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How Managers Find Out About Common Mental Disorders Among Their Employees

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and Angelique de Rijk, PhD

Objective: To explore how managers find out about common mental disorders (CMDs) among employees and associations with managers' work- and knowledge-related characteristics and attitude to CMDs. **Methods:** Data from an online survey in 2017 with Swedish managers ($n = 1810$) were used. Different ways managers find out about CMDs were measured, and multivariate logistic regression analysis was conducted for associations with manager characteristics. **Results:** Few managers found out about CMDs themselves; another source was more common, for example, employees' self-disclosure. Managers' overseeing fewer subordinates and those with a negative attitude to depression were more likely to find out about CMDs themselves. The significance of mental health training and education could not be established. **Conclusion:** Managers' awareness about employees' CMDs mainly came about through employees' self-disclosure. Managers' attitudes and work conditions were related to the way of finding out.

Keywords: attitude, common mental disorders, managers, mental health, workplace prevention

BACKGROUND

Common Mental Disorders at Work

Mental health is an increasingly relevant topic for contemporary working life. The prevalence of common mental disorders (CMDs) including mood, anxiety, and stress-related illness has increased in several countries during the last decades and has become an area of major concern in the field of occupational health and employment research.¹ Data from a large global review estimated the life-time prevalence of CMDs in a working-age population (16 to 65 years of age) to be almost one in three (29.2%) and the prevalence during the last 12 months, before assessment, to be approximately 18%.²

CMDs exact a high price on individuals and on work organizations and societies. The Organization for Economic Co-

operation and Development (OECD) estimated the costs for mental health problems in general in the EU in 2016 to be more than 600 billion euros per year.³ Most people with CMDs are working, therefore a large part of the costs consist of secondary costs due to reduced work performance, loss of productivity, and absenteeism.⁴

Previous studies have shown that, compared with healthy workers, individuals with CMDs often experience concentration difficulties, indecisiveness, difficulties managing inter-personal demands, irritability, and fatigue, among other medical symptoms.⁵⁻⁷ All these symptoms can affect the individual's work capacity and professional career. Furthermore, negative and often long-term consequences of CMDs on an individual's working life have been shown in terms of sickness absence.^{6,8} CMDs are recognized as one of the leading causes of work disability and sickness absence in many countries.^{9,10} Studies have shown that CMDs influence both the onset and recurrence of sickness absence.^{1,9} In Sweden, where the current study took place, psychiatric diagnoses accounted for 59% of the increase in sick-leave spells between 2010 and 2015, and similar figures have been reported from other Nordic and European countries.¹⁰ In a study among Finnish employees, CMDs were associated with an increased risk of short and intermediate as well as long duration of sickness absence.¹¹ Moreover, extended sickness absence has been shown to reduce the probability of a successful return to work with an increased risk of early exit from the labor market.⁹ These negative consequences not only affect single individuals but also the employers in terms of loss of human resources and competencies. In addition to the human aspects, there is a strong financial argument (eg, costs of productivity loss, sickness absence, and disability claims) for addressing CMDs in the workplace.¹² However, this requires that managers realize the employees' situation. But to date, we know little about how managers learn about CMDs among their employees.

The Role of Managers in Early Prevention of CMDs at the Workplace

Previous studies have called for prevention instead of only reacting to mental health problems at work.¹³ Moreover, the importance of a workplace-based approach has been addressed in improving work disability outcomes among employees with CMDs.^{14,15} This approach is underpinned by the European Pillar of Social Rights, which concedes the employee's right to a working environment adapted to their professional needs.¹⁶ European employers also have a statutory duty to prevent and protect employees from occupational hazards and are obliged to monitor and manage work environmental risks according to the Directive 89/391/EEC – OSH.¹⁷ The Swedish Working Environment Act¹⁸ states, for example, that working conditions must be adapted to people's conditions in physical and mental terms. Adding a work-oriented approach, beyond clinical treatment, may increase the possibility of returning to work and also facilitate the transition to work after a period of absence.^{19,20}

Managers have a pivotal role in organizations (workplaces) to support employees by virtue of their position and responsibility.²¹ Managers' duties include allocation of work tasks and work team development, therefore they highly influence their employees' work

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Ethical Considerations & Disclosure: The study was approved by the Regional Ethical Review Board at Gothenburg University, Sweden, registration number: 165-17.

Clinical Significance: A supporting work environment for employees with mental health problems relies on the manager having low levels of stigma toward mental ill-health (which improves employee self-disclosure) and a small number of subordinates, which helps managers to find out about the mental health condition.

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situation. Moreover, managers should be at the front line in noticing decreased work function, detecting problems, encouraging employees to seek help and organizing work adjustments.²² Based on their function, managers are therefore in a key position to support employees with mental health problems, including CMDs, and to take the initiative to provide a sustainable work situation in times of decreased work capacity in the employee,^{22–24} given that they are aware of the difficulties.

Managers Finding Out About CMDs Among Employees

A prerequisite for offering support and work adjustments is “knowing” that an employee has a CMD. A study in the Netherlands demonstrated that a good relationship with the manager was one of three reasons to disclose CMDs in the workplace.²⁵ Research in organizational behavior further suggests that a contextual approach is necessary to explain managers’ behavior.²⁶ Situational factors can exert a strong effect on human behavior and managers’ way of acting are likely to include factors on a structural organizational level, such as work design, nature of the work duties, work culture, and work environment. Research has found higher levels of stress and more administrative tasks among managers in the non-profit and public sectors compared with their counterparts in the for-profit sector.²⁷ Accordingly, the managers’ ability to recognize CMDs among employees in the public sector might be affected by lack of time. The same argument applies to the number of subordinates; a high number might make it difficult for managers to take part in the everyday business at the workplace, hence hampering their ability to recognize symptoms of CMDs. Regarding the importance of sex, previous studies have shown that men are less likely to display how they feel and seek help for mental health problems.^{28,29} Therefore, it can be assumed when staff are mostly men, managers will likely need to find out by themselves, whereas self-disclosure by the employee might be higher when the staff are mostly women. In addition, contextual factors on a micro organizational level, such as knowledge, experience, and skills of the manager, may have an impact on how they act.^{30,31} Managers in the private sector were found to be more relationship oriented,³² which may increase the possibilities for recognizing behavioral changes indicating CMDs. There is evidence that more managerial experience increases expertise in information processing, and mental health training increase general knowledge about the topic,³³ hence more experienced and trained managers may be more likely to recognize CMDs than their peers without such skills. Moreover, having experienced CMDs themselves or in a close relationship could make managers feel more aware of the topic and may increase sensitivity to early symptoms. Qualitative studies show that managers often discover CMDs through employees being unfocused, forgetful, easily irritated or distressed, with reduced performance, lack of ability to cope with the workplace environment, as well as absences or complaints from colleagues or customers.^{21,34}

