that the results will inform policy and practice.

The literature reveals that there is not adequate research to inform the practice of accommodating depressed employees in the workplace. This study will inform practice. Experts, health care professionals and service providers will have access to these recommended accommodations in the pursuit of their work with clients disabled by depression.

Employers bear the brunt of the economic burden of depressed employees through presenteeism and absenteeism. This study will provide the employer with a more comprehensive appreciation of the needs of the disabled employee and the benefits of establishing mental disability management programs within industry. It is hoped that employers will be able to access these guidelines for recommended job accommodation/employment of persons with depression.

Individuals who are experiencing a depressive illness may benefit from the recommended accommodation guidelines that could enhance their return-to-work potentials.

Research Question

Participant (Expert) Interviews. This exploratory investigation involved interviewing 21 participants with renowned expertise in the treatment and rehabilitation of individuals with depression. The semi-structured interview protocol considered the issues of current and recommended practices in the job accommodation of individuals with depression. Barriers to implementing these accommodations and approaches to overcoming these barriers were also explored.
Delimitations

This study reports on Major Depressive Disorder, Dysthymic Disorder and Minor Depressive Disorder (Diagnostic and Statistical Manual of Mental Disorders, 1994) which is referred to as subclinical depression (Martin, Blum, Beach & Roman, 1996; Kessler, Zhao, Blazer, & Swartz, 1997; Lavertsky & Kumar, 2002), and the impact of these disorders on the functioning of employees in the workplace. Co-morbid depression is not included in this study. Exploratory interviews of experts considered current and recommended practices in the accommodation of workers with depression. Barriers to implementing these accommodations and the solutions for minimizing these barriers were also be explored. The data reflect the experts' perspectives and recommendations on the issue of accommodations for individuals with depression. The research design is qualitative and retrospective incorporating the knowledge and experience of the experts in regards to the rehabilitation and job accommodation of individuals with depression.

Limitations

In this study it is explicitly acknowledged that the sociolegal context that the experts (and literature) represent likely influences their perceptions. Experts were selected from Canada (12), the United States (8) and Australia (1), and all data was integrated in the development of categories and themes.

Other potential limitations include the lack of input from the employees with depression and the absence of employer interviews, which limits the opportunity for a holistic understanding of the accommodation process. There is inadequate literature to inform practice, which is one of the key reasons for selecting a qualitative method of inquiry. This qualitative study explores the participants' knowledge of and experiences
with job accommodations, and induces hypotheses regarding the process involved in accommodating workers with depression. Suitable accommodations evolve from an objective functional assessment of the individual and analysis of the job. Since empirically derived psychological functional assessments or job analysis have yet to be developed, the utility of the accommodations will be anecdotally not empirically established.

During the expert interviews the researcher, where possible, documented the exact responses of the experts. However, at times it was necessary, due to time constraints, to summarize the participants' comments. While the interviewer reviewed these summaries with the participants for clarification and confirmation, reactivity (Creswell, 1998) might have influenced participants' responses. The interviewer's world view in regards to mental disability management must be considered in the development of the interpretations. To minimize the investigator's influence, the various threats to validity were addressed systematically and rigorously (Maxwell, 1996).

This study used a purposive sampling procedure implying that the results are not generalizable to all experts, disabled individuals or employers. The qualitative categories and themes were compared to the literature. A solely open-ended interview protocol might have provided the opportunity for greater insight into the process of accommodation, but is not incorporated into this study due to the focus of the research questions.

This study does not explore the influences of individual differences related to gender, culture, occupation or other contextual factors on job accommodation needs.
However, these factors need to be taken into consideration during the accommodation process.

**Overview of Thesis**

In this chapter I have identified the importance of this study, established the questions which we will explore, summarized the parameters, and suggested potential limitations of this study. Chapter II provides a review of the literature pertinent to the job accommodation of individuals with depression. Chapter III details the methods used in conducting this qualitative study including topics related to the research design, role of the researcher, and methods of data collection and analysis. In Chapter IV the results are presented as categories and subcategories with references to the research questions. Chapter V contains the discussion and conclusions sections which synthesize the accommodation recommendations extrapolated from the experts responses.
CHAPTER II

REVIEW OF THE LITERATURE

Depression

Magnitude of the Problem

According to cross-cultural primary care data collected by the World Health Organization (WHO) at 14 international sites, rates of major depression in primary care patients varied from a high of 29.5% reported in Santiago, Chile to a low of 2.6% in Nagasaki, Japan (WHO, 2001). The rationale given for the wide discrepancy in reporting was cultural factors such as varying levels of discrimination and receptiveness to the disclosure of emotions. When the WHO data was pooled across all primary care study sites, the prevalence were 10.5% for major depressive episodes (Ormel, VonKorff, Ustun, Pini, Korten, & Oldehinkel, 1994). Currently there is no Canadian national database capable of providing information on the prevalence rates of mental disorders in the Canadian population (The Standing Committee on Social Affairs, Science and Technology, 2004). In 2002, however, Statistics Canada carried out the Canadian Community Health Survey (CCHS), Cycle 1.2 on Mental Health and Well-being (Statistics Canada, 2003). According to the CCHS, 1 in every 5 Canadians over the age of 15 reported symptoms of mental disorder during the past year. The most prevalent reported disorder was unipolar major depression, with 4.5% of respondents reporting symptoms.

The symptoms of depression impact upon the individual in most aspects of his/her daily life. The psychosocial implications of depression include the individual’s responses to experiencing a disabling condition; the impact on the family involving changes in
roles, relationships, routines and assumptions (Schlossberg, Waters, & Goodman, 1995, p. 45); impaired social functioning and the subsequent loss of social supports; and reduced educational or vocational functioning often resulting in job termination and the loss of the capacity to make a livelihood. Gnam (2005) reports that mental disorders, especially depression and anxiety, disable the individual to a similar or greater extent than other chronic medical conditions. Of the mood disorders, depression appears to have the strongest relationship with occupational disability due to its pervasive nature. Hirshfield et al. (2002) reported that an estimated one third of depressed individuals experience symptoms for a period greater than two years. This chronic depression is related to moderate to severe psychosocial impairments in work functioning. Psychosocial impairment was found to persist long after the symptoms of depression were resolved (Hirshfield et al. 2002; Bosc, 2000).

Stuart (2004) reported that stigma towards individuals with mental illness negatively impacted their opportunities for securing employment, career advancement and tenure. Stigma is also the main reason employees do not self-identify for treatment (Kusznir, 2001). Hergenrather et al. (2004) identified that only 21.7% of individuals with depression receive appropriate treatment. The stigma of mental illness causes duress around the issue of disclosure. Should an individual disclose he/she may be subject to discriminatory responses from the employer and coworkers. However, not disclosing causes considerable stress as workers attempt to conceal their illness from supervisors and fellow workers (MacDonald-Wilson & Whitman, 1995). Ultimately, increases in duress may cause an increase in the individual's level of depression. The World Health Organization and the World Psychiatric Association report that the effects of stigma
towards individuals with mental illness is the most salient barrier to work that needs to be addressed by the mental health field today (WHO, 2001: Sartorius, 2004).

De Lisio, Maremmani, Perugi, Cassano, Deltito and Akiskal (1986) had previously suggested that recurrent episodes of depression resulted in long-term personality changes and subsequent difficulties in vocational adjustment. Also, disabled individuals’ relationships with family and coworkers are salient variables in supporting, motivating and facilitating the individual’s rehabilitation and successful return to work. Studies have inferred that workers with depression have 1.5 to 3.2 more sick leave days, during a 30 day period, than non-depressed workers (Brinbaum, Cremieux, Greenberg, & Kessler, 2000). Wang et al. (2004) reported that depressed individuals experience twice the number of sick days as their non-disabled coworkers.

A significant component of the burden of mental disorders is their deleterious effects upon employment. The productivity of employees with mental disorders was found to be reduced in two ways, by presenteeism, where the working individual was functioning at less than full capacity, and absenteeism, defined as “days during which an employee did not report to work” (The Standing Committee on Social Affairs, Science and Technology, 2004, p.112).

Individuals who are absent from work due to their depression are removed from the financial security and feelings of independence that accompany the experience of employment. Simultaneously, they are faced with the degrading experiences of the unemployed. Davison and Neale (2001) have reported: “psychological stress plays a role in depression” (p. 253). Holmes and Rahe (1967) developed a stress rating scale. Their research identified that out of 43 stressors personal illness was sixth and loss of work was
eighth. The individual who becomes disabled from work due to depression is faced with not just the illness but also additional stressors that compound their initial diagnosis. Soares and Prestridge (1992) in their three-year study of the major sources of stress found that financial concerns were consistently within the top two categories of stressors. These psychological stressors were associated with symptoms of depression, physiological and psychosomatic disorders. Reliability and validity coefficients in this study approximated .90 and .50 respectively. The results were significant implying that financial concerns, which occur when disability benefits, are unjustly terminated, result in a high level of stress. The consistent threat of benefit termination, which is inherent in many disability insurance companies, claims administration processes, is likely to increase and prolong depression. Wade (1999) in his study of stress and its effects on spousal depression found that a spouses' stress had a significant effect on the others distress. The threat of loss or the loss of the means to make a livelihood manifests a significant stress on the husband and his increased level of distress causes a significant increase in distress in the wife. Pitman and Lloyd (1988) studied the impact of stress on the quality of family life. Their results were consistent with previously reported studies. Financial stress was shown to significantly impact on family distress.

These individuals are at risk of increased disability stemming from the major stressors of acquiring the stigma of a mental illness; being displaced from the social supports at work; and not being in control of their financial resources. "Uncertainty, the lack of information and the loss of control" (Mate, 2003, p. 34) are reported in the literature to be significantly related to elevated levels of stress. Chronic stress has a deleterious impact on the immune, endocrine (hormones) and neurological (autonomic)
systems resulting in increased susceptibility to illness. Mate, (2003) reported that individuals diagnosed with MS who experienced significant stressors such as marital duress and financial uncertainty were up to four times more likely to have an exacerbation. The chronic uncertainty of disability benefits causes elevated financial concerns, subsequent marital duress and a perceived loss of control over the individuals’ ability to earn a livelihood. These significant stressors increase depression and the likelihood of the later onset of a secondary medical illness. Holmes and Rahe (1967) on the basis of their stress hierarchy were able to predict those individuals who would be more likely to experience a medical illness based on their history of stressful experiences.

The studies just cited reinforce the need for proactive prevention, early intervention and collaborative rehabilitation programs in order to minimize the risk of an acute depressive incident manifesting into a lost time chronic disability. The employees experiencing presenteeism “the walking wounded” require a work environment that cultivates trust between the supervisor and employee. It is only within this trusting relationship that the employee will feel comfortable in disclosing their disability and receiving the necessary treatment and accommodations. Attending to presenteeism is particularly significant due to the magnitude of this problem. Stewart, Ricci, Chee, Hahn and Morganstein (2003) reported that presenteeism accounts for 81% of the total economic losses attributed to low work performance.

**Economic Impact**

The economic burden of mental disorders is experienced in various ways. Direct costs are related to the making of direct payments and indirect costs are related to lost resources (Rice, Kelman, & Miller, 1992). Canadian data revealed that the total
economic burden of mental disorders (excluding substance abuse disorders) was estimated in 1998 to be $14.4 billion (Stephens & Joubert, 2001). This was subdivided into $6.3 billion for direct health care costs and $8.1 billion for indirect costs related to lost productivity and premature death (Stephens & Joubert, 2001). Long-term disability costs were estimated at $1.7 billion, and the costs associated with premature death were $400 million (Stephens & Joubert, 2001). The estimated indirect cost to the Canadian economy of short term disability alone was $6.0 billion (Stephens & Joubert, 2001).

In terms of direct health care costs, mental health expenditures were second only to cardiovascular disease (The Standing Committee on Social Affairs, Science and Technology, 2004).

With respect to American data, the data from the National Comorbidity Survey (NCS) (Kessler et al., 1994) indicated that one of the mental illnesses associated with statistically significantly increased occupational presenteeism was major depression. Those employed individuals with major depression were 28 times more likely to take a work loss disability day than their non-depressed colleagues (Kouzis & Eaton, 1994).

International data collected from primary care patients as part of the WHO Collaborative Study indicated that across all 14 international sites, mental disorders with the strongest association with disability were depression, panic disorder and generalized anxiety (Ormel et al. 1994). The Medical Outcomes Study found that the functioning of depressed patients was comparable or worse compared with patients with a major chronic medical disease (Ormel et al., 1994).

The costs to the overall economy associated with mental disorder-related occupational presenteeism or absenteeism have been studied extensively. The estimates
regarding major depression indicated that the disorder leads to an annual loss of $17US billion due to work absenteeism in the United States alone (Kessler & Frank, 1997). When the costs of presenteeism were added, estimates were raised to an annual salary-equivalent loss of $US 24 billion (Kessler, Greenberg, Mickelson, Meneades, & Wang, 2001).

According to estimates based on Canadian data collected in 1998, a total of 677,625 Canadians (6%) were diagnosed with depression (Stephens, Dulberg, & Joubert, 1999). This cohort of depressed individuals experienced 39,075 total person-years lost due to depression, translating into a $451 million in lost productivity cost (Stephins & Joubert, 2001). According to the Standing Senate Committee on Social Affairs, Science and Technology's Report (2004), “when compared with all other diseases (such as cancer and heart disease), mental illness and addiction rank first and second in terms of causing disability in Canada, the United States and Western Europe” (p. 110).