Legal obligations such as health protection and privacy policies, may also affect managers’ ways of detecting and acting on CMDs. Following the European General Data Protection Regulation,³⁵ the employer is obliged to provide protection measures concerning employees’ personal data including health status. Under Swedish law, employees’ medical certificates for sick leave must not reveal the illness to the employer but rather how work capacity is affected.³⁶ Consequently, the manager might not receive direct information on the condition. Moreover, mental health conditions are to some extent concealable, and problems might remain unobserved.³⁷ This leaves the manager with the challenge of respecting the confidentiality of employees and simultaneously fulfilling the obligation to offer adequate support.^{21,38} A solution can be self-disclosure by the employee. However, disclosure about medical conditions is a complex decision, involving extrinsic (work-related)

and intrinsic (personal-related) factors in a risk-benefit analysis requiring consideration of associated benefits and detriments.^{39–41} A huge barrier to disclosure by employees is stigma; this involves labeling, stereotyping, and discriminating.^{40,42} Bryan et al³³ found that managers with high levels of a stigmatizing attitude were less likely to initiate communication with employees with CMDs. Elsewhere, it is argued that managers expressing a positive attitude toward employees with depression might encourage employee self-disclosure,^{22,43} resulting in them not only relying on finding out for themselves.

CMDs among employees have a multidimensional impact on work performance with decreased work capacity and productivity and increased absenteeism, creating high costs for individuals, employers, and societies. Hence, there is a strong argument for investigating ways to prevent and manage CMDs at an early stage in the workplace. Managers are key actors in the workplace in detecting and supporting employees with CMDs; however, their perspective is still largely unexplored. Furthermore, to date no survey has been conducted to systematically investigate managers’ perspectives.

AIM OF THE STUDY

The aim of this study was to explore the different ways in which managers find out about CMDs among their employees and whether managers’ work- and knowledge-related characteristics and their attitude to CMDs are associated with the different ways of finding out about employees’ CMDs.

METHODS

Study Design and Participants

This study has an exploratory design and was part of the multipurpose project, “Managers’ perspective – a missing piece” designed to investigate managers’ understanding and need for knowledge in supporting employees with CMDs. Moreover, the project aims to improve early preventive measures and best practice in managers’ ways of supporting their employees at the workplace. The study was approved by the Regional Ethical Review Board at Gothenburg University, Sweden (registration number: 165–17).

Participants in the project were recruited from the Citizen Panel at The Laboratory of Opinion Research (LORE) at University of Gothenburg (<https://lore.gu.se/surveys/citizen/aboutcp>) and from HELIX Competence Centre at the University of Linköping, Sweden (<https://liu.se/en/research/helix-competence-centre>). The HELIX Centre is the hub of a collaboration between 22 private and public organizations with the aim to promote sustainable organizational development.

Eligible members of the LORE citizen panel were identified by two specific questions on managerial position included in the 26th panel survey in 2017.⁴⁴ Through a randomized selection process, 5000 of the individuals (aged 20 to 65 years) identified as holding a managerial position, were invited to participate in the project. From the HELIX Competence Centre another 556 individuals were identified using the same criteria and invited to take part in the project. Invitations were sent out by e-mail. All individuals also received information about the aim of the project and were asked to provide informed consent.

In total, 5556 randomly selected individuals were invited to participate in the project. Responses revealed that some of the selected individuals were misclassified, that is, not currently in a managerial position ($n = 795$), and some individuals were excluded due to technical error ($n = 24$), leaving 4737 eligible participants. The total number of dropouts was 1379 (non-response, $n = 963$; individuals actively denied participation, $n = 416$); 70% and 30% from the LORE and the HELIX sample, respectively. Consequently, the final study population in the project consisted of 3358 participants.

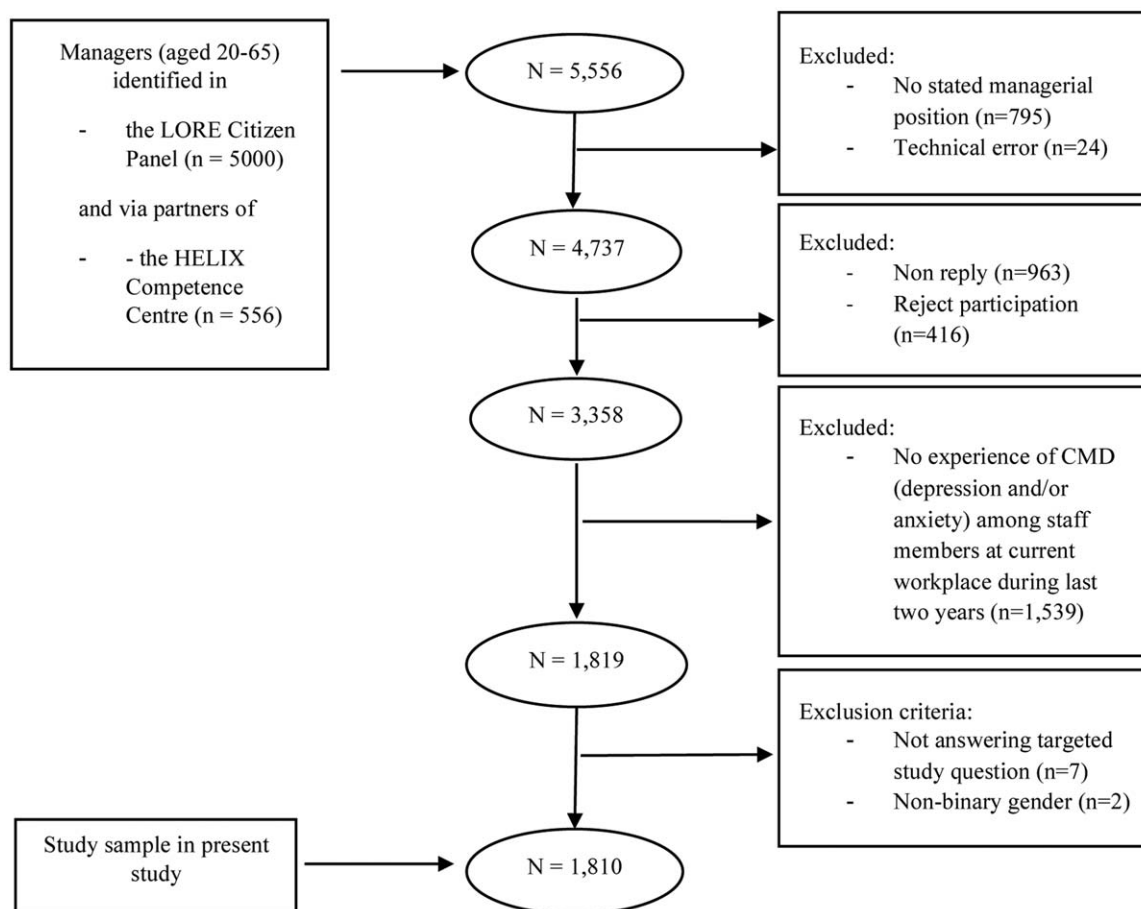


FIGURE 1. Flow chart of the study population in the project managers' perspective—the missing piece 2017 and the study sample in the present study.

Data were collected through a web survey, including two reminders, distributed in autumn 2017 by LORE. Because participants may not be familiar with the concept of CMDs, the words “depression” and “anxiety,” the two main categories of CMDs, were used throughout the questionnaire.

The study group in the present study consisted of managers with experience of CMDs (ie, depression or anxiety disorder) among one or more staff members at their current workplace in the last 2 years. Because the aim of this study was to explore the ways managers find out about CMDs among their staff members, participants with no response to the question “How did you learn about your employee’s CMDs?” were excluded from the study sample ($n=7$). Previous research has showed a sex difference in managers; preventive approach.⁴⁵ In order to be able to control for female/male influence, individuals who stated sex as non-binary were excluded ($n=2$). In total, the study sample consisted of 1810 managers (for details, see the flowchart in Fig. 1). The AAPOR Standard Definition was used to identify the internal response rate.⁴⁶ The study sample is described in Table 1.

Measures

How Managers Find Out About CMDs Among Employees: Outcome Variable

The outcome measure in the present study was the different ways managers find out about CMDs among their employees. This was measured by the question “When you think about the last time

you had a staff member with a depression and/or anxiety disorder, how did you learn about it?” Six fixed response options were used: “The person (employee) told me,” “A colleague of the person told me,” “I noticed changes in the person’s behavior,” “I noticed that the work was not being done,” “When the person was first granted sick leave for such problems,” or “I don’t remember how I found out about it.” The respondent could indicate several options. The question was inspired by Martin et al.⁴⁷ In the analysis, response alternatives were dichotomized into the following categories: “managers finding out themselves only” including responses on noticing changes in the employee’s behavior and/or noticing that the work was not being done; and “managers finding out in other ways” including all other response alternatives (person [employee] told me, colleague of the person told me, granted sick leave for such problems, do not remember). Participants who indicated response alternatives from both categories were included in the second category, leaving “finding out themselves” as a pure category.

Managers’ Characteristics: Independent Variables

The following measures on work- and knowledge-related factors and attitudes to CMDs were used as independent variables. For details, see Table 1. Questions marked with an asterisk were developed by the researchers.

Work-Related Characteristics

Work sector with the response options “Governmental,” “Municipal,” “County council/regional,” “Private,” or “Non-

TABLE 1. Descriptives of the Study Sample (N= 1810)

Variables	n	%
Independent variables		
Work-related characteristics		
Work sector		
Private	937	51.8
Public or non-profit	872	48.2
Missing values	1	0.1
Industry		
Blue collar	356	19.7
White collar	529	29.2
Pink collar	636	35.1
Other	284	15.7
Missing values	5	0.3
Number of staff members		
0–250	866	47.8
>250	943	52.1
Missing values	1	0.1
Manager position		
Senior or operations managers	471	26.0
Middle/first-line managers	1291	71.3
Missing values	48	2.7
Responsibility for work environment		
Yes	1326	73.3
No/Do not know	467	25.8
Missing values	17	0.9
Total years of managerial experience		
0–10	884	48.8
>10	906	50.1
Missing values	20	1.1
Total years as manager at current workplace		
0–5	1026	56.7
>5	772	42.7
Missing values	12	0.7
Number of direct subordinates		
0–10	1023	56.5
11–30	510	28.2
>30	270	14.9
Missing values	7	0.4
Staff composition by gender		
More female	699	38.6
As many males as females	517	28.6
More male	589	32.5
Missing values	5	0.3
Knowledge-related characteristics		
Management training on CMD		
Yes	513	28.3
No	1291	71.3
Missing values	6	0.3
Medical training on CMD		
Yes	253	14.0
No	1552	85.7
Missing values	5	0.3
Worked in occupation treating people with CMD		
Yes	332	18.3
No	1472	81.3
Missing values	6	0.3
Personal experience of CMD		
Yes	1426	78.8
No	379	20.9
Missing values	5	0.3
Education on stress*		
Yes	802	44.3
No/Do not know	959	53.0
Missing values	49	2.7
Education on CMD*		
Yes	298	16.5
No/Don't know	1462	80.8
Missing values	50	2.8

TABLE 1. (Continued)

Variables	n	%
Attitude to CMDs		
No negative attitude	1335	73.8
Negative attitude	444	24.5
Missing values	31	1.7
Covariates		
Age		
<50 years	882	48.7
≥50 years	927	51.2
Missing values	1	0.1
Gender		
Male	1112	61.4
Female	692	38.2
Missing values	6	0.3
Level of formal education		
Low educated	247	13.6
High educated	1561	86.2
Missing values	2	0.1

*Education provided at the workplace as preventive measures.
CMD, common mental disorders.

profit organization/foundation” were dichotomized into “private” and “public/non-profit” in the analysis.

Industries were measured by the question “In which industry does the company’s/organization’s main activity belong?,” in accordance with the Swedish Standard Industrial Classification (SNI).⁴⁸ The 16 different industries were clustered into four categories based on a modified version of the people-data-things hierarchy investigated by Fine.⁴⁹ In the concept of Fine, “Blue collar industries” refers to industries working with things, “white collar” refers to industries working with data, and “pink collar” refers to industries working with people. A fourth category “Other type of industry” was added for those reported industries that did not fit one of the other categories. For an overview of the classification of the industries, see Table 2.

Number of staff members in the organization with the response options “0 to 9 staff members,” “10 to 49,” “50 to 250,” “251 to 1000,” or “more than 1000” were dichotomized into “0 to 250 staff members” and “more than 250 staff members” to compare small and medium-sized organizations with large organizations.⁵⁰

Manager position* with the response options “Senior manager” (ie, administration manager, managing director), “Middle manager” (ie, manager of managers), “First-line manager,” “Group leader/supervisor,” or “Expert/operation manager” (ie, personnel manager, finance manager), developed by the researchers in the absence of any standards in Sweden, were dichotomized based on the positions’ core activities into “senior and operations managers” and “middle/first-line managers”; the latter included group leaders/supervisors.