One measure of disability due to mental disorder is the disability-adjusted life year (DALY) (World Health Organization, 2001). This measure represents the sum of years of life lost due to premature mortality and years lost to disability. Worldwide estimates indicate that major depression was found to account for 4.4% of all DALYs worldwide and cerebrovascular disease accounted for 3.1% (p. 25). An in-depth, large-scale study of employment and mental health in the United States based upon the National Comorbidity Survey database identified that the impact of major depression showed a statistically significant reduction of employment rates for women and men (Ettner, Frank, & Kessler, 1997). Dewa and Lin (2000) reported that those workers
suffering from major depression had higher rates of short-term disability and a longer mean duration of disability than did their non-depressed colleagues.

Functional Capacities/Limitations Assessment

The goal of the current study is to explore the job accommodations required by workers with depression. In order to determine suitable job accommodations it is imperative to have knowledge of the individual’s psychosocial functional capacities and the psychosocial demands of the worker’s pre-onset job. The literature search substantiated that there is a dearth of empirical knowledge in either of these areas. The rehabilitation community would benefit from empirically developed measures in order to assist depressed workers in interfacing their functional capabilities with the job demands through the integration of suitable job accommodations.

MacDonald-Wilson, Rogers and Anthony (2001) reported that empirically derived functional assessments of individuals with psychiatric disabilities for the purpose of job placement have yet to be developed. Symptoms of depression which should be considered in a psychosocial functional analysis include the ability to concentrate, level of energy and fatigability, exaggerated self doubts, social withdrawal, cognitive slowing, indecisiveness and sleep habits, all of which may be impediments to work productivity (Berndt et al., 1998; Houlihan & Reynolds, 2001). Wang et al. (2004) suggested that major depression was significantly correlated to a reduction in both the ability to focus on a task and the individual’s level of productivity. MacDonald-Wilson, Rogers and Massaro (2003) have identified the social, affective and cognitive areas of functioning necessary for work performance to include:
maintaining a consistent work pace, following directions, concentrating on work
tasks, interacting with supervisors, responding to feedback, cooperating with
coworkers, adjusting to changes in work routine, making decisions, prioritizing
tasks, initiating new tasks, ...understanding and remembering job related
procedures or instructions, maintaining appropriate social behaviours, sustaining
concentration and persistence...adapt and be reasonably independent. (p. 16)

MacDonald-Wilson et al. (2003) provide a “taxonomy of functional limitations by
category and specific limitations” (p. 18). As psychosocial impairment continues long
after a reduction in symptoms (Hirshfeld et al. 2002; Bosc, 2000), separate measures,
such as the Beck Depression Inventory (BDI-11) and Social Adjustment Scale-Self Report
(SAS-SR), or the Social Adaptation Self-evaluation Scale (SASS) are recommended in
order to plan reasonable accommodations (Hirshfeld et al. 2002; Bosc, 2000). The SASS
was specifically developed to measure the social functioning of individuals with
depression. Contemporary approaches to assessment have attempted to directly link the
assessment of work capacity with the actual employment situation in an effort to attend to
the comprehensive array of factors that influence productivity. Assessments of functional
capacity that are situational, assessing individuals in the actual job context or within
environments constructed to closely resemble the real or potential work site, have
demonstrated promising results in predicting vocational capacities (Cooke & Pickett,
1994; Catellani, Tanzi, Lombardi, & Mazzuchi, 2002; McDonald-Wilson, et al, 2001;
Dowdy, 1996).

Tsang, Lam, Ng and Leung (2000) conducted a systematic literature review and
found that the literature did not support a relationship between diagnosis (depressive
symptoms) and work function. What was identified were significant relationships between pre-disability work history, including skills and attitudes; current social skills, involving the ability to get along with others; cognitive functioning, related to perception, interpretation and processing of social information; family relationships; and current work function. Social competence has been significantly associated with positive employment outcomes. Employers and rehabilitation professionals may enhance the return-to-work outcomes of depressed workers through the development of empirically substantiated psychosocial functional capacities assessments taking into consideration the above variables which are correlated with improved work function after the onset of a disability.

*Job Demands Analysis*

Suitable job accommodations for depressed workers must take into consideration the essential requirements of the individual's pre-onset job and include factors that may have contributed to or may exacerbate the depressive symptoms. Psychosocial workplace factors which may contribute to depression are predictability of expectations, controllability or autonomy as well as understanding and support from supervision and coworkers (Truax & Mcdonald, 2002). Suggested components of a psychosocial job analysis should include an assessment of cognitive, interpersonal and emotional requirements. This analysis should consider such specifics as technical and interpersonal demands of the job, assessing the implicit social and behavioural expectations of the specific job situation and the supervisory style used, evaluating the employees functioning regarding these demands and skills, and recommending the skills to be developed in the employee, the supports or
reasonable accommodations to be developed in the environment (physical, intellectual and interpersonal), and the services needed to improve employee functioning. (MacDonald-Wilson & Whitman, 1995, p. 17)

Disclosure

Rehabilitation professionals should also be able to conduct a mental disability management audit that incorporates the variables explicit in a psychosocial job demands analysis. Worksite modifying interventions initiated by these professionals may include education and training programs for supervisors and coworkers in order to facilitate an environment receptive to disclosure. Disclosure training refers to the development of those competencies that support an individual’s ability to fully benefit from reasonable accommodations in the workplace. It is based on the assumption that personal disclosure at work is complicated, having the potential to simultaneously weaken the individual’s credibility and status in the workplace and to provide important opportunities to support workplace productivity and well-being. Disclosure training includes developing knowledge of personal rights in the workplace, problem-solving and informed decision-making related to disclosure and use of work accommodations (Goia & Brekke, 2003; Marrone et al, 1998; Carling, 1993).

Gates (2000) and Gates, Akbas and Oran-Sabia (1998) suggest that the social network within the workplace requires careful consideration, particularly in light of the potential impacts of reasonable accommodations. Reasonable accommodations can provoke opposition among co-workers when their own job activities are affected, or when the accommodation is perceived as a privilege. Employment interventions in this area typically address processes for disclosure to co-workers. Gates et al. (1998) suggests
a systematic method for collaborating with the individual to identify potential sources of support among co-workers, methods for eliciting their support and counseling that focuses on the qualities and structures inherent in supportive relationships, such as reciprocity. A disclosure plan assesses the advantages and disadvantages of disclosing to the employer and/or coworkers in order that the disabled employee can make the decision to disclose or not.

The workplace factors that encourage job confidence, empowerment and recovery are related to the individual’s receptiveness to disclosure and being accepting of help for his/her depression (Ellison, Russinova, MacDonald-Wilson, & Lyass (2003). Accommodations might include initiatives that cultivate employee autonomy and facilitate recovery. Where residual disability predisposes the need for accommodations, disclosure may be unavoidable. In order to minimize the extent of disclosure, employers and rehabilitation professionals can consider a job matching approach. Job matching entails assessing the individual’s capacities and limitations and identifying work which the individual can competitively perform without the need for obvious modifications (Dalgin & Gilbride, 2003).

Early Intervention

It is imperative that early intervention strategies be initiated by employers in order to circumvent the development of the more severe, chronic depressive symptoms. The more chronic and severe the depression, the more treatment resistant, disabling and susceptible to recurrence the individual becomes (Brinbaum et al., 2000). Dewa, Hoch, Lin, Paterson and Goering (2003) reported that early intervention was significantly associated with shorter durations of disability by approximately 3 weeks. Early
identification and diagnosis have gained prominence, particularly for mental illnesses, such as depression that are highly prevalent and potentially effectively treated. However, often, these go undetected and are disruptive to the individual’s work status (Bender & Kennedy, 2004). Effective treatment is considered essential for those symptoms and impairments that have proven to be alterable by pharmacological or psychological treatments. While residual functional impairments frequently remain, research suggests that where effective treatment exists, there is a positive influence on employment outcomes (Bishop, 2004). Workplace Employee Assistance Programs (EAP) are believed to enhance access to focused psychological interventions for a range of psychological and psychiatric disabilities, but the actual impact of these interventions requires further research (Bender & Kennedy, 2004; Henderson, Hotopf, & Wessely, 2003).

Depression is inherently chronic and recurring in up to 80% of diagnosed individuals (Stewart, Ricci, Chee, Hahn & Morganstein, 2003). Treatment, rehabilitation and employer based disability management strategies may be more effective if interventions incorporate prevention strategies (Scott & Dickey, 2003). Disability management programs are employer based and focus on the prevention and early intervention of disabilities. Disability management practices integrate the resources within the organization with external resources to ensure that interventions are provided in a comprehensive, coordinated and cost-effective manner (Currier, Chan, Berven, Habeck, & Taylor, 2001; Habeck & Hunt, 1999). Workplace accommodations should be initiated which reinforce the goal of relapse prevention.
Accommodations

Reasonable accommodation was legally defined by the American Rehabilitation Act of 1973 as the process for integrating individuals with disabilities into mainstream society and reducing their reliance on the state (Light, 2001). In 1990, the Americans with Disabilities Act (ADA) stated that the employer must provide reasonable accommodations to individuals with physical and mental disabilities (Crampton & Hodge, 2003). In 1997, the American Equal Employment Opportunity Commission (EEOC) detailed the ADA rules pertinent to the job accommodation of individuals disabled with mental illness. The EEOC specified that while individuals with mental illness are considered disabled, they are able to work provided appropriate treatment and job accommodations are available. Employers are required to provide modifications which will “support and maximize the employees’ work performance” (Binui & Kleiner, 2000, p. 62).

The Canadian Human Rights Act (Canadian Human Rights Commission, 2005) requires that employers and unions have the obligation to initiate measures that will remove the barriers to employment for individuals with mental illness. The duty to accommodate is required other than on the occasion that the accommodation would cause undue hardship to the employer in terms of health, safety or costs. The Supreme Court of Canada established the Meiorin Test as the three step approach to determining whether an employer is justifiably relieved from the requirement of accommodating a specific individual in a particular job. An employer is required to prove that an employment standard set for a specific job is considered a bona fide occupational requirement based
on the Meiorin Test. This three step process requires the employer to show that a discriminatory standard can be justified as;

1. The standard was established as it was rationally related to job performance.
2. The standard was selected in good faith and in the honest belief that it was legitimately essential for the purpose of job performance.
3. The discriminatory standard is reasonably necessary to ensure job performance and it must be shown that it is impossible to accommodate the employee without causing the employer “undue hardship” (Canadian Human Rights Commission, 2005).

Gates (2000) defines accommodation as the balance between the disabled individual’s needs, the policies and procedures required by the employer, and the needs of supervisors and coworkers to ensure that the individuals’ functional limitations do not prevent the performance of the essential job duties. The traditional view of accommodation does not consider the most salient component of successful outcome; that is the social impact of the accommodation. This is also referred to as relationship accommodation. It is through an integration of accommodations at both the technical level of modifying job tasks and the social level where relationships are affected, that successful rehabilitation outcomes are achieved.

Provencher, Gregg, Mead and Mueser (2002) suggested that accommodations incorporate components which reinforce the themes of the individual’s “self-definition, empowerment, connection to others, meaning of work, vocational future, and meaning of recovery” (p. 135). These are the variables significantly correlated to a positive experience of recovery and are influenced by the corporate culture, supports and the individual’s experiences with supervisors and coworkers. Goldner et al. (2004) reported
the contextual workplace factors such as a supportive culture and employer policies and
disability management practices that encourage respect, trust and communication were
salient determinants of successful return to work programs.

Stigma and the resultant discriminatory actions of employers and coworkers may
be circumvented by providing supervisors and coworkers with educational materials as
well as involving them in sensitivity training. Employers may consider retaining
rehabilitation professionals who have expertise in the vocational rehabilitation of workers
with psychiatric disabilities and cognitive behavioural interventions. Education and
awareness training initiatives supporting employer efforts to meet their social and legal
obligations to provide reasonable job accommodations are also encouraged.

Another approach to return to work planning entails the rehabilitation professional
counselling the disabled worker about his/her role in ensuring that management and
coworkers have a positive experience during the graduated return-to-work (GRTW)
process. Employers and coworkers are more receptive and comfortable with
accommodating an employee with a mental illness if he/she has previously had positive
experiences with similarly diagnosed individuals. Counselling provided in conjunction
with direct exposure to the workplace provides the opportunity to develop the
recognition, problem-solving and decision-making competencies needed to manage
disability-related issues on the job. For example, counselling efforts can be directed to:
assisting individuals to ensure that the self-view reflects a balance of strengths and
limitations; reframing or interpreting work-related issues in a positive manner; gaining
awareness of how the work situation may provoke or trigger features of the disability;
developing proactive approaches to dealing with specific issues arising in the workplace;
and understanding how workplace accommodations can be constructed to support employment success. (Krupa, 2004; Carroll & Ponterotto, 1998; Dowdy, 1996; Gerber, Ginsberg & Reiff, 1992).

Coping skills training is a form of individual accommodation and focuses on enhancing the individual’s personal management of emotions in response to difficult situations at work and developing a repertoire of effective behavioural skills (Wallace, Tauber, & Wilde, 1999; Smith, Bellack, & Liberman, 1996). Coping skills are taught using a cognitive-behavioural approach. These interventions are offered to individuals or groups using psychoeducational and behavioural learning techniques. Coping skills training includes time management, stress management and relaxation training, energy conservation, assertiveness and communication skills training, anger/frustration management, social skills training and training in generalized problem-solving methods (Weiss & Murray, 2003; Bell, Lysaker, & Bryson, 2003, Storey, 2002; Hesslinger, 2002; Bozzer, Samson, & Anson, 1999; Wallace, Tauber, & Wilde, 1999; Parente, Stapleton, & Wheatley, 1991).

Other accommodations the rehabilitation professional might facilitate are changes in supervisor responses, support and communication style, work schedules and the physical environment (MacDonald-Wilson & Whitman, 1995). It was also inferred that early intervention, supportive case management and benefits policies that encourage disabled individuals to return to work were employer practices which minimized the extent and duration of disabilities. Gates (2000) emphasizes that since supervisors are the connection between the employer and the individual, they contribute the most to the success or failure of an accommodation. Supervisors’ attributes that affect employment
outcomes through accommodations include their attitudes towards mental disabilities; level of communication established between the supervisor and employee; supervisory style in regards to collaboration with the employee; and the support provided by the supervisor. Gates (2000) further reports that the disabled employees' receptiveness to disclose and benefit from reasonable accommodations is highly dependent upon the support from and relationship with supervision. Fabian, Waterworth and Ripke (1993) reported that the most salient accommodation was the training and orientation of supervisors and coworkers.

Depressed employees may require more intensive supervision and support for extended durations, flexible work schedules and removal of productivity time lines in order to build success into the individual's work experience (Houlihan & Reynolds, 2001). Fabian, Waterworth and Ripke (1993) identified the reasonable accommodations of job task modifications incorporating psychological and cognitive demands, schedule modifications, modifications to work policies and procedures, altering job performance expectations, providing physical assistance and initiating changes in corporate norms.

Social support from the employer and coworkers is significantly associated with positive employment outcomes. Storey and Certo (1996) reported on the incorporation of natural supports to enhance social reintegration, provide emotional support, reinforce technical and social skills development and assist with job modifications and accommodations. Suggested natural supports might include family members, coworkers or supervisors. The early intervention and accommodation process might include natural supports to ensure timely responses to potentially confounding work circumstances which otherwise might compromise the depressed worker's attempts to return to work. Natural
supports may also provide a supportive monitoring function as up to 80% of depressed individuals experience relapse (Health Canada, 2002, p. 38; Davison & Neale 2001, p. 243). The early identification of symptoms may reduce the severity of subsequent recurrences.

Social contextual factors and individual factors determine the individual’s level of functioning and integration with society and work. Kirsh (2000) reports on the significant impact of the work environment on the employment of individuals with a mental illness. In establishing employment options and accommodations employers and rehabilitation professionals should consider matching the depressed worker with a work environment which will accommodate the disabled worker’s critical limitations in order to reduce the likelihood of a disability manifesting in a handicap.

Research has shown that the longer a person is away from a job, the less likely it is that he or she will ever resume a productive work life (The Standing Committee on Social Affairs, Science and Technology, 2004). According to the Standing Senate Committee Report, “Statistics show that after six months on disability leave an individual has a 50% probability of returning to work; this is reduced to 20% after one year, and to 10% after two years” (p.107).

The literature suggests that there is not adequate research to understand the rehabilitation process as it incorporates the work environment and the individual’s disability related accommodation needs. There has been little direct work in studying how accommodation practices are actually evolving in the field with this population. This study explored specific aspects of job accommodations including current practices,
barriers, solutions to barriers, and recommended practices for individuals with depression.
CHAPTER III

METHODS

Type of Research Design

The purpose of this study is to explore the perspective of experts regarding the barriers and solutions to job accommodation of individuals with depression. The study will also report on participants’ recommendations for job accommodations. Maxwell (1996) recommends qualitative analysis for the purpose of identifying novel influences on phenomenon and generating new hypothesis. The qualitative focus is on the “process” rather than the “outcomes,” which are inherent in quantitative studies (p. 18). Creswell (2003) emphasizes that qualitative research is “interpretive” and facilitates an understanding of the “process and how things occur” in regards to the phenomenon of interest (p. 182). Therefore, in order to achieve the purpose of the study and gain an understanding of the process of successful job accommodation, a qualitative paradigm is indicated.

The research question guides us towards a retrospective exploration of the phenomenon of job accommodations. Maxwell (1996) reports that “Interviewing is the approach of data collection to understand events that have taken place in the past” (p. 76). The researcher’s interest is in gaining an understanding of the “expert’s” knowledge and experience in recommending or establishing job accommodations for individuals with depression. In order to understand the process of job accommodation and the contextual factors related to barriers to accommodations, Maxwell (1996) recommends a qualitative study. Sixteen of the twenty-one participants were practitioners. That infers a professional collaborative approach to this study for which Maxwell (1996) indicates a
qualitative paradigm of inquiry. Creswell (2003) emphasizes that qualitative research inherently and holistically focuses on the participants’ lived experiences in order to gain a comprehensive understanding of the unique perceptions of each participant.

The research question demands a focus on specific aspects of job accommodations including current practices, recommended practices, barriers and solutions to barriers. The traditional open-ended questions inherent in qualitative studies might not facilitate the participants’ emphasis on these aspects. Therefore, a semi-structured interview format, consistent with qualitative inquiry (Mcleod, 2001; Creswell, 2003) was developed in order to respond to the focus of the research question.

**Taxonomy of Accommodations**

One of the goals of the literature search was to identify accommodations for individuals disabled with depression. The Job Accommodation Network (JAN) ([http://www.jan.wvu.edu/media/atoz.htm](http://www.jan.wvu.edu/media/atoz.htm)) is an organization to which employers can submit examples of successful accommodations from their work site. These accommodations are then categorized and made available to other employers, rehabilitation professionals and the general public. Commencing with this taxonomy, additional examples of accommodations recommended by Gates (2002), Sahi and Kleiner (2001), MacDonald-Wilson et al. (2002), and Franche et al. (2004) at the Institute of Work and Health ([www.iwh.on.ca](http://www.iwh.on.ca)) were added. There were four broad categories of accommodations for individuals disabled with mental illness including depression, identified in the literature and incorporated into the JAN taxonomy. These included changes in the work environment, intellectual limitations, social limitations and emotional limitations. This enhanced taxonomy was then made available to the
participants as a reference during the interviews. For a detailed listing of accommodations the reader is referred to the above JAN website or to Appendix A.

Participant (Expert) Interviews

The qualitative component of this study was to interview a sample of 21 individual experts who have recognized training and experience in the rehabilitation and accommodation of individuals with depression. The sampling method for this study was intensity sampling. This is similar to purposive sampling. Palys (2003) defines this method as “sampling people whose ...vocation makes them ‘experiential experts’ because of their ongoing exposure to the phenomenon” (p. 144). As the study progressed, snowball sampling was introduced as the interviewed experts recommended colleagues with exemplary knowledge and experience in the accommodation of depressed workers (Palys, 2003).

Twenty-one participants were selected from a variety of backgrounds to ensure participant triangulation (Creswell, 1998). The 21 participants were characterized in the following way:

- 9 female and 12 male;
- 12 Canadians, 8 Americans and 1 Australian;
- 7 with MA's, 7 PhD's, 1 BNS, 5 MD's and 1 unknown;
- 8 psychiatric rehabilitation counsellors, 5 psychologists, 3 psychiatrists, 2 doctors, 1 nurse manager, 1 sociologist, and 1 human resources consultant;
- 10 had academic positions at universities;
- 16 were practitioners.

Primary positions held by the participants included: 1 president/CEO,
1 VP/Medical Director, 5 medical/department directors; 5 university professors/instructors; 2 senior rehabilitation counsellors; 2 senior human resources consultants; 2 managers, 1 occupational physician and 2 private practice psychologists.

Primary places of employment included: 8 at universities, 3 at international insurance companies, 2 at international financial institutes, 2 at national human resource consulting firms, 1 at an international service for individuals with disabilities, 1 with a provincial organization, 1 with municipal employee health, 1 with a hospital and 1 with an international primary industry.

Role of Researcher

Professionally, for 19 years, I worked as a rehabilitation counsellor. During 8 of those years my primary clientele were workers displaced from their jobs due to depression. My position also entailed working directly with employers and unions in establishing mental disability management programs. As disabled workers are often entitled to disability insurance benefits, my role also brought me in contact with claims adjudicators and adjusters. Based on this background, I have observed the stigma and lack of understanding from society, employers and coworkers towards the depressed worker as well as the unfair benefit entitlement practices enacted by some insurers.

Philosophically, my paradigm is humanitarian, and my professional approach is client centered. The theoretical framework of my counselling practice draws from the humanistic and constructivist traditions. I believe in social justice and hope that through this study some benefit will unfold to enhance the awareness of service providers, employers and coworkers towards the needs of those individuals who become disabled with depression.
The development of self-awareness in regards to values, beliefs and emotional responses to specific client issues is an integral component in graduate level counsellor training. Counsellors are sensitized to issues of counter transference in order to avoid the possibility of the therapeutic relationship fulfilling the counsellor’s emotional needs as opposed to helping the client. During the interviews and subsequent data analysis process, this researcher practiced reflexivity through the process of introspection (Creswell, 2003; Maxwell, 1996). In this way, objectivity and the process of thinking outside the box were a constant academic and ethical focus during this study. Maxwell (1996) remarks that “Eliminating the researcher’s theories, preconceptions, or values ... is not [the] primari[y] concern[ed]” of qualitative validity (p. 91). What is important is the expressed “understanding [of] how a particular researcher’s values influence the conduct and conclusions of the study” (p. 91).

Data Collection Instruments and Procedures

Participant (Expert) Interviews

This study purposively sampled 21 participants who have varied, recognized, professional and experiential backgrounds in the disciplines involved in the treatment and rehabilitation of individuals with depression. A semi-structured telephone interview protocol was developed with the input of three graduate level researchers. This interview approach allowed the participants to express opinions related to the overall concept of accommodation through responding to the questions (Palys, 2003). The semi-structured format allowed comparisons of the data and the suggestion of variance amongst accommodations as to their degree of significance (Maxwell, 1996). The interview questions were defined by the variables inherent in the research question. These included
current and recommended practices, the barriers to implementing accommodations and the solutions to the barriers. One question pertained to the participants' experiences with the accommodation of individuals with depression. (See Appendix B)

The question format followed the technique of funneling. It emphasizes that the more open-ended questions be included first (Palys, 2003). These questions were followed up by “successively narrower, more well-defined structured questions” (p. 177).

In the development of the questions consideration was given to ensure that

- Bias is minimized by using neutral terms that don’t influence the respondent;
- the interviewer presents as being objective and interested in the interviewee;
- ambiguity is avoided to maintain clarity and accuracy in communication;
- double-barreled items (i.e. 2 questions in 1) are avoided; and
- acronyms are not used as they can be confusing to the respondent. (Palys, 2003)

The sample taxonomy of potential job accommodations was based on psychosocial functional limitations appended to the expert interview protocols as a reference for the interviewer and participants. (See Appendix C)

The advantages of telephone interviews are that participants from various geographical areas can be interviewed. There is a substantially higher response rate than through mail surveys. Telephone surveys are less costly than face-to-face interviews. The interviewer can clarify ambiguities in the questions as they arise. The disadvantages of telephone interviews are that they are typically more limited in length than a face-to-face interview. Visual cues are virtually non-existent (Palys, 2003).
Prior to commencing the interviews, the interview protocol was piloted with a small sample of participants in order to ensure the utility of the format and process. As a result slight revisions were made prior to initiating the study.

The expert interview process was sequentially initiated in order to maximize the response rate of the experts.

1. An introductory e-mail was sent to the expert introducing the study, inviting him/her to participate and indicating an interviewer would be in contact by telephone in order to set a date and time for a telephone interview. (See Appendix A)

2. With the affirmative response to the e-mail, a copy of the interview protocol was sent to the participants, and times for interviews arranged. (See Appendix B)

3. The interviews were conducted and the experts' comments documented during the interview. The focus was on verbatim documentation where feasible. Where summaries or interpretations were made by the interviewer, it was important to confirm with the experts that the meaning of his/her response was maintained.

4. When there was no response from the initial introductory e-mail, a follow-up e-mail was sent once again requesting the expert's participation.

5. In the event that the letter and e-mail did not illicit a response, the interviewer telephoned the expert and invited him/her to
participate emphasizing the valuable contributions he/she would be making to an important study.

6. As a last resort when the previous systematic efforts failed to ascertain a response, a final e-mail was sent to the expert. He/she were requested to confirm their lack of availability to participate

7. At the end of each interview, the participant was requested to recommend a colleague who could make a valuable contribution to the study.

Data Analysis Procedures

Participant (Expert) Interviews

In qualitative studies, ongoing analysis is an integral part of the iterative process from the beginning of the study (Creswell, 2003; Maxwell, 1996). However, in studies where research questions are well formulated in advance, it is recommended to commence the analysis once all interviews are complete. In this way, the analysis of data from earlier interviews did not bias the conducting or analyzing of subsequent interviews (Seidman, 1991 in Maxwell, 1996). Due to the semi-structured nature of this study’s interview questions, analysis began once all interviews were complete. Maxwell (1996) recommends that initially the researcher reads the entire documented interviews and develops a tentative understanding of potential categories and relationships within the data. The process of coding, then, ensued. This involved rearranging data bits by categories identified by the researcher. Maxwell (1996) emphasizes that the research questions must guide the strategies of analysis. Next, themes were developed by
examining the data bits within and across categories. The categories and/or themes of data can then be represented descriptively in frequencies, tables or matrices. Creswell (1998) also recommends the initial reading of all interviews to get a general sense of the data. The researcher was attentive to the participants background, words used (i.e. metaphors) and potential categories it the data. Tentative codes were, then, developed with the end goal of reducing the total to 5 or 6 key themes. These were emphasized in the final write-up. The counting of data bits with-in each code or theme aided in understanding the “representativeness of the data” and “assists in defining and redefining the data (Palys, 2003, p. 317). The understanding of the data in qualitative analysis may be based on the researcher’s “hunches, insights and intuition” (Creswell, 1998, p. 145). The data codes and/or themes may also be represented in tables or matrices (Creswell, 1998).