Responsibility for work environment* (ie, responsibility due to the Swedish Work Environment Act) was measured by the question “Are you responsible for the work environment in your managerial/leadership role?.” Response options were “Yes,” “No,” or “Don’t know.” In the analysis options were dichotomized into “Yes” and “No or don’t know.”

Total years of managerial experience⁴³ was measured by the question “How long have you worked as a manager/supervisor in all your working life?” Response options were “0 to 2 years,” “3 to 5,” “6 to 10,” or “More than 10 years.” Following distribution, this variable was dichotomized into “0 to 10 years” and “more than 10 years.”

Total years as a manager at current workplace* with the response options “0 to 1 year,” “2 to 3 years,” “4 to 5 years,”

TABLE 2. Categorization of Industries Reported in the Study Sample*

Category	Type of Industry
White collar	IT, information and communications activities Financial and insurance activities Public administration and defense Legal, economic, scientific, and technological activities
Blue collar	Agriculture, forestry, fishing Mineral extraction (industry) Manufacturing industry Construction and craftsmanship Provision of electricity, heat, water, sewage, waste Transport
Pink collar	Trade/commerce Hotel and restaurant operations Education Health care, social services
Other type	Culture, entertainment, recreation Other type of activity

*A modified version of the people-data-things hierarchy by Fine⁴⁹ was used for categorization.

“more than 5 years” was dichotomized into “0 to 5 years” and “more than 5 years.”

Number of direct subordinates* with the response options “0,” “1 to 5,” “6 to 10,” “11 to 20,” “21 to 30,” “31 to 40,” “41 to 50,” or “More than 50 direct subordinates” was trichotomized into “0 to 10,” “11 to 30,” and “more than 30” to compare low, medium, and high number of subordinates. The option “0” was included because managers with zero direct subordinates may still oversee employees.

Composition of staff by sex⁵¹ was measured by the question “What is the composition of your staff by gender?,” with response options “Most are women,” “There are as about as many women as men” or “Most are men.”

Knowledge-Related Characteristics

Having had management training on CMDs⁴³ was measured by the question: “Have you participated in any managerial training where you received information about what you as a manager can do to support a staff member with depression and anxiety?” The response options were “Yes, during the last two years,” “Yes, more than two years ago,” or “No,” dichotomized into “Yes” and “No.”

Having had medical training on CMDs* was measured by the question “Do you have any medical training that provides you with knowledge about depression and/or anxiety disorders?,” “Yes” or “No.”

Worked in occupation treating people with CMDs* was measured by the question “During your professional life, have you worked in occupations where you cared for or treated people with depression and/or anxiety disorders?,” “Yes” or “No.”

Personal experience,⁵² was assessed with the question: “Have you personally, or a close relative or a friend, had depression and/or anxiety disorders?,” “Yes” or “No.”

Education was measured by the question “Workplaces can engage in preventive measures to forestall the emergence of depression and/or anxiety disorders among staff members. Have staff members at your current workplace been offered any of the following options during the past two years?” Two different educational preventions were presented: “Education about stress at work” and “Education about depression and anxiety disorders at work.” The responses were dichotomized into “Yes” and “No/Do not know.” The question was adapted from Shann et al.⁵²

Attitude to CMDs

Attitude was measured with the instrument “Managerial stigma toward employee depression” (MSED) which was originally developed by Martin in 2010.⁴³ The instrument consists of 12 statements which were rated by the participants on a six-point Likert scale (1 = strongly disagree to 6 = strongly agree). Internal consistency was checked by calculating the Cronbach alpha coefficient ($\alpha = 0.79$). For the current analyses, MSED scores were dichotomized at the 3rd quartile into “no negative attitude” (scores 12 to 32) and “negative attitude” (scores more than or equal to 33), and thus score “1” indicating a clearly negative attitude.

Covariates

Factors such as age and sex and educational level may influence the way managers find out about CMDs in employees. Moreover, these factors may covary with certain characteristics⁵³ and were therefore controlled for in the multivariate analyses.

Sex with response options “woman,” “man,” or “non-binary.” Due to a low number of responses, “non-binary” ($n = 2$) was excluded from the study sample, and the variable was dichotomized into “male” and “female.”

Age with response options: “Younger than 20 years,” “20 to 29,” “30 to 39,” “40 to 49,” “50 to 59,” “60 to 65” or “Older than 65 years.” Due to the distribution of the responses, they were dichotomized into “less than 50 years” and “more than or equal to 50 years.”

Level of formal education with response options: “Compulsory school,” “Upper secondary school or equivalent,” “Degree from college/university (minimum 3 years),” or “Other post-secondary education.” For the analysis, the responses were dichotomized into “low education” and “high education.”

Statistical Analyses

Descriptive statistics were calculated for the managers’ way of finding out about CMDs among their employees. Binary logistic regression analyses were performed to calculate odds ratios (ORs) with 95% confidence intervals (CIs) of the associations between managers finding out themselves about CMDs among employees in comparison with finding out through others and work- and knowledge-related characteristics and attitude to CMDs. Correlations between independent variables were checked first for multi-collinearity. Having had medical training and having worked in an occupation treating people with CMDs showed the highest correlation ($r = 0.59$). Binary logistic regression analyses in five models yielding ORs with 95% CIs for associations between the independent variables and managers finding out themselves were performed. In model 1, all independent variables were analyzed separately. Model 2 encompassed all work-related variables, model 3 all knowledge-related variables, and model 4 managers attitudes to CMDs. Finally, all three categories of independent variables were examined simultaneously in model 5. Adjustments were made for age, sex, and educational level for associations in models 2–5. A sensitivity analysis was performed to test for the possible effect of managers finding out both through recognizing by themselves and through other ways; these participants were included in the group “managers finding out in other ways” but they were excluded in the sensitivity analysis.

IBM SPSS statistics 25.0 was used for all analyses (IBM Corp., Armonk, NY).

RESULTS

Descriptive Analyses

About one in five of the managers (23.2%) reported that they found out themselves about employees experiencing CMDs by noticing changes in employee behavior and/or performance. The

TABLE 3. Frequencies of the Different Ways Managers Find Out About CMD in Employees, Grouped Into Two Categories

Category	Total N (%)	Response Options	n (%)
Managers finding out by themselves only	419 (23.2)	I noticed changes in the person's behavior	315 (17.4)
		I noticed that the work was not being done	41 (2.3)
		Managers indicating both options in this category	63 (3.5)
Managers finding out in other ways	1391 (76.8)	The person (staff member) told me	561 (31.0)
		A colleague of the person told me	86 (4.7)
		When the person was first granted sick leave for such problems	89 (4.9)
		I do not remember how I found out about it	36 (2.0)
		Managers indicating several options in this category	88 (4.9)
		Managers indicating options from both categories	531 (29.3)
	1810 (100)		

remainder found out about their employees' CMDs in other ways; a staff member disclosing to the manager was the most prevalent. Almost a third (29.3%) of the managers reported a mix of finding out by themselves and finding out in other ways (Table 3).

Bivariate analyses between work-related characteristics and managers finding out by themselves showed significant positive associations with working in the private sector and having less than 30 subordinates; negative associations were found for working in pink collar industries, holding a middle/first-line managerial position, or being responsible for staff with mostly women. Among the knowledge-related characteristics, only education on stress showed a significant (negative) association with managers finding out by themselves; having a negative attitude to CMDs was positively associated.

In the multivariate analyses for work-related characteristics, the number of staff members was positively associated with managers finding out about CMDs in their employees by themselves (OR, 2.02; 95% CI, 1.33 to 3.05) and holding a middle or first-line managerial position was negatively associated (OR, 0.71; 95% CI, 0.53 to 0.94), after adjustments for age, sex, and educational level. Among the knowledge-related characteristics, only education on stress offered to the staff through the workplace was associated with managers finding out for themselves in the final model (OR, 0.68 [0.51 to 0.91]). For attitudes toward CMDs, managers finding out by themselves showed higher ORs than those not holding a negative attitude (OR, 1.58; 95% CI, 1.20 to 2.06) (Table 4). Sensitivity analysis did not alter the results.

DISCUSSION

This is the first survey-based study exploring different ways through which managers find out about CMDs among their employees and what influence different characteristics may have on their way of finding out. The study showed that it was more common that managers were informed about their employees' mental health status by other sources than finding out by themselves. Only about one in five found out by themselves, meaning that they noticed changes in an employee's behavior or performance. Their information mainly relied on self-disclosure. This finding was in line with previous research on managers' challenges in recognizing mental illness among staff due to organizational and/or personal barriers.^{31,54} The relative concealability of CMDs means that symptoms and decreased work capacity can be difficult to notice in a workplace, especially in less severe cases or among employees consciously concealing their condition.^{37,39} Moreover, employees can adapt a partial disclosure strategy, only selecting information about their health condition that is not related to their work situation or work performance. In addition, Munir et al⁵⁵ found that employees are likely to adopt a disclosure strategy at work that is closely connected to the employee's self-management needs in the particular work situation. In light of the reported general difficulties on disclosing mental health problems at work,^{39,40} the findings from

the present study are promising and may indicate a more supportive and to some extent CMD friendly work environment. Moreover, the low number of disclosures by colleagues or by information on sickness absence was expected and showed good compliance with the Swedish statutory privacy policy for working life.⁵⁶

As earlier research in the field of organizational behavior has suggested,²⁶ the importance of a contextual approach was supported by the results in this study. Johns²⁶ defines context as opportunities and constraints that affect the occurrence and meaning of organizational behavior. In line with this thinking on work-related factors, managers overseeing a smaller number of subordinates (less than 30) were twice as likely to find out about CMDs among their employees themselves compared with managers with responsibility for a greater number of subordinates (more than 30). The association did not alter when controlling for the managers' age, sex, and educational level. This finding adds to previous research stressing the relevance of the size of organization's units.⁵⁷

The reality of the managers' role in an organizational context is multifaceted, often characterized by juggling diverse work tasks and time pressure.²⁷ Moreover, constraints and stress may lead to avoiding and passive behavior,⁵⁸ resulting in managers paying less attention to early signs of mental health problems among staff members. Smaller numbers of subordinates will offer more opportunities for managers to monitor their employees' development and behavioral changes and may result in managers paying more attention to the early signs of mental health problems among their staff members. In addition, middle- and first-line managers found out more often via communication. Communication with employees is an essential part of the first-line managers' work, for instance in terms of regular feedback and being the employees' contact person in case of problems.

Training and education are frequently used within workplace-based mental health prevention programs,⁵⁹ although the scientific findings in existing research are mixed concerning the effects on organizational behavior. Some studies have shown that these programs facilitate managers' supportive behavior toward individuals with mental health problems,^{45,60} but the managers' mental health literacy and their proneness to contact an employee on sick-leave due to mental health conditions were not associated in another study.³³ In the present study, knowledge-related factors concerning receiving management training on CMDs, were not significantly associated with managers' finding out about CMDs themselves. However, education on stress offered to staff members as a preventive measure showed a negative association with managers finding out themselves. A reason may be that organizations offering education on stress to staff members at the same time encourage the employee her-/himself to recognize early signs of mental health problems and promote a more disclosure-friendly climate concerning mental health problems. This education to staff members might make managers less attentive and rely on employees' self-disclosure instead. Based on the present data, it was not

TABLE 4. Crude and Adjusted Odds Ratios (ORs) With 95% Confidence Intervals (CIs) for “Managers’ Finding Out by Themselves Only” Compared With “Managers Finding Out in Other Ways” With Respect to Independent Variables