Creswell (2003) recommends a generic approach to the analysis of qualitative data. Following is a summary of the steps in this process:

1. Ensure that all interviews were documented, and the data was organized by source.
2. Review all data in each interview in order to ascertain a general understanding of the meaning presented by the participants. The researcher jotted down notes as a preliminary process in the development of codes and themes.
3. Drawn directly from the data, codes were established, and participant responses were segmented into the smallest units of thought and organized by these codes. This process was
facilitated by selecting one interview document for each of three graduate level raters. The data was analyzed for its underlying meanings. Then, these meanings were clustered into tentative codes. These clusters were formed by organizing related topics to reduce the total list of codes. Once each rater had completed the coding for his/her assigned interview an alternate rater independently recoded the same interviews. Once this process was completed, the interviews were compared for similarities and differences in coding. Where discrepancies occurred, discussion ensued. Where necessary, new codes were established until consensus was reached on all three interviews for all three raters. In this way the main categories for the data bits were developed.

In order to maintain the relationship of the data to its participant sources, as the data is transformed into clusters of codes, a colour coding system was initiated.

4. These coded data were then further analyzed into a limited number of categories. Once this process was complete the 2 raters each reviewed ½ of the data to assess consensus or discrepancies. Of the 39 pages of data bits there were only 26 data bits in which there were discrepancies in coding. These discrepancies were resolved through consensus decision making. These categories are reported in the results section as being the salient aspect of the study’s outcomes.
5. At this step the researcher contemplated on how the themes would be represented in the narrative discussion. In the results section individual and integrated themes are detailed and substantiated with tabular representation of the counted data.

6. The interpretation or discussion phase involved the expression of this researcher's perspective on the overall meaning of the data compared to and integrated with the results of the systematic literature review.

Strategies for Validating Findings

Maxwell (1996) describes validity as how “credible” the findings are in relation to the “real world” (p. 86). Validity is the means by which the qualitative researcher rules out “threats” to the study’s conclusions (p. 88) and determines whether “the findings are accurate from the standpoint of the researcher, the participant, or the readers of an account” (Creswell & Miller, 2000 in Creswell, 2003, p. 196). Creswell (1998) recommends that a qualitative researcher use at least two of the most common validity processes in any given study. Threats to validity which were considered in this study included the detail and accuracy of the documented interviews; interpretations which are researcher biased; the researcher not considering discrepant data; and reactivity or the influence of the researcher on the participants’ responses (Maxwell, 1996).

The strategies for clarifying the validity of findings which were incorporated into this study have been recommended by Creswell (2003; 1998) and Maxwell (1996). These included triangulation of participants’ interviews by purposively selecting experts from varied professional backgrounds (i.e. psychology, psychiatry, vocational
rehabilitation counselling, consultants and professional from different countries).

Reflexivity through introspection, objectivity and the maintaining of an open and honest narrative process addressed and minimized the influence of researcher bias. At step 3 of the data analysis a subset of interviews were independently rated by another trained rater. In step 4 the coded data was reviewed by two trained investigators for consistency of interpretation. As mentioned, the interviews were documented by the researcher during the interviewing process. Since these were not verbatim transcriptions, a threat to the study’s validity is implied. In order to minimize this threat to the valid description of the participant’s response, during the interview, the researcher clarified with the participant that the interpretation was an accurate reflection of the intended meaning. This process is defined as member checking (Creswell, 2003, p. 196). During the analysis process all negative, contradictory information was thoroughly examined through the process of “analytic induction” (Palys, 2003, p. 322). Where inferred by the data, the hypothesis was revised in order to incorporate discrepancies and eliminate exceptions to the overall interpretation (Creswell, 1998, p. 201).

Ethical Issues Related to This Study

The lack of confidentiality pertaining to the comments made by participating experts by attributing specific comments to a particular individual would pose a breach of confidentiality.

The solution to eliminating this risk was that comments made by participants, positive or negative were kept confidential. Only aggregated data was reported with care taken so that identifying information would not be revealed, and no specific comments were attributable to any specific individual. Participants were advised verbally of the
ethical issues inherent in interview research, and informed consent was ascertained verbally from participants.

This research is contained within the Social Development Canada (SDC)-University of British Columbia (UBC) study investigating similar issues relating to mental illness and addictions. Approval has been provided by the UBC Behavioural Ethics Review Board (BERB). Dr. W. Borgen and Dr. I. Schultz confirmed that this study is within the ethical parameters of the larger SDC-UBC study, and ethics approval is inherently given.
CHAPTER IV

RESULTS

In this chapter the results of the interviews with rehabilitation experts are presented. The major categories resulting from the qualitative analysis of the interviews were guided by the research questions. The synthesis of these categories identified major theme(s) relevant to the removal of barriers and the implementation of reasonable accommodations for individuals with depression.

Participant (Expert) Interviews

The semi-structured interviews focused the participants' responses on the current barriers to job accommodations for individuals with depression; the solutions to these barriers and the current practices regarding accommodations. Participants were also requested to comment on their recommendations for solutions to accommodation barriers as well as accommodation practices for individuals with depression. After reviewing the sample job accommodations list attached to the interview protocol (see Appendix C), participants noted that it did not report on salient aspects of the return-to-work process. The examples provided were primarily from the Job Accommodation Network taxonomy of accommodations previously cited. The participants indicated that factors not indicated included workplace demands; nature of workplace; or limitations of the workplace.

As indicated in Chapter 3, twenty-one participants were selected using a combined purposive and snowball sampling approach. Twelve of the participants were Canadian, eight were American, and one was Australian. During the analysis and interpretation of the data, it is explicitly imperative to acknowledge that the socio-legal context that the experts (and literature) represent may affect their perceptions in relation
to the diagnosis of depression, and reasonable accommodations for individuals with depression.

The process of coding and counting of the participants' responses identified 1236 data bits (distinct phrases of meaning) that were reorganized into 5 broad categories. Each category was subsequently differentiated into 4 to 6 related subcategories. The subcategories are reported hierarchically on the basis of the frequency of related data bits. The first and largest category reported by the participants was Current Barriers to Accommodations. This one comprised 442 data bits. Current Practice Processes and Solutions to addressing these barriers included 169 data bits. Current Practice Accommodations for individuals with depression incorporated 164 data bits. Recommended Practice Processes and Solutions category contained 348 data bits. Finally, the Recommended Practice Accommodations comprised a total of 112 data bits.

In this chapter the categories will be described. The examples of comments from the participants are considered to be idiosyncratic. It is the themes which evolve out of the coding and synthesis of these individuals' comments which are relevant to this study. The following table identifies the number of data bits and experts' participation rates for each of the subcategories synthesized from this study. The participants were drawn from varied professional and occupational backgrounds related to the treatment, rehabilitation and accommodation of individuals with depression. It is important to note that even with this diversity in backgrounds the majority of the experts shared similar concerns.
Table 1: Comparison of the Number of Data Bits to Participation Rates per Subcategory

<table>
<thead>
<tr>
<th>Categories</th>
<th>Subcategories</th>
<th>Number of data bits</th>
<th>Participation Rate (% of Participants)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barriers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Magnitude of the problem</td>
<td>14</td>
<td>10 (47.6%)</td>
</tr>
<tr>
<td></td>
<td>Lack of education/knowledge/awareness/research</td>
<td>138</td>
<td>21 (100%)</td>
</tr>
<tr>
<td></td>
<td>Institutional limitations</td>
<td>70</td>
<td>15 (71.4%)</td>
</tr>
<tr>
<td></td>
<td>Attitudes</td>
<td>67</td>
<td>19 (90.5%)</td>
</tr>
<tr>
<td></td>
<td>Lack of employee centered approach &amp; Employee self-preservation</td>
<td>64</td>
<td>15 (71.4%)</td>
</tr>
<tr>
<td></td>
<td>Individual limitations</td>
<td>48</td>
<td>13 (62.0%)</td>
</tr>
<tr>
<td></td>
<td>Employer characteristics and expectations</td>
<td>41</td>
<td>15 (71.4%)</td>
</tr>
<tr>
<td>Solutions to remove barriers</td>
<td></td>
<td>518</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Help from others</td>
<td>259</td>
<td>20 (95.2%)</td>
</tr>
<tr>
<td></td>
<td>Education/knowledge/awareness/research</td>
<td>207</td>
<td>19 (90.5%)</td>
</tr>
<tr>
<td></td>
<td>Assessment</td>
<td>30</td>
<td>13 (62.0%)</td>
</tr>
<tr>
<td></td>
<td>Cost/benefit and financial issues</td>
<td>22</td>
<td>8 (38.1%)</td>
</tr>
<tr>
<td>Accommodations</td>
<td></td>
<td>276</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Changing job tasks/work requirements</td>
<td>75</td>
<td>17 (81.0%)</td>
</tr>
<tr>
<td></td>
<td>Workplace social support</td>
<td>91</td>
<td>17 (81.0%)</td>
</tr>
<tr>
<td></td>
<td>Changes in the work environment</td>
<td>68</td>
<td>15 (71.4%)</td>
</tr>
<tr>
<td></td>
<td>Social skills training</td>
<td>32</td>
<td>11 (52.4%)</td>
</tr>
<tr>
<td></td>
<td>Memory deficit accommodations</td>
<td>10</td>
<td>4 (19.0%)</td>
</tr>
</tbody>
</table>
Current Practice Barriers

In this category the participants identified the lack of education/knowledge/awareness/research as being the most referenced subcategory. The second most referenced subcategory was institutional limitations including issues related to the lack of treatment, funding and the practices of disability insurance companies and employers. Workplace attitudes, primarily related to the impact of stigma were also identified as substantially hindering the accommodation process. The participants referenced the lack of consideration to employees and the response of employees to the employer as being yet another barrier to effective accommodations.

The participants emphasized the magnitude of the problem of depression in the work force. Their greatest concern was the increasing incidence of depression, followed by the related costs and utilization of resources. These concerns are reflected in the following examples of comments:

- Depression is the most predominant disability next to anxiety.
- Depression is the number 1 reason there is [work] absence.
- ...a large number of employees experience presenteeism.
- ...insurers are saying that 40% to 50% of disability is depression...
- The most costly illness is depression.
- Individual counselling (EAP) has doubled.

Lack of Education/Knowledge/Awareness/Research

Of the 6 subcategories making up Current Barriers, the Lack of Education/Knowledge/Awareness/Research was most predominant consisting of 138 data bits. This subcategory primarily emphasizes the deficiencies in the education about
depression of individuals with depression, employers, coworkers and service providers. Key issues for employers are their lack of understanding and knowledge about the symptoms, functional implications and accommodation needs of workers with depression. Employers do not understand the mental illness of depression and are perceived as being apprehensive and fearful of becoming involved with individuals with this disorder. Service providers, referring to doctors, psychiatrists, psychologists, employee assistance providers (EAP) and vocational rehabilitation counsellors (VRC) are perceived as lacking training in psychiatric vocational rehabilitation and meaningful accommodations for individuals with depression. Co-workers, due to their lack of knowledge of the functional implications of depression, often become resentful, resistant and fearful in dealings with fellow workers disabled with depression.

To a lesser degree, participants were concerned about the practicality for some employers of being able to accommodated employees with depression as well as the lack of research to inform practice.

Examples of comments related to the lack of education/knowledge/awareness/research.

- Organizational health is not acknowledging or understanding the psychiatric disabilities [depression].

- Employers may not understand what accommodations may be needed based on the workers’ disability and limitations.

- Depression is an invisible illness and people don’t understand depressions behavioural symptoms.

- Employers are uncertain and fearful of how to interact with individuals with mental illness (MI) [depression].

- Employers are operating from a position of a lot of ignorance as to a model of what a meaningful accommodation means.
• Very few VRC are trained in psychiatric rehabilitation.

• Typically EAP counsellors are not trained in return-to-work (RTW) approaches or issues for mentally disabled [depressed] employees.

• Co-workers lack of understanding of mental illness [depression]

• Ignorance of psychological disabilities by the co-workers restricts opportunities

• The worker’s doctor, psychiatrist or therapist are usually not trained in accommodations or the graduated return-to-work (GRTW) processes for the psychiatrically disabled [depressed].

• A lot of efforts focus on symptom reduction but we don’t have a lot of information on function in relation to job demands.

Institutional Limitations

The second most referenced subcategory of barriers with 70 data bits was Institutional Limitations. This consisted of treatment limitations, lack of funding, insurance company practices and employer programs/services. The lack of funding was identified as being the most emphasized issue in this subcategory. Financial resources were identified as being inadequate for governments, companies and individuals to fund effective psychiatric (depression) vocational rehabilitation programs. This situation has resulted in inadequate treatment, interventions and follow-up as well as training for employers, co-workers and service providers. Participants reported that the traditional medical model is not an effective paradigm for the treatment and rehabilitation of individuals with depression. The more holistic biopsychosocial model is recommended in a collaborative process involving the employee, employer, doctor and vocational rehabilitation counsellor.

Some insurance company practices were reported as being adversarial and cumbersome. This approach causes conflict, confrontation, and anguish resulting in an
increase in the worker’s symptoms. The overall effect was the deterring of the return-to-work process and higher claims costs per case. Participants noted that some employers’ receptiveness to accommodating was dependent on how skilled and valuable employee was.

*Examples of comments related to institutional limitations.*

- Many of the barriers are inherently systemic.
- Systems are overwhelmed.
- It is often difficult to rehabilitate as funding is often not provided for an effective duration of service.
- Current practice is a state funded program and this doesn’t work due to economics.
- Can’t expect too much now as the system is broken.
- Time limits on the VRC or RTW coordinator to do the work required in the accommodation of more [an increasing number of] disabled clients. This is influenced by high caseloads.
- With the traditional medical model and current insurance practices an independent medical assessment (IMA) is arranged if the insurer or employers do not agree with [the individual’s] doctor.
- The claims adjudication process is cumbersome and deters the return-to-work (RTW).
- The claims adjudication process is cumbersome and causes individual’s anguish and grief.