Independent Variables	n	Managers Finding Out by Themselves Only				
		Model 1 Crude OR (95% CI)	Model 2 OR (95% CI) (n = 1724)	Model 3 OR (95% CI) (n = 1746)	Model 4: OR (95% CI) (n = 1773)	Model 5: OR (95% CI) (n = 1648)
Work-related characteristics						
Sector private (ref. Public/Non-profit)	1809	1.50 (1.20–1.87)	1.17 (0.88–1.55)			1.08 (0.81–1.45)
Total number of employees in organization 0–250 (ref. >250)	1809	1.18 (0.95–1.47)	0.92 (0.71–1.19)			0.89 (0.68–1.16)
Manager position middle/first-line managers (ref. Senior, operations)	1762	0.63 (0.50–0.80)	0.68 (0.51–0.89)			0.71 (0.53–0.94)
Number of direct subordinates (ref. >30)	1803					
11–30		1.52 (1.02–2.27)	1.45 (0.95–2.23)			1.45 (0.94–2.25)
0–10		2.19 (1.52–3.16)	1.98 (1.32–2.96)			2.02 (1.33–3.05)
Staff composition by gender (ref. majority male)	1805					
Majority female		0.69 (0.53–0.90)	0.90 (0.65–1.26)			0.97 (0.69–1.36)
As many females as males		0.90 (0.69–1.18)	0.99 (0.73–1.34)			1.05 (0.77–1.44)
Responsibility for work environment yes (ref. no)	1793	0.96 (0.75–1.23)	1.05 (0.80–1.38)			1.13 (0.85–1.50)
Industry (ref. blue collar)	1805					
White collar		1.10 (0.81–1.49)	1.25 (0.88–1.76)			1.31 (0.92–1.87)
Pink collar		0.71 (0.52–0.97)	0.94 (0.64–1.37)			0.98 (0.66–1.47)
Other		0.73 (0.50–1.07)	0.79 (0.52–1.21)			0.79 (0.51–1.22)
Total years of managerial experience >10 (ref. 0–10)	1790	1.18 (0.95–1.47)	1.20 (0.90–1.60)			1.21 (0.90–1.63)
Total years at current workplace >5 (ref: 0–5)	1798	1.09 (0.87–1.36)	0.94 (0.73–1.22)			0.94 (0.72–1.23)
Knowledge-related characteristics						
Having had management training on CMD yes (ref. no)	1804	1.01 (0.79–1.28)		1.12 (0.85–1.44)		1.07 (0.81–1.42)
Having had medical training on CMD yes (ref. no)	1805	0.89 (0.64–1.23)		1.10 (0.73–1.65)		1.28 (0.82–2.00)
Worked in occupation treating people with CMD yes (ref. no)	1804	0.79 (0.59–1.06)		0.80 (0.55–1.17)		0.86 (0.57–1.29)
Personal experience yes (ref. no)	1805	0.97 (0.75–1.27)		0.99 (0.75–1.30)		1.09 (0.80–1.47)
Preventive measure: education on stress yes (ref. no/Do not know)	1761	0.68 (0.54–0.85)		0.63 (0.48–0.83)		0.68 (0.51–0.91)
Preventive measure: education on CMDs yes (ref. no/Do not know)	1760	0.98 (0.73–1.32)		1.26 (0.89–1.78)		1.20 (0.83–1.73)
Attitude to CMDs						
Negative attitude (ref. no negative attitude)	1779	1.71 (1.34–2.18)			1.65 (1.29–2.11)	1.58 (1.20–2.06)

Values in bold are significant.

Model 1: Bivariate analyses.

Model 2: Multivariate analysis for work-related characteristics entered together and adjusted for age, gender, and level of formal education.

Model 3: Multivariate analysis for knowledge-related characteristics entered together and adjusted for age, gender, and level of formal education.

Model 4: Bivariate analysis for attitude adjusted for age, gender, and level of formal education.

Model 5: Full model adjusted for age, gender, and level of education.

possible to determine whether the managers themselves had participated in the educational programs together with the staff or if the education was only aimed at the staff.

There is evidence to suggest that stigma towards mental health problems is operating within workplace settings, and the importance of managers’ attitudes have already been established.^{15,21,37} Findings from the present study showed that a negative attitude was more likely to be seen in managers who themselves found out about CMDs. This may also imply, in line with earlier studies,⁴³ that employee’s self-disclosure or other ways of finding out may be more likely when managers express a positive attitude to mental health problems.

It might need to be considered whether it is to be preferred that managers find out themselves or rather rely on a positive

approach to mental health problems at the workplace facilitating employee self-disclosure. In theory, managers recognizing symptoms and work incapacity themselves might be inclined to facilitate dialog and offer preventive measures.^{1,37} However, this might also be experienced as a sign of checking and controlling the employee or confronting the employee with a verdict (“you have a CMD”) that the employee is not yet able to accept. The finding that managers with negative attitudes found out more often themselves, might represent such repressive manager behavior. Research shows that even general practitioners meet resistance and other barriers when medically diagnosing depression.⁶¹ Brouwers et al⁶² have pointed to the importance of creating a setting in which disclosure can take place. Although highly important, the employee disclosing this problem also faces a potential risk of stigma, discrimination,

and perhaps fewer work opportunities.^{62,63} However, the results in this study and previous research within the field of organizational behavior imply that work settings in practice are far more complex and the managers' access to available resources and measures will largely depend on the context in which they operate.

Improvements of work disability outcomes in employees with, or at a risk of, mental health problems most likely need a wide range of organizational preventive actions. This means that increased knowledge about whether and how managers' find out about mental health problems in their employees, is important in order to develop tailored preventive actions that are contextually well founded and align with the respective organization. Because of managers' vital positions in the organization and their far-reaching responsibility for the work environment, this furthermore underlines the importance of assessing and addressing managers' needs for support in their management of preventive actions at the workplace. From the results in this study, it could for example be important that stress education offered to staff members is paralleled by training and support on early prevention of mental health problems at work offered to managers.

Strengths and Limitations

The main strengths of this study are the large sample size of managers representing different work sectors and managerial levels, the randomly selected sample avoiding selection bias and the comprehensive measure of potential influencing factors on the ways managers find out about CMDs among their employees, covering both work-related and knowledge-related characteristics in managers as well as their attitude to CMDs in general. The sex composition in the study sample represented the sex distribution among managers in Sweden (32% in the sample, 39% in Sweden). Regarding work sector, the sample included a higher proportion of managers representing the public sector (41% in the sample, 21% in Sweden).⁶⁴ To some extent, managers in different countries and work contexts face similar tasks and challenges. However, the results need to be interpreted bearing in mind that legal aspects concerning managers responsibilities as well as cultural views on mental health problems differ.⁶⁵ Sweden is an individualistic, democratic, and open country focusing on equality, where mental health might be less of a taboo than in other countries. In a study comparing discrimination in the workplace because of depression across 35 countries, far more discrimination was reported in the countries with a high Human Development Index (HDI), an indication of wealth. Although Sweden was not included in that study, the current findings might thus be more representative for countries with a high HDI.⁶² The results were corrected for background variables such as sex which might be of specific relevance in a Swedish work context. A predominant proportion of the managers (78.8%) indicated personal experience with CMDs, which might have influenced their interest in the objective of the study, making them more eager to participate in the study than the general managerial population. The internal attrition was high, as is often the case using a web-based design.⁶⁶ The AAPOR Standard Definitions 2011⁴⁶ for respondents was used to identify three groups of participants. Among the total respondents ($n = 3358$), 2821 answered more than or equal to 80% of the questions in the survey, 278 answered between 50% and 79% of the questions, and 259 answered less than 49% of the questions. Dichotomizing the outcome variable whereby managers finding out both themselves and in other ways were included in the reference group may need to be discussed. Employee self-disclosure in comparison with the other ways of finding out might have been an alternative way of categorizing. To avoid losing focus on the manager perspective, the categorization that we used was found to be the most appropriate. Moreover, the sensitivity analysis showed no significant differences when excluding the group answering both options of finding out,

indicating the robustness of the categorization. Lastly, the dichotomization of the independent variables may have influenced the results. The cut-off points were chosen according to distribution and theoretical reasoning, but the loss of data cannot be fully ruled out. Further, due to the cross-sectional design, conclusions about causal relationships between ways of finding out and influencing factors of relevance cannot be established.

Future Research

This study contributes to an important field within occupational medicine where the scientific knowledge so far has been very scarce. Findings from this explorative study can form a base for future development of hypotheses on associations between work- and knowledge related characteristics and managers' different ways of finding out about mental ill-health among employees. Generally, studies with longitudinal designs are warranted in order to investigate causal relations between managers' recognition and actions on mental ill-health at the workplace and employee outcomes. Furthermore, future studies must integrate managers' access to structural as well as individual resources to capture the complexity in developing preventive actions against mental ill-health at work. To be able to classify the recognition of CMDs within the different levels of prevention, future research might differentiate between certain phases of CMDs. Finally, research is needed on the positive and possibly negative consequences of managers finding out about CMDs and of self-disclosure.

CONCLUSION

Finding out about CMDs among employees is a prerequisite for managers to offer support and accommodations at the workplace. By exploring the ways in which managers find out about CMDs among their employees, this study adds to the literature on CMD prevention and management in the workplace. The results show that a minority of managers finds out through noticing changes in behavior and performance only. A majority finds out via more than one way and mainly through employees' self-disclosure. Managers' with fewer subordinates as well as those holding a negative attitude to mental health problems were more likely to find out about CMDs themselves. The significance of mental health training and education on managers' tendency to find out about CMDs themselves could not be established.

REFERENCES

1. OECD. *Fit Mind, Fit Job, From Evidence to Practice in Mental Health and Work*. Paris: OECD; 2015.
2. Steel Z, Marnane C, Iranpour C, et al. The global prevalence of common mental disorders: a systematic review and meta-analysis 1980-2013. *Int J Epidemiol*. 2014;43:476-493.
3. OECD/EU. *Health at a Glance: Europe 2018: State of Health in the EU Cycle*. Paris/Brussels: OECD/EU; 2018.
4. Hassard J, Teoh KRH, Visockaite G, Dewe P, Cox T. The cost of work-related stress to society: a systematic review. *J Occup Health Psychol*. 2018;23:1-17.
5. Kessler R, White LA, Birmbaum H, et al. Comparative and interactive effects of depression relative to other health problems on work performance in the workforce of a large employer. *J Occup Environ Med*. 2008;50:809-816.
6. Hensing G, Bertilsson M, Ahlberg G, Waern M, Vaez M. Self-assessed mental health problems and work capacity as determinants of return to work: a prospective general population-based study of individuals with all-cause sickness absence. *BMC Psychiatry*. 2013;13:259.
7. Lerner D, Henke RM. What does research tell us about depression, job performance, and work productivity? *J Occup Environ Med*. 2008;50:401-410.
8. Stansfeld S, Fuhrer R, Head J. Impact of common mental disorders on sickness absence in an occupational cohort study. *Occup Environ Med*. 2011;68:408-411.
9. Knudsen AK, Harvey SB, Mykletun A, Overland S. Common mental disorders and long-term sickness absence in a general working population. The Hordaland Health Study. *Acta Psychiatr Scand*. 2013;127:287-297.