*Attitudes*

Attitudes were identified by participants as being the third most recurring subcategory referenced in 67 data bits. Attitudes were defined as either general or related to the effect of stigma towards individuals with mental illness/depression. Co-worker attitudes were referenced as a main barrier to success of accommodations. Co-workers
were reported to being resentful of the perceived preferential treatment given to the
depressed worker causing reluctance to participate in assisting the individual. Co-workers
would often avoid contact with their colleagues who are disabled with depression.
Similarly, employer representatives were reluctant to engage in the accommodation
process with employees disabled with depression.

All individuals disabled with depression reportedly experienced social stigma.
Many fear losing their jobs, and others experience hostility at the workplace. Stigma is
often due to the employers' and co-workers' lack of knowledge about depression.
Feelings of guilt and shame that accompany stigma can exacerbate the individual's
condition resulting in increased symptoms and a decrease in job function.

Participants emphasized that employers often will not take responsibility for the
accommodation of workers with depression, preferring to avoid any involvement. Many
employers have negative attitudes towards and are fearful of individuals with depression.
Supervisors may give the politically correct responses but differentiate between their
approach to mental and physical illness. The attitude in the business community towards
depression is that it is a sign of weakness of character. Stigma towards depression also
exists in the helping professions.

Participants reported that a paradigm shift from the current medical model
approach to treatment, and the adversarial, avoidant responses to accommodations were
necessary to facilitate effective approaches to the vocational rehabilitation of individuals
with depression. A biopsychosocial, collaborative approach is recommended. However,
participants indicated that this paradigm shift would require "great effort" and "a
transformation, not just a transition”. Neither employees nor management are ready for this transformation.

*Examples of comments related to attitudes.*

- A significant barrier is the individual worker’s reluctance to disclose their mental illness to the employer for fear of being discriminated against.

- Stigma may be experienced by all MI [depressed] individuals due to the lack of knowledge about the symptoms of depression.

- Companies have trouble making accommodations for workers with mental illness/depression as nobody [supervisors] even in large corporations, will take responsibility for the client.

- Work environments [in] which the typical attitude toward the mentally disabled is that the mentally disabled worker is often best out of sight and out of mind

- Due to the stigma of mental disability, managers are often uncertain of how to deal with the individual.

- Managers experience a great deal of fear on how to handle people with MI [depression].

- Due to burnt bridges managers may be reluctant to provide support in the individual’s RTW program.

- Stigma about psychological disabilities deter[s] effective RTW and accommodations.

- This [segregation of mental illness from physical disabilities] is challenging when psychological disabilities make up the majority of claims (i.e. stress claims)

- The MI [depressed] worker is often isolated, as they don’t have a confidant at work to counter the stigma of mental illness.

- Main barriers are within the attitudes and beliefs of co-workers

- Coworkers may become resentful of the special treatment towards the disabled individual, as mental disabilities are not visible.

- Stigma is the #1 barrier to getting re-employed [for the depressed employee].
Lack of an Employee/Client-Centered Approach and

Employees' Self-Preserving, Counter-Productive Responses

This was the fourth most referenced subcategory incorporating 58 data bits. Issues that defined actions towards the employees included employee support, relationships at work, communication, flexibility, control/autonomy, specialized consideration and advocacy. Issues delineating the employees’ responses included confidentiality/disclosure and workplace avoidance.

The workplace was referenced as typically being adversarial where the individual disabled with depression is not contacted by the employer during absences from work. Appropriate support is also not initiated. The absence of these two factors is thought to increase the individual’s chances of relapse. Co-workers become resistive and resentful towards the perceived preferential treatment towards the individual. Participants reported that “most illness in the workplace is related to the lack of meaningful relationships with supervisors and co-workers.” It is top management and the ensuing corporate culture that needs to cultivate and promote these relationships. There is a lack of communication and collaboration between the treatment component and work component of the recovery process. The individual subsequently experiences a sense of disconnection from the workplace. Unions are reported to usurp Human Rights legislation relating to the “duty to accommodate” by invoking the “seniority rights” clause in contracts. On the other hand employers will often resort to the “undue hardship” claim as opposed to providing “suitable accommodations”. Participants identified that the main cause of health care costs are the workers feeling a lack of control, autonomy and uniqueness in the performance of their duties. Often trust is an issue between the individual and vocational
rehabilitation counsellor if the latter is employed by the employer or insurer. The absence of a trusting therapeutic relationship with the counsellor will compromise the success of job accommodations.

The employees’ resistance to disclose confidential information regarding their depression is a considerable barrier to vocational rehabilitation and accommodation. Employees do not disclose for fear of the impact of stigma on the employer’s and co-workers’ understanding and support. In the current, primarily adversarial system confrontation between the employee and employer evolves as an underlying theme in their discourse. The individual disabled with depression may defend him/her self through passive-aggression. The individual may “fight to prove he/she is sick … in order to avoid the workplace [which] is the source of depression.” The passive-aggressive employee response “lies at the heart of an adversarial system.” Other employees may believe they should be entitled to retraining should they experiencing a chronic disabling condition.

*Examples of comments related to this subcategory.*

- The employers are not maintaining supportive contact with the worker who subsequently feels uncared for.

- Almost all illness in the workplace is related to “supervision” and the impact of management on the worker’s meaningful relationships at work.

- There is a gap between the mental health care system and the workplace – one is concerned with symptom relief and the other is concerned with vocational functioning and there is no integration of the two.

- Regarding depression, disabled employees (in a unionized environment) are not accepted back at work until they can work a full shift, unless they have the seniority to post on alternate less demanding positions.

- This factor [the workers perceived lack of control] alone is more significant than health related behaviours (i.e. smoking) in predicting the onset of illness [depression].
• Vocational rehabilitation counsellors (VRC) not trained in psychiatric rehabilitation don’t know how to advocate on behalf of the client to the employer.

• The result of the mentally disabled worker not disclosing is that employers often don’t know what is going on when the worker exhibits behavioural symptoms of MI [depression].

*Depressed Individuals’ Limitations Related to Mental Illness.*

This subcategory consisting of 48 related data bits and delineates specific symptoms and limitations experienced by the individual with depression. The functional implications in relation to work performance issues are also identified. Social limitations resulting in relationship difficulties were identified as having the most profound impact on the individual’s functional abilities. Intellectual limitations result in difficulties in performing job tasks. The information in this section is of importance to all stake-holders and is provided in its entirety in Appendix D: Table 1.

*Employer Characteristics and Expectations*

This final subcategory of barriers comprises 41 data bits and focuses on an understanding of contextual workplace factors. Some of the highlights impacting on the accommodating of employees with depression are emphasized. These include the substantial influence top management has over corporate culture and practices towards workers with disabilities. In this regard, changing corporate culture is compared to changing a personality. The company must desire a change or efforts to intervene will not be successful. The main barriers to accommodating employees are the employers’ attitudes and beliefs. Participants report that few employers promote good employee relationships and they (employers) do not understand depression and lack receptiveness to accommodating employees. Companies are resource lean and the pressure on
managers is for productivity. The individual returning from sick leave often must be fully
recovered and perform the essential job duties.

*Examples of comments related to employer characteristics and expectations.*

- Problem is when there has been a bad experience by the employer with a mentally
disabled individual.
- Productivity pressures of the work place.
- Manager's fear about the potential for success in light of previous disruptive
  incidences at work.
- Many organizations lack an employee focus when considering disability
  management.

*Current Practice for Processes/Facilitators/Solutions to Remove Barriers*

This category was the least referenced by the participants, consisting of 169 data
bits. The key issues identified in the current practices of resolving the barriers to
accommodations were primarily related to employee support, increased knowledge by all
stakeholders, the need for efficient assessments, and funding issues.

*Help From Others*

This subcategory was identified in over half (103) of the data bits of the broader
category. Vocational rehabilitation is a "systemic approach" involving collaboration
between the vocational rehabilitation counsellor (VRC), doctor or psychiatrist, employer,
client, co-workers and union. A collaborative approach facilitates involvement, support
and commitment from all parties. This approach offers the opportunity to repair
relationship issues with supervisors and co-workers. Doctors are informed of the
"patient's" transitional graduated return-to-work opportunities, and the VRC maintains
informed communication between all stakeholders. All of these efforts are initiated for
the benefit of the employee.
Flexibility in the accommodation of employees disabled with depression is the primary message in planning the necessary, individualized-tailored return-to-work process. This is required as a result of the cyclical, recurring nature of depression as well and the individual’s “unique style of working”.

Participants emphasized that some employers have been “proactive.” It is the larger employers who have the resources, manpower, and disability management structure to initiate reasonable accommodations. Co-workers are identified as a key to the success of accommodation initiatives. These natural supports (co-workers) require additional time to support the individual through coordinating job tasks, and providing regular, concrete feedback. It is important to resolve any previous relationship issues between the individual and co-workers, and to work collaboratively with co-workers to ensure that accommodations are acceptable and realistic to them. To do otherwise would sabotage the rehabilitation process.

*Examples of comments related to help from others.*

- All supports have to be individualized collaboratively with the worker.
- Employers are encouraged by the overall [rehabilitation] team
- The team has more influence on the employer than just one service provider.
- Ongoing collaboration between the supervisor and worker ensures that problems are identified and resolved together with the individual.
- Dr. are invited to tour the work place in order to gain an understanding of the pressures, stimuli and stresses of the workers job.
- Dealing with coworkers to prepare them and the individual for challenges all may encounter as the disabled individual returns to transitional work.
- Necessary to do damage control and repair issues with coworkers at the onset of the rehabilitation process
Education/Knowledge/Awareness/Research

Education and awareness development for management from the top down, union representatives and co-workers is an ongoing requirement in effective mental disability management programs. The educational themes include; the needs of the individual with depression; the impact of depressive symptoms on work function; the benefits of rehabilitation interventions and accommodations and challenges the individual faces as he/she transition back to the workforce. Participants identified education as being effective. In some cases, unions supported and participated in the education process.

Participants indicated that employers (especially large employers) are becoming more aware of the magnitude of the impact of depression on their workforce. These employers have acknowledged that “it will be the workplace where the solutions [for workplace depression] are developed.” Overall, the most receptive employers and co-workers were those who have had a previous, positive experience with someone disabled with depression.

The participants recommended that a “much more expansive knowledge base [is needed] regarding the efficacy of specific interventions and accommodations.” The VRC “must be aware of the social behaviours and norms inherent in the corporation’s culture.”

Examples of comments regarding education/knowledge/awareness/research.

- Education and awareness development for management and co-workers is important to sensitize the work environment to the needs of the MI worker.
- Dealing with coworkers to prepare them and the individual for challenges all may encounter as the disabled individual returns to transitional work.
- Management and co-worker education regarding psychological disabilities should be on a regular basis
Assessment

Participants recommended that psychosocial functional assessments and job analysis be conducted in order to establish suitable modified work or reasonable accommodations for the employee with depression. This assessment process should be collaborative involving the employee, employer and union representative. One suggestion was to utilize the work place to assess memory function in relation to the essential job duties.

Examples of comments regarding assessments.

- Initially the vocational rehabilitation counsellor (VRC) must review essential functions of the job to ensure these are incorporated into the graduated return-to-work (GRTW) and accommodations.

- Difficulty with social interaction, social subtlety and miscuing requires an assessment of explicit social skills in the environment and which [social skills] are essential to job duties.

Responsibility

The VRC is responsible for coordinating timely interventions and monitoring the return-to-work process. Social skills training, for employees experiencing the symptoms of social limitations is not the responsibility of the employer. By taking responsibility and doing his/her part the individual benefits from developing improved social skills and this achievement increases his/her self-confidence.

Cost/Benefit and Financial Issues

The financial costs of depression are experienced by employers through employee absenteeism and presenteeism. These economics demand that “solutions for workers with depression be developed in the workplace.” For large employers, solutions to the
economic burden of depression focus on effective and efficient treatment, rehabilitation and accommodation.

Examples of comments regarding cost/benefit and financial issues.

- The solutions for depressed workers are to be developed in the workplace due to the economic implications on employers in regards to presenteeism

Current Practice Accommodations

This category incorporated 164 data bits that emphasized accommodations related to the following: changing job tasks/work requirements (51 data bits); workplace social support (43 data bits); changes in the work environment (42 data bits); social skills training (19 data bits) and memory enhancements (9 data bits). Participants suggested that insurers and employers have to deal with the impact of depression in the workplace as this “problem has not disappeared.” Employers who have been proactive tend to practice the norm of good management for all employees. Both presenteeism and absenteeism require the employers’ attention when considering accommodations. The return-to-work process should plan for success, not failure and include early intervention to reduce the development of chronic conditions. The graduated return-to-work (GRTW) process should be implemented on a transitional basis involving a process of progressive psychological work hardening. The goal of all accommodations is the return to full regular duties. Participants indicated: “Sometimes informal arrangements between the supervisor and employee are compromised as they should have been formalized.”

Changing Job Tasks/Work Requirements

Temporary changes in job requirements are effective accommodations for individuals experiencing social, emotional and intellectual limitations. Reducing the hours of work, eliminating some tasks from the job, moving the individual to a private
office, allowing the employee to temporarily work from home or relocating him/her to a different department are just a few of the effective reasonable accommodations identified.

*Examples of comments regarding changing job tasks/work requirements.*

- Main accommodations [for depression] are shortened hours of work
- Main accommodations [for depression] are reduced responsibility in a GRTW.
- Accommodations [for individuals with intellectual limitations] might involve allowing more time for task completion
- Allow workers [with depression and anxiety] to change hours of work such as not coming in as early and staying later in the day
- A supervisor may have to present the individual’s progress update on a project in order to minimize the requirement of social contact.
- Long term modified duties for individuals with permanent limitations.