10. Järvisalo J. *Mental Disorders as a Major Challenge in Prevention of Work Disability: Experiences in Finland, Germany, the Netherlands and Sweden*. Helsinki, Finland: Kansaneläkelaitos; 2005.
11. Mauramo E, Lallukka T, Lahelma E, Pietilainen O, Rahkonen O. Common mental disorders and sickness absence: a register-linkage follow-up study among Finnish Municipal Employees. *J Occup Environ Med*. 2018;60:569–575.
12. Olesen J, Gustavsson A, Svensson M, Wittchen HU, Jonsson B. CDBE2010 study group European Brain, Council. The economic cost of brain disorders in Europe. *Eur J Neurol*. 2012;19:155–162.
13. Pomaki G, Franche R, Murray E, Khushrushahi N, Lampinen T. Workplace-based work disability prevention interventions for workers with common mental health conditions: a review of the literature. *J Occup Rehabil*. 2012;22:182–195.
14. Joyce S, Modini M, Christensen H, et al. Workplace interventions for common mental disorders: a systematic meta-review. *Psychol Med*. 2016;46:683–697.
15. Henderson C, Williams P, Little K, Thornicroft G. Mental health problems in the workplace: changes in employers' knowledge, attitudes and practices in England 2006-2010. *Br J Psychiatry Suppl*. 2013;55:s70–s76.
16. European Commission. *The European Pillar of Social Rights in 20 Principles*. Brussels: EU Publications Office; 2012.
17. Union E. Directive 89/391/EEC - OSH "Framework Directive" The OSH Framework Directive, Brussels: European Agency for Safety and Health at Work; 2018.
18. Work Environment Act, Amendments: up to and including SFS 2020:476, Stockholm.
19. Thisted CN, Labriola M, Vinther Nielsen C, Kristiansen ST, Strom J, Bjerrum MB. Managing employees' depression from the employees', co-workers' and employers' perspectives. An integrative review. *Disabil Rehabil*. 2020;42:445–459.
20. Thisted CN, Nielsen CV, Bjerrum M. Work participation among employees with common mental disorders: a meta-synthesis. *J Occup Rehabil*. 2018;28:452–464.
21. Kirsh B, Krupa T, Luong D. How do supervisors perceive and manage employee mental health issues in their workplaces? *Work*. 2018;59:547–555.
22. Martin A, Fisher CD. Understanding and improving managers' responses to employee depression. *Ind Organ Psychol*. 2014;7:270–274.
23. Van de Poll M, Nybergh L, Lornudd C, et al. Preventing sickness absence among employees with common mental disorders or stress-related symptoms at work: a cluster randomised controlled trial of a problem-solving-based intervention conducted by the Occupational Health Services. *Occup Environ Med*. 2020;77:454–461.
24. Nieuwenhuijsen K, Verbeek JH, de Boer AG, et al. Supervisory behaviour as a predictor of return to work in employees absent from work due to mental health problems. *Occup Environ Med*. 2004;61:817–823.
25. Dewa CS, Weeghel JV, Joosen MC, Brouwers EP. What could influence workers' decisions to disclose a mental illness at work? *Int J Occup Environ Med*. 2020;11:119–127.
26. Johns G. The essential impact of context on organizational behavior. *Acad Manage Rev*. 2006;31:386–408.
27. Hamann D, Foster N. An exploration of job demands, job control, stress, and attitudes in public, nonprofit, and for-profit employees. *Rev Public Pers Adm*. 2014;4:332–355.
28. Wilhelm KA. Gender and mental health. *Aust N Z J Psychiatry*. 2014;48:603–605.
29. Andersson LM, Moore CD, Hensing G, Krantz G, Staland-Nyman C. General self-efficacy and its relationship to self-reported mental illness and barriers to care: a general population study. *Community Ment Health J*. 2014;50:721–728.
30. Burke J, Bezyak J, Fraser R, Pete J, Ditchman N, Chan F. Employers' attitudes towards hiring and retaining people with disabilities: a review of the literature. *Aust J Rehab Counsel*. 2013;19:21–38.
31. Shankar J, Liu L, Nicholas D, et al. Employers' perspectives on hiring and accommodating workers with mental illness. *SAGE Open*. 2014;4:1–13.
32. Andersen J. Public versus private managers: how public and private managers differ in leadership behavior. *Public Admin Rev*. 2010;70:131–141.
33. Bryan BT, Gayed A, Milligan-Saville JS, et al. Managers' response to mental health issues among their staff. *Occup Med (Lond)*. 2018;68:464–468.
34. Martin A, Woods M, Dawkins S. How managers experience situations involving employee mental ill-health. *Int J Workplace Health Manage*. 2018;11:442–463.
35. Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to processing personal data and on the free movement of such data, and repealing Directive 95/46/EC (General Data Protection Regulation) Off J Eur Union, 2016; 1–88.
36. Sick Pay Act, Amendments: up to and including SFS 2020:191, Stockholm.
37. Bertilsson M, Petersson EL, Ostlund G, Waern M, Hensing G. Capacity to work while depressed and anxious - a phenomenological study. *Disabil Rehabil*. 2013;35:1705–1711.
38. Malachowski C, Boydell K, Sawchuk P, Kirsh B. The "Work" of workplace mental health: an institutional ethnography. *Soc Ment Health*. 2016;6:207–222.
39. Brohan E, Henderson C, Wheat K, et al. Systematic review of beliefs, behaviours and influencing factors associated with disclosure of a mental health problem in the workplace. *BMC Psychiatry*. 2012;12:11.
40. Toth KE, Dewa CS. Employee decision-making about disclosure of a mental disorder at work. *J Occup Rehabil*. 2014;24:732–746.
41. Mendel R, Kissling W, Reichhart T, Buhner M, Hamann J. Managers' reactions towards employees' disclosure of psychiatric or somatic diagnoses. *Epidemiol Psychiatr Sci*. 2015;24:146–149.
42. Link B, Phelan J. Conceptualizing stigma. *Annu Rev Sociol*. 2001;27:363–385.
43. Martin A. Individual and contextual correlates of managers' attitudes toward depressed employees. *Human Resour Manage*. 2010;49:647–668.
44. Martinsson J, Andreasson M, Lindgren E. *Technical Report Citizen Panel 26-2017*. Gothenburg: LORE; 2017.
45. van de Voort I, de Rijk A, Hensing G, Bertilsson M. Determinants of managerial preventive actions in relation to common mental disorders at work: a cross-sectional study among Swedish managers. *J Occup Environ Med*. 2019;61:854–862.
46. The American Association for Public Opinion Research. *Standard Definitions: Final Dispositions of Case Codes and Outcome Rates for Surveys*. AAPOR (ed.): Lenexa, KS; 2011.
47. Martin A, Woods M, Dawkins S. Managing employees with mental health issues: Identification of conceptual and procedural knowledge for development within management education curricula. *Acad Manage Learn Edu*. 2015;14:50–68.
48. Statistics Sweden. *SNI Swedish Standard Industrial Classification*. Örebro: Statistics Sweden; 2007.
49. Fine S. A structure of workers functions. *Person Guide J*. 1955;34:66–73.
50. European Commission. *User Guide to the SME Definition*. Luxembourg: European Union; 2020.
51. Jonsson R, Lidwall U, Holmgren K. Does unbalanced gender composition in the workplace influence the association between psychosocial working conditions and sickness absence? *Work*. 2013;46:59–66.
52. Shann C, Martin A, Chester A. Improving workplace mental health: a training needs analysis to inform Beyond Blue's online resource for leaders. *Asia Pacific J Hum Resour*. 2014;52:298–315.
53. Mangerini I, Bertilsson M, de Rijk A, Hensing G. Gender differences in managers' attitudes towards employees with depression: a cross-sectional study in Sweden. *BMC Public Health*. 2020;20:1744.
54. de Rijk A, van Raak A, van der Made J. A new theoretical model for cooperation in public health settings: the RDIC model. *Qual Health Res*. 2007;17:1103–1116.
55. Munir F, Leka S, Griffiths A. Dealing with self-management of chronic illness at work: predictors for self-disclosure. *Soc Sci Med*. 2005;60:1397–1407.
56. Government of Sweden. *SOU 2009:44. A new act on the protection of personal privacy in working life (Summary of Swedish Government Official Report Protection of personal privacy in working life)*. Stockholm; 2009.
57. Curral L, Forrester R, Dawson J, West M. It's what you do and the way that you do it: team task, team size, and innovation-related group processes. *Eur J Work Organ Psychol*. 2001;10:187–204.
58. Sherf E, Venkataraman V, Gajendra R. Too busy to be fair? The effect of workload and rewards on managers' justice rule adherence. *Acad Manage J*. 2019;62:469–502.
59. Gayed A, Milligan-Saville JS, Nicholas J, et al. Effectiveness of training workplace managers to understand and support the mental health needs of employees: a systematic review and meta-analysis. *Occup Environ Med*. 2018;75:462–470.
60. Kitchener BA, Jorm AF. Mental health first aid training in a workplace setting: a randomized controlled trial [ISRCTN13249129]. *BMC Psychiatry*. 2004;4:23.

61. Schumann I, Schneider A, Kantert C, Lowe B, Linde K. Physicians' attitudes, diagnostic process and barriers regarding depression diagnosis in primary care: a systematic review of qualitative studies. *Fam Pract*. 2012;29:255–263.
62. Brouwers EP, Mathijssen J, Van Bortel T, et al. Discrimination in the workplace, reported by people with major depressive disorder: a cross-sectional study in 35 countries. *BMJ Open*. 2016;6:e009961.
63. OECD. *Sick on the Job? Myths and Realities About Mental Health and Work*. Paris: OECD; 2012.
64. Statistics Sweden. *Women and Men in Enterprise 2013*. Örebro: Statistics Sweden; 2013.
65. Abdullah T, Brown TL. Mental illness stigma and ethnocultural beliefs, values, and norms: an integrative review. *Clin Psychol Rev*. 2011;31:934–948.
66. Hochheimer CJ, Sabo RT, Krist AH, Day T, Cyrus J, Woolf SH. Methods for evaluating respondent attrition in web-based surveys. *J Med Internet Res*. 2016;18:e301.