*Workplace Social Support*

Prior to initiating a GRTW, the VRC should collaborate with the individual’s supervisor and relevant co-workers in order to address and resolve any relationship difficulties related to previously “burnt bridges,” This situation often arises as the depressive symptoms of agitation and irritability can manifest in relationship conflict. The VRC should offer counselling to the individual regarding the issues of his/her feelings of guilt, shame and fear in relation to the stigma of mental illness. The supervisor and co-workers should be informed regarding the impact of these issues during the return-to-work process. Accommodations must be developed collaboratively with the supervisor, individual and necessary co-workers or these well meaning interventions may “backfire.” Job modifications and accommodations must be perceived as realistic for all parties. Individuals with depression may experience intellectual limitations, concentration difficulties and social deficits. Supervisors can accommodate workers by providing more
1 on 1 supervision and documenting tasks by priority. Co-workers play an important role as natural supports through instructing, prompting and encouraging the individual.

*Examples of comments regarding workplace social support.*

- The employee can also be allowed to call their counsellor or whatever support seems to work for that issue.

- Need accommodations that account for the fluctuating nature of depressive symptoms.

- Dealing with coworkers and supervisors to prepare them and the individual for challenges all may encounter as the disabled individual returns to transitional work.

- Social deficits outlast depressive symptoms and therefore employers need to be informed that inappropriate social behaviours may be symptoms of depression.

- The accommodation of workers with emotional limitations depends on the ability of the organization to provide appropriate therapeutic supports.

*Changes in the Work Environment*

Common symptoms of depression are anxiety, agitation, irritability and fear. These can limit the individual’s tolerance for working near others and cause work relationship conflict. Individuals with depression may need to screen out stimuli, reduce noise and avoid co-worker traffic. Affected individuals may be accommodated by being moved either to a different part of the department or temporarily out of the department. This may include moving to a private office, working from home or temporarily moving to a different department. Other accommodations that may be beneficial include using dividers to isolate the individual and the wearing of headphones.

*Examples of comments regarding changes in the work environment.*

- Medication can affect visual acuity. Therefore visual aids may be necessary.

- The depressed workers need access to a source of natural light.
• The individual should be able to take a break to go outside for a few minutes.

• Individuals with social limitations such as low impulse control and agitation may need to be socially isolated.

Social Skills Training

Individuals with depression often develop social limitations either due to low self esteem, fear of the stigma of depression, agitation and irritability, difficulties with decision making or phobias. These individuals can benefit from social skills training facilitated by a qualified counsellor. This training has to do with conflict resolution, the development of an awareness of workplace cultural expectations, stress management and assertiveness training.

Examples of comments regarding social skills training.

• A major issue for the MI [depressed] worker is how to ask questions or receive feedback. In these situations, the accommodation might be the VRC counselling the worker and consulting to the employer.

• VRC can help with social skills development, which is a behavioural intervention.

• Should irritability be an issue, the rehabilitation professional needs to work with the individual to learn more effective coping skills.

Accommodations for Memory Deficits

Depression often affects the individuals’ ability to concentrate and make decisions. There are numerous compensatory strategies which can reduce depressions impact on job functioning. Some of these include note taking and the use of diagrams as visual instructions.

Examples of comments regarding accommodations for memory deficits.

• For difficulties with memory or concentration, have a supervisor organize in writing the tasks for the day.
• These accommodations [for memory and concentration difficulties] will minimize the amount of decision making required by the worker.

• Where concentration or cognitive processing is a problem, provide written instructions that are simple and concrete.

Recommended Practice for Processes/Facilitators/Solutions to Remove Barriers

This category was the focus of 348 data bits emphasizing the need for substantial enhancements in overall education, knowledge, awareness and understanding of the needs and abilities of individuals disabled with depression. Increased appropriate support from resources both internal and external to the company is essential to minimizing the impact of depression on performance and productivity. Concern was raised regarding the need for objective assessments of the individuals’ function, the psychosocial contextual requirements of the job and the evaluation of outcomes pertaining to interventions and accommodations. A holistic, collaborative, biopsychosocial approach to treatment and vocational rehabilitation comprises the paradigm shift essential to optimize intervention and accommodation outcomes. This shift incorporates the emphases on each individual’s strengths and abilities, not disability. The necessary, but not sufficient, component of all models of effective mental disability management is the commitment, support and involvement of top management. Increased funding for treatment and rehabilitation is also essential for the appropriate allocation of required resources.

Education/Knowledge/Awareness/Understanding

This subcategory drew the most input from participants (169 data bits) of all subcategories in this study. Increased awareness of the incidence, causes, symptoms and successful interventions for depression was recommended. This includes education to “reduce the worksite stigma towards MI [depression]”; facilitate “the acceptance that
[depression] is an illness like any other” and inform employers about “what works...what other employers have implemented.” Employers need to know what resources are available and where and how to access them. An employee/client centered approach should guide the relationships between the employee with a disability and the employer, coworkers and service providers. The employer should show “concern, interest, respect and care for the individual employee.” Managers require training in empathic communication with employees in order that problems can be discussed with the employee tactfully in a supportive rather than punitive, judgmental fashion. Supervisors require the support and mandate from senior management to be accepting and nonjudgmental towards the needs of the employee with depression. This management approach will reduce “the supervisor’s anxiety about focusing on employees’ well being.” Employees also require training about the symptoms, treatment and accommodations for depression. Collaboratively, the supervisor and employee with depression establish when the worker is fit to return-to-work and identify the necessary accommodations.

Employers’ knowledge of the benefits of early intervention will facilitate the timely response to employees’ display of symptoms and “reduce the likelihood of an acute episode manifesting into a chronic disability.” In this way the individual’s symptoms can be managed as work is incorporated as a therapeutic modality.

The recommended transformation from a medical model to a biopsychosocial model of treatment, rehabilitation and accommodation requires “extensive training and workshops.” Supervisors and co-workers require training about the signs and symptoms of depression, the impact of symptoms on job function, the fear and avoidance issues of
the employee with depression, the awareness of the fluctuating symptoms of depression and "an understanding that the individual’s problematic behaviours exhibited prior to going off of work were symptoms of the disability."

Establishing suitable accommodations for the employee with depression necessitates counsellors/case managers who are trained in business, disability management and the signs, symptoms, functional impact and accommodation needs of these individuals. It is the rehabilitation professional not the employer who is trained in mental disability management. The employer should ensure that the rehabilitation counsellor, trained in psychiatric rehabilitation, consults with a psychologist when considering accommodations for individuals with cognitive limitations.

Participants suggested three distinct models of mental disability management. One model has been successfully practiced in a national financial institute for 7 years. This model developed a training program for "facilitators" who work under the supervision of rehabilitation coordinators/managers. Facilitators support the RTW process, identifying barriers and collaboratively participating as a team member in facilitating successful rehabilitation outcomes. A second mental disability management model incorporates the role of therapeutic counsellor with that of vocational rehabilitation counsellor. Subsequently, the counselor provides "therapy and later case management and vocational rehabilitation counseling." There is a dispute between proponents of the second and third models who disagree on the merging of the counselling and vocational rehabilitation functions. This latter model argues that "confidentiality is confounded by involvement of the VRC role as it includes meetings..."
with the employer and reports to the insurer.” Research is necessary to establish the effectiveness and efficacy of models of mental disability management.

Economics determines top management’s support of accommodations for employees with disabilities. Research outcomes infer the efficacy of rehabilitation and accommodations. Therefore, evidence informed strategic interventions are essential in implementing and monitoring the disability management process. Evidence based psychosocial functional capacity evaluations, and job demands analyses are in need of development to guide the accommodation process. Data on health risks and the benefits of accommodations on productivity and profit should be collected and disseminated to appropriate stakeholders. “The disability management and rehabilitation process should be guided by these analyses.”

Participants indicated that it is difficult to engage companies that are unaware of having problems with mentally ill employees. The lack of awareness by these companies does not seem to be resolved through training. One participant reported that “education and knowledge does not change [corporate] minds.” It was suggested that if a company does not change its attitude towards accommodating the employees with MI [depression] after two approaches by an advocate, the advocate should “move on.” Suitable companies are those that are “receptive to change…diversity…interested in the process of accommodation.” With the reluctant companies the “herd mentality” may be of influence in relation to initiatives such as the Global Business and Economic Roundtable on Addiction and Mental Health. In essence, “no one wants to be first but is always interested in comparing self to peers.”
Examples of comments regarding education/knowledge/awareness/understanding

- Early intervention to reduce the likelihood of an acute episode manifesting into a chronic disability.

- A lot of the disability from depression does not need to happen. Organizations need to be sensitive to performance of individuals in order to prevent the onset of disabling depression and intervene early.

- Education, policy development, prevention and early intervention will all reduce the necessity for reactive responses to mental disorders.

- Initially it is important that the worker's depressive symptoms are brought under control enough to incorporate work as a therapeutic modality.

- Reduce worksite stigma towards MI through education and depression awareness.

- Showing employers the economic benefits of improving the moral and health of employee is key in initiating changes within the work environment.

- Top management should partner with those who know about it [the experts in mental illness rehabilitation] to facilitate corporate cultural changes in the awareness of workers with mental illness.

- The employer should provide psychoeducational information to coworkers on the symptoms of mental illness in order to breakdown the stigma about mental illness at work.

- Monthly column promoting psychiatric disability management in the company newsletter

- Supervisors need more help in having someone knowledgeable about accommodations to talk to.

Help From Others

This subcategory incorporates 156 data bits that focus on the issues of collaboration, communication, individually tailored support, employer support, service provider support and institutional support. The main issue emphasized by the participants was the need for a collaborative effort by the employer, employee, co-workers, union, doctor and service providers. It is imperative that top management endorse and actively
participate in the development of a corporate culture that supports the accommodation of all employees with disabilities. Top management should establish partnerships with experts in mental disability management and rehabilitation in order to facilitate the necessary changes within the corporate culture. A collaborative corporate culture is typified by "flattening the corporate hierarchy," "cultivating communication between all workers and management so everyone has a say and are listened to," and ongoing communication which ensures that employer/employee values are expressed and concerns are reviewed.

The rehabilitation professional develops and maintains good relationships with the doctor and health care providers. The rehabilitation professional must be an "advocate for the employee with depression and be sensitive to the employer's needs." This professional attends regular return-to-work (RTW) meetings with the employer and employee (and union) to review the employee's progress in the graduated return-to-work (GRTW) program. Minutes are taken of these meetings and shared only with attending parties. In the event that the employee is concerned about his/her ability to progress in the GRTW, the committee suggests they take the meeting minutes to his/her doctor. Only functional issues are shared with this RTW committee, and confidentiality is maintained with the supervisor, employee and rehabilitation professional. Prior to commencing the GRTW the rehabilitation professional will have counselled the employee regarding the issue of disclosure. The employee and counsellor will decide what to disclose, when to disclose and who to disclose to.

Participants emphasized the benefits of open and timely communication. A new paradigm of mental disability management has evolved since 1991. The emphasis is on
“good communication between the managers and mentally disabled employees.”

Employers with successful mental disability management programs advocate enhanced communication including ongoing conversations between management and the employees’ with depression. To ensure clarity the GRTW should be a written document specifying the program objectives and time frames. Employers should monitor for the early identification of employee difficulties in the GRTW and provide clear, concise and supportive feedback to the employee to facilitate the judicious resolution of problems.

Accommodations are individualized and based on the employee’s functional abilities and limitations. The level of monitoring is established collaboratively between the employer and employee. Once the GRTW program commences the supportive supervisor may meet with the employee weekly to collaboratively assess the individual’s progress in relation to the “workload” and “worksite relationships.” The rehabilitation professional continues to reassess the individual’s progress in the GRTW and provides appropriate interventions as the employee improves or relapses.

Companies should ensure that extended health coverage for individuals with mental illness parallels that available for employees with physical disabilities. The company should also endorse paying for specialists to assess, treat, rehabilitate and educate. The provision of psychological/counselling and vocational rehabilitation counselling services on site is recommended. Should the employee’s mental illness necessitate time off work for a term of treatment, a company support system should retain the individual’s job for up to 18 months. This level of support shows the workers “care, concern and respect” and maintains his/her connection with the employer.
Examples of comments related to help from others.

- This issue of inequity in health coverage for MI and physical disabilities relates to health insurance coverage as well as disability benefits.

- In establishing GRTW programs and accommodations build in a fail-safe so that if the individual is unable to complete the assignments he/she will not feel denigrated.

- There will be a period of adjustment and may be a relapse. The individual and manager need HR/VRC support that things will get better and therefore stay the course.

- A collaborative approach with all stakeholders is essential.

- It is important for management to recognize that the workers performance problems are symptoms of social limitations relating to his/her mental illness.

- With severe MDD “baby steps” are recommended through behavioural activation, progressive increase in activity levels, and gradual increases in levels of productivity.

Assessments

Situational work assessments (SWA) are established in a work environment away from the employer. These assessments can be arranged by the rehabilitation professional with receptive employers, either on an individual basis or with a formal program offering various work stations to individuals with a variety of disabilities. The individual has the opportunity to self assess and build up tolerances and confidences to return to work successfully with his/her employer. The SWA allows the opportunity for the employee to experience failure on the job “without compromising themselves at work through failure in front of supervisors or co-workers.”

The rehabilitation professional commences the GRTW process with a semi structured intake interview to identify the employee’s symptoms and psychosocial functional abilities and limitations. Psychological or neuropsychological testing is at
times recommended to assist in establishing the impact of depression on the employees' function. Prior to commencing the GRTW the rehabilitation professional determines, in conjunction with the employee and doctor, whether additional assistance is required from other professionals. The individual's doctor should provide medical clearance for commencement of the GRTW.

**Recommended Practices for Accommodations**

This category incorporated 112 data bits that emphasized accommodations related to; changing job tasks/work requirements (24 data bits); changes in the work environment (26 data bits); workplace social support (48 data bits); social skills training (19 data bits); and memory enhancement (1 data bit).

**Changing Job Tasks/Work Requirements**

Temporary changes in job requirements are effective accommodations for individuals experiencing social, emotional and intellectual limitations. Accommodations may include flexible hours of work and time off; limiting multitasking; and having more time to manage tasks.

*Examples of comments regarding changing job tasks/work requirements.*

- With emotional limitations accommodations may include taking extra breaks
- Breaks away for medical appointments.
- Where the individual is unable to multi-task due to intellectual limitations the accommodation is to determine what tasks can temporarily be eliminated and then slowly reintegrated.
- Diminished energy, memory and concentration [due to depression] mean that the person may need more time to accomplish a task
- The person [with a mental disability] may also need a flexible schedule to allow time for psychotherapy.
Changes in the Work Environment

Individuals with depression may have concentration difficulties, personality conflicts with supervisors or co-workers and sleep difficulties. Accommodations may improve the employees’ function. These include changing the work group and increasing natural light.

Examples of comments regarding changes in the work environment.

- Where the barrier is a personality conflict accommodation may require changing managers or departments.
- Where the barrier is a personality conflict accommodation may require changing shifts.
- Tele-working or working from home part-time
- Try to reduce interaction with customers and coworkers [for workers with social limitations] by scheduling work at times when fewer people are around.

Workplace Social Support

Rehabilitation professionals should attend empathically to the employee and not be “agency driven or directive.” Individuals with depression are ill and should not be pushed too hard as elevations in stress can exacerbate their symptoms reducing functional abilities. Employees with emotional limitations need a supportive supervisor or co-worker for support and mentoring.

Examples of comments regarding workplace social support.

- Individuals should be allowed the opportunity to fail if it is beneficial to helping them gain self-awareness.
- To help stay at work the worker needs to feel comfortable in talking to a supervisor about his/her mental illness.
- Workers with emotional limitations need to take a regular break and remove themselves from the situation
• For sales persons accommodations might include initially modifying sales targets.
• Many have to move into other careers
• Assist the worker in selecting and pursuing alternate work.

_Social Skills Training_

Employees with social limitations may benefit from interpersonal skills training. Individuals with intellectual limitations may benefit from having additional time for training. Individuals with emotional limitations benefit from learning stress management techniques.

_Examples of comments regarding social skills training._

• Social skills training can be provided to the disabled worker as damage control regarding performance issues which developed prior to being off.

• Accommodations for individuals with intellectual limitations include helping the individuals organize time, and manage calendars.

This chapter highlighted the pervasiveness of depressive symptoms and the flexibility in which accommodations need to be applied. Different functional limitations may require the same accommodation or in other cases different accommodations may be required for the same limitation. The challenge is to collaboratively individualize all accommodations.
CHAPTER VIII
DISCUSSION

The research question focused on an exploration of the issues of current and recommended practices in the job accommodation of individuals with depression. Barriers to implementing these accommodations and approaches to overcoming these barriers were also explored. Although accommodations are seen as one of the most important strategies for promoting employment of individuals with depression, there has been little direct work to study how job accommodations are actually evolving in the field for individuals with depression. The literature reveals that there is not adequate research to inform the practice of accommodating depressed employees in the workplace (Goldner, Bilsker, Gilbert, Myette, Corbiere, & Dewa, 2004). The significance of this study is that it identifies barriers which many employees with depression experience and provides recommendations for resolving the barriers through workplace accommodations for these individuals. This study also identifies approaches to accommodations that will be of benefit to policy makers, researchers, practitioners, employers and individuals disabled with depression. Employers bear the brunt of the economic burden of employees with depression. This study provides the employer (and other stake-holders) with a comprehensive appreciation of the needs of the employee with depression and the benefits of establishing mental disability management programs within industry.

Barriers

Participants’ responses focused on the primary themes of barriers to accommodations, solutions to these barriers and reasonable accommodations for individuals disabled with depression. The barrier cited most often by participants was the
lack of education, knowledge and awareness of depression by the employers, co-workers, service providers and individual with depression. The largest subcategory, within the entire study, developed from participants’ responses, was for education and awareness development for all stakeholders. It was stated that the employers’ and co-workers’ lack of knowledge and awareness about depression resulted in the social stigma of depression. Social stigma was reportedly the cause of the lack of meaningful relationships with supervision and co-workers. This absence of workplace relationships was cited as being the main cause of “most illnesses in the workplace.”

The second largest subcategory within the category of barriers was institutional limitations. The main concern of participants was the lack of funding. Financial resources were identified as being inadequate for governments, companies and individuals to fund effective psychiatric (depression) treatment and vocational rehabilitation programs. This situation has resulted in inadequate treatment, interventions and follow-up as well as a lack of training for management, co-workers and service providers.

Participants indicated that depression is often seen as a character weakness even by individuals in the helping professions. Employees with depression often feel threatened, guilty and ashamed and attempt to hide their symptoms from supervision and co-workers. These employees often feel isolated and are apprehensive about disclosing their disability for fear of being discriminated against and loosing their jobs. The corporate culture of most employers is not conducive to the employees’ experiencing a sense of control or autonomy. Mate (2003) reports that the loss of control is significantly related to elevated levels of stress. Chronic stress has a deleterious impact on the immune, endocrine and neurological systems resulting in increased susceptibility to
illness. The result on the employee can be an increase in workplace distress. This may aggravate and increase the affected employee's depression. Individual limitations experienced by the employee with depression substantially impact upon the return-to-work process and must be considered in the planning of effective job accommodations. The individual's symptoms, limitations and the resulting impact on his/her function are detailed in Appendix D.

Participants referenced social limitations and the resulting negative impact on work relationships more often than any other individual limitation. Judd et al. (2000) studied the relationship of psychosocial disability to the severity of depressive symptoms. The outcomes inferred that changes in psychosocial functioning parallel the fluctuations in the individual's level of depressive symptomology. Hirshfeld et al. (2002) evaluated the affect of antidepressants and/or psychotherapy on psychosocial functioning in individuals with depression. The results of this research inferred that the combination of treatments were significantly superior to either treatment alone in improving work and social functioning. The authors referenced previous studies which inferred that "significant psychosocial impairment persist[s] well beyond symptomatic improvement" (Hirshfeld, 2002, p. 131).

Employer characteristics and expectations are workplace contextual factors which are often neglected when job accommodations are being considered. Such characteristics include workplace demands, the nature of the workplace and the limitations of the workplace in providing practical accommodations. Participants, overall, reported that "few employers promote good employee relationships."
Solutions to Barriers

For this discussion, the solutions to overcoming barriers have been merged from both the current and recommended practices sections of the data. The "recommended practices" section contributed the most to this section. When responding to the issue of "current practiced" solutions, participants highlighted the provision of "help from others." In the query regarding "recommendations" for solutions, participants highlighted the provision of education, knowledge, awareness and understanding as being the most significant. Participants emphasized that "it would be the workplace where the solutions [for workplace depression] are developed." It is imperative that early intervention strategies be initiated by employers in order to circumvent the development of the more severe, chronic depressive symptoms. The more chronic and severe the depression, the more treatment resistant, disabling and susceptible to recurrence the individual becomes (Brinbaum et al., 2000). Early identification and diagnosis have gained prominence, particularly for mental illnesses, such as depression that are highly prevalent and potentially effectively treated, but they are frequently undetected and disruptive to the individual's work status (Bender & Kennedy, 2004). All stake-holders benefit from training in the cost and humanitarian benefits of early intervention.

Rehabilitation professionals trained in psychiatric rehabilitation, depression counseling and disability management are essential to the accommodation process. Goldner et al. (2004) recommend that employers may retain rehabilitation professionals who have expertise in the vocational rehabilitation of workers with psychiatric disabilities and cognitive behavioural interventions. Rehabilitation professionals may also be effective in counselling the disabled worker about his/her role in ensuring that
management and co-workers have a positive experience during the individual's return to work process.

Participants delineated the need for education and knowledge transfers in regards to the following issues:

- "Increased awareness of incidences, causes, symptoms, and successful intervention"
- "Education to reduce stigma"
- "Training supervisors in empathic communication"
- "Benefits of early intervention"
- Intensive training and workshops in the transformation form the medical model approach to a biopsychosocial model.
- The benefits and how to of a collaborative approach
- Taking a humanitarian approach to employees
- "VRC/Case manager training in depression, mental disability management, and business"
- "The employer is not aware of the impact of depression or presenteeism."

Kessler et al. (1994) indicated that one of the mental illnesses associated with statistically significant increases in occupational presenteeism was major depression. Stewart et al. (2003) inferred that the majority of the lost productivity costs related to depression were from presenteeism. Eighty-one percent of the lost production costs were attributable to reduced work performance while working. Lerner (2004) inferred that individuals with depression and/or dysthymia who are working have significantly more new employment, job turnover, presenteeism and absenteeism than either the non
disabled control or the rheumatoid arthritis control group. The authors suggested that
greater attention should be paid to the individuals' symptoms, limitations and needs
within the workplace in order to reduce the impact of depression on performance and
productivity. Wang et al. (2004) inferred that major depression was significantly
associated with a reduction in the individuals' ability to focus on a task and on his/her
productivity. The researchers estimate that presenteeism costs the employer 2.3 days of
lost production per month per individual with depression. Waterworth and Ripke (1993)
reported that the most salient accommodation was the training and orientation of
supervisors and co-workers. Goldner et al. (2004) recommended educational materials
and sensitivity training to reduce stigma towards employees with depression.

The need for the education of employers, from top management down, of the
benefits of an evidence informed disability management approach to employee illness
was advocated by participants. Effective tracking and monitoring of risk factors,
incidence, demographics, interventions and accommodations by the employer allows for
the development of the most effective and efficient rehabilitation interventions.

"Help from others" commences with the endorsement and active participation of
top management in the development of a corporate culture supportive and understanding
of the salient issues and needs of all employees with disabilities. Participants identified
that co-workers were "key" to the success of accommodations, and, as such, interventions
needed to be realistic and acceptable to them. De Lisio et al. (1986) suggested the
disabled individual's relationships with family and co-workers are salient variables in
supporting, motivating and facilitating the individual's rehabilitation and successful
return to work. It was also important that co-workers were provided with the extra time
needed to mentor and support the disabled employee. Since positive work relationships were necessary for a collaborative approach to accommodations, it is essential that relationship difficulties be addressed and resolved prior to the commencement of the graduated return-to-work (GRTW) process. Due to the cyclical, chronic, recurring nature of most depressive disorders, a flexible approach to accommodations is indicated. Ongoing monitoring of a GRTW should consider both “work load” and worksite relationships.”

**Accommodations**

The subcategories of accommodations which were identified the most by participants were changing job tasks/work requirements, workplace social support, changes in work environment, skills training and memory enhancements. Temporary changes in job requirements are effective accommodations for individuals experiencing social, emotional and intellectual limitations. Depressed employees may require more intensive supervision and support for extended durations, flexible work schedules and removal of productivity time lines in order to build success into the individual’s work experience (Houlihan & Reynolds, 2001). Fabian, Waterworth and Ripke (1993) identified the reasonable accommodations of job task modifications incorporating psychological and cognitive demands, schedule modifications, modifications to work policies and procedures, altering job performance expectations, providing physical assistance and initiating changes in corporate norms.

Workplace social support involves supervisors and co-workers being informed of the impact relationship difficulties can have and ensuring these difficulties are resolved with the employee prior to he/she commencing the GRTW. Goldner et al. (2004) reported
the contextual workplace factors, such as a supportive culture and employer policies and
disability management practices, encourage respect, trust and communication. These
were salient determinants of successful return to work programs. Provencher, Gregg,
Mead and Mueser (2002) suggested that accommodations incorporate components that
reinforce the themes of the individual’s “self-definition, empowerment, connection to
others, meaning of work, vocational future, and meaning of recovery” (p. 135).
Supportive co-workers as natural supports (Storey & Certo, 1996) are instrumental in
encouraging, prompting, mentoring and instructing the employee disabled with
depression. Natural supports may also provide a supportive monitoring function as up to
80% of depressed individuals experience relapse (Scott & Dickey, 2003). The early
identification of symptoms may reduce the severity of subsequent recurrences.

Changes in the work environment might include relationship accommodations.
Gates (2000) describes that the most important factor in the accommodation process is
the social impact of the accommodation. This is referred to as relationship
accommodation. However, employees must be receptive to disclosure of their disability
to supervision and essential coworkers for functional limitations and accommodations to
be discussed. Ellison et al. (2003) identified that workplace factors encouraging job
confidence, empowerment and recovery are related to the individual’s receptiveness to
disclosure.

The symptoms of depression can manifest as low impulse control, agitation,
distractibility and difficulties being around others. Temporary accommodations are
designed to reduce the impact of these symptoms on work performance and productivity.
Social limitations often necessitate social skills training in order to reduce the risk of
relationship difficulties developing. Training may include conflict resolution, awareness development of workplace cultural expectations, stress management, assertiveness and anger management. Coping skills training is a form of individual accommodation and focuses on enhancing the individual’s personal management of emotions in response to difficult situations at work and developing a repertoire of effective behavioural skills (Wallace, Tauber & Wilde, 1999; Smith, Bellack, & Liberman, 1996). Coping skills are taught using a cognitive-behavioural approach. These interventions are offered to individuals or groups using psychoeducational and behavioural learning techniques. Coping skills training includes time management, stress management and relaxation training, energy conservation, assertiveness and communication skills training, anger/frustration management, social skills training and training in generalized problem-solving methods (Weiss & Murray, 2003; Bell, Lysaker & Bryson, 2003, Storey, 2002; Hesslinger, van Elst, Nyberg, Dykierek, Richter, Brener & Ebert, 2002; Bozzer, Samson & Anson, 1999; Wallace, Tauber, & Wilde, 1999; Parente, Stapleton & Wheatley, 1991). Social/cop ing skills training are provided by qualified rehabilitation professionals either individually or in groups. Participants learn and practice these skills in the safety of the therapeutic counselling environment prior to applying them in the workplace.

Conclusions

The main theme arising out of this study is that the problem of and solution to workplace depression is directly related to workplace social support and the level of compassion within the work environment. The primary barriers to effective accommodations are the lack of understanding by others, and the individual’s social, emotional and intellectual limitations. The primary solution to these barriers is the help
informed others in the work environment can offer. However this solution is confounded by the need for a top down paradigm shift in the corporate perception of depression; the pervasiveness of social stigma; the individual’s guilt, shame and fear of disclosure; and the resulting lack of meaningful relationships at work. The advocated solution to the lack of understanding by supervisors, coworkers and service providers is education and training. This solution is compromised by government and insurance policies which treat psychiatric illness less favorably than physical illness, and the overall lack of funding by all stakeholders. Subsequently, early intervention is not practiced and this often results in an acute depression developing into a chronic, severe, treatment resistant depression.

The approach to the effective treatment and rehabilitation of depression requires interventions at different levels of the system. Individuals with depression benefit from the knowledge of resources and their rights. Receptive employers will benefit from retaining rehabilitation professionals trained in psychiatric rehabilitation and mental disability management to establish programs within industry. Non receptive employers may be influenced by the advocacy efforts of the Canadian Mental Health Association, BC Business and Economic Roundtable on Mental Health, the Global Roundtable on Addiction and Mental Health and the World Health Organization and International Labour Organization (WHO/ILO). The training of rehabilitation professionals in Canada will require some ingenuity by universities and colleges. One option might be to establish a one year vocational rehabilitation specialty for individuals who have completed an MA in counselling psychology, as there are very few MA in vocational rehabilitation in Canada.
The thoughts from a varied sample of "experts" within the field of depression treatment and rehabilitation reflect a consistency in their experience of the current status of workplace accommodations. Most of these individuals are practitioners working at different levels of the system and are reporting the same concerns from all levels. The barriers, solutions and accommodations identified by these individuals are also referenced in the literature. Many solutions to the identified barriers are practical, concrete and have utility for employers and service providers. Ultimately, whichever interventions are deemed necessary, it is essential that they be provided within a workplace relationship of strong social support. In many respects we know how, it is the "will" which is lacking. Depression in the workplace is a problem which will not go away on its own and will require a concentrated, sustained effort by advocates at all levels of the system to affect change.

Limitations

This study involved a semi-structured interview format which may have reduced the richness and expansiveness of participants' responses. An open-ended interview format may have offered greater insight into the complexity of the problem of workplace depression. One of the questions in the interview may be revised as it is asking 2 questions in 1. Participants are queried about their "knowledge and experience" in working with individuals with depression. Therefore, in their response we are not sure if the participant is reflecting on what they have read or what they have actually experienced. Their responses may alter the interpretation of the data.
Implications for Further Research

The participants and the literature reflect on the need for empirically derived psychosocial functional assessments and job demands analysis in order to identify and facilitate effective accommodations. The theme of this study has been that it is the contextual work factors and meaningful work relationships which are essential for successful accommodations. This area requires further research to identify the effectiveness and efficiencies of different mental disability management models, interventions and educational/training initiatives.

The participants experience and knowledge of job accommodations has primarily been from the perspective of large business. There were some references in the interviews and the literature that small business does not have the resources to develop disability management programs or initiate reasonable accommodations. Many small employers are excluded from the legislation requiring the "duty to accommodate" due to their limited number of employees. What needs to be studied is the number or percentage of the labour force that is employed by "small business". What should be considered is the development of mental disability management models of intervention that would accommodate these small employers. This will be required in order to facilitate the job accommodation of employees with depression, by small business.

Social stigma has been identified by participants and reported in the literature to be the most significant barrier to the accommodation of individuals with depression. The fear of being discriminated against and the possibly loosing one's job stops individuals from disclosing their depression. This fear coupled with the very real social stigma of the work environment prevents affected employees from receiving timely, effective
treatment. Many depressive illnesses could be treated in the acute stage but due to the lack of early intervention become chronic, recurring disorders which impact upon the individual’s long term functioning.

The transformation from the medical model paradigm of treatment and rehabilitation to the biopsychosocial, collaborative paradigm of intervention is recommended. This paradigm shift was recommended both by participants and in the literature as being essential for the development of effective, efficient mental disability management programs.

The transformation to a collaborative, biopsychosocial paradigm of intervention may necessitate the revision of how we perceive “depression”. The term depression is synonymous with stigma. Perhaps by defining the symptoms of depression in a socially acceptable language the negative influences of social stigma could be reduced. In other words, is depression an illness or is it the response of the psychoneuroimmunoendocrine systems (Mate, 2003, pp. 6) to contextual factors within the work environment. One participant suggested that a politically correct term is “behavioural disorder” to encompass all the signs and symptoms consistent with depression.

Previous studies reported in the “Literature Review” section have identified that; 50% of individuals with depression are still working; only 12.5% of individuals with depression receive proper treatment; 81% of the employer costs attributable to depression are from presenteeism; and the transformation of corporate cultures to being supportive and offering meaningful relationships to employees are essential to resolving depressions impact on the individual’s performance and productivity.
Pharmaceutical companies should be encouraged to consider partnering with the rehabilitation community in order to develop and study mental disability management models of intervention incorporating the factors reported in this and other studies. The benefits to the pharmaceutical companies could be the substantial increase in individuals who would feel comfortable in disclosing their depression and receiving effective pharmacotherapy during the acute phase of their condition.

The Job Accommodation Network's (JAN) taxonomy of accommodations for mental illness is anecdotally synthesized from the examples of contributing employers. The relationships between the individual’s symptoms, resulting functional limitations and recommended accommodations have not been empirically substantiated. Participants in this current study reported that the taxonomy of accommodations did not incorporate salient workplace contextual factors. Perhaps the employers who contributed to the taxonomy of accommodations are unique. A survey of these employers could assess whether their characteristics are consistent with the variables suggested as being necessary for successful job accommodations. Such a study would be a move towards quantifying whether the solution to accommodating individuals with depression is to foster a corporate culture that is strongly socially supportive.
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APPENDIX B:
EXPERT INTERVIEW PROTOCOL

EXPERT INTERVIEW

My name is Douglas Hanson and I'm a research assistant with the Vocational Rehabilitation Counselling Program at the University of British Columbia. We're working on a research study sponsored by Social Development Canada (formerly Human Resources Development Canada) about employer attitudes and job accommodations for people with mental health disabilities, for example: depression, anxiety, other mental illness, and people with severe learning disabilities. Our goal is to develop best job accommodation practices for employers. You were identified as a person with special expertise in the area of mental health/depression and we would like to ask if we could take a moment of your time to discuss your thoughts, opinions and experiences with employment of individuals with mental health disabilities including both psychological and neuropsychological disabilities. We are particularly interested in your experiences, views and ideas regarding job accommodation issues.

1. The first question is just a general one. What are your thoughts on the current practices and what could be the best practices in accommodating individuals with mental health or learning disabilities (or specific area of expertise)?

<table>
<thead>
<tr>
<th>Current practices</th>
<th>Best practices</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. We're interested in what your experience has been with specific job accommodations for mental health issues. As you know, these disabilities involve functional limitations that require accommodations. Please indicate whether you have had any experience with (or knowledge of) the following areas (Yes or No): (*For the 4 questions below (a,b,c & d) see attached list of job accommodations for brainstorming assistance, if needed)

   a. Changes in work environment?
   b. Intellectual limitations?
   c. Social limitations?
   d. Emotional limitations?
3. We’re looking at a number of different psychological and neuropsychological disabilities. Have you had experience with any of the following conditions? (Yes or No)
   - mood and anxiety disorders, for example depression: Yes or No, if Yes please name the condition
   - persons with neuropsychological disabilities including brain injuries, seizure disorders, brain tumours, neurovascular disorders, severe learning disabilities and other neurological disorders affecting the brain: Yes or No, if Yes please name the condition
   - persons with psychiatric disorders such as schizophrenia or bipolar disorder: Yes or No, if Yes please name the condition

4. Could you give us some specific best practices that would aid accommodating individuals with any of the above disabilities, for example mental health/depression.

5. What barriers to implementing the above accommodations come to mind when reviewing your response to question 4?

6. Do you have any ideas about how to facilitate the implementation of these job accommodations/ remove the barriers to implementing these job accommodations? (barriers specified in question 5)

7. Would you like to leave us with any general thoughts, suggestions or key themes about facilitating sustained employment of persons with mental health and learning? Any best practices that you would suggest or additional ideas you might have?

Thank you very much for assisting us with our research
APPENDIX C:
JOB ACCOMMODATION REFERENCE LIST

EXPERT INTERVIEW PROTOCOL
PART II

Job Accommodations

A) Changes in Work Environment

Maintaining Stamina during the Workday:

☐ Flexible scheduling
☐ Allow longer or more frequent work breaks
☐ Provide additional time to learn new responsibilities
☐ Provide self-paced workload
☐ Provide backup coverage for when the employee needs to take breaks
☐ Allow for time off for counseling
☐ Allow for use of supported employment and job coaches
☐ Allow employee to work from home during part of the day, or week
☐ Part-time work schedules

Maintaining Concentration:

☐ Reduce distractions in the work area
☐ Provide space enclosures or a private office
☐ Allow for use of white noise or environmental sound machines
☐ Allow the employee to play soothing music using a cassette player and headset
☐ Increase natural lighting or provide full spectrum lighting
☐ Allow the employee to work from home and provide necessary equipment
☐ Plan for uninterrupted work time
☐ Allow for frequent breaks
☐ Divide large assignments into smaller tasks and goals
☐ Restructure job to include only essential functions

Attendance Issues:

☐ Provide flexible leave for health problems
☐ Provide a self-paced work load and flexible hours
☐ Allow employee to work from home
☐ Provide part-time work schedule
☐ Allow employee to make up time
Employ job sharing.

**Issues of Change:**

- Recognize that a change in the office environment or of supervisors may be difficult for a person with a psychiatric disability
- Maintain open channels of communication between the employee and the new and old supervisor in order to ensure an effective transition
- Provide weekly or monthly meetings with the employee to discuss workplace issues and productivity levels
- Providing retraining for alternate duties.

**B) Intellectual Limitations**

**Difficulty Staying Organized and Meeting Deadlines:**

- Make daily TO-DO lists and check items off as they are completed
- Use several calendars to mark meetings and deadlines
- Remind employee of important deadlines
- Use electronic organizers
- Divide large assignments into smaller tasks and goals

**Memory Deficits:**

- Provide day planners
- Allow the employee to tape record meetings
- Provide type written minutes of each meeting
- Provide written instructions
- Allow additional training time
- Provide written checklists
- Allow for software organizers with/without highlighting capabilities
- Allow for use of electronic mail (email)
- Provide environmental cues to assist in memory for locations of items such as labels, colour coding, or bulletin boards
- Post instructions over all frequently used equipment
C) Social Limitations

Working Effectively with Supervisors:

- Provide positive praise and reinforcement
- Provide written job instructions
- Develop written work agreements that include the agreed upon accommodations, clear expectations of responsibilities and the consequences of not meeting performance standards
- Allow for open communication to managers and supervisors
- Establish written long term and short term goals
- Develop strategies to deal with problems before they arise
- Develop a procedure to evaluate the effectiveness of the accommodation
- Provide extra supervision hours.

Interacting with Coworkers:

- Educate all employees on their right to accommodations
- Provide sensitivity training to coworkers and supervisors
- Do not mandate employees attend work related social functions
- Encourage all employees to move non-work related conversations out of work areas
- Pair up the individual with a psychiatric/neuropsychological disability with a mentor to assist them with their interpersonal skills

D) Emotional Limitations

Difficulty Handling Stress and Emotions:

- Provide praise and positive reinforcement
- Refer to counseling and employee assistance programs
- Allow telephone calls during work hours to doctors and others for needed support
- Allow the presence of a support animal
- Allow the employee to take breaks as needed

Other Accommodations Not Listed Above
APPENDIX D:

EFFECTS OF DEPRESSION ON WORK FUNCTION

Table 2: Effects of Depression on Work Function

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Limitation</th>
<th>Functional Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>agitation</td>
<td>social limitations</td>
<td>relationship difficulties</td>
</tr>
<tr>
<td>misinterpret feedback</td>
<td>social limitations</td>
<td>reacting inappropriately</td>
</tr>
<tr>
<td>boundary issues</td>
<td>social limitations</td>
<td>relationship difficulties</td>
</tr>
<tr>
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<td>social limitations</td>
<td>relationship difficulties</td>
</tr>
<tr>
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<td>social limitations</td>
<td>relationship difficulties</td>
</tr>
<tr>
<td>memory problems</td>
<td>social limitations</td>
<td>difficulties with co-workers</td>
</tr>
<tr>
<td>negative attitude</td>
<td>social limitations</td>
<td>difficulties with co-workers</td>
</tr>
<tr>
<td>low self-esteem</td>
<td>social limitation</td>
<td>difficulties with others</td>
</tr>
<tr>
<td>phobic</td>
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