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Mental Illness, Social Suffering and Structural Antagonism in the Labour Process

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Abstract

Workplace conditions and experiences powerfully influence mental health and individuals experiencing mental illness, including the extent to which people experiencing mental ill-health are 'disabled' by their work environments. This article explains how examination of the social suffering experienced in workplaces by people with mental illness could enhance understanding of the inter-relationships between mental health and workplace conditions, including experiences and characteristics of the overarching labour process. It examines how workplace perceptions and narratives around mental illness act as discursive resources to influence the social realities of people with mental ill-health. It applies Labour Process Theory to highlight how such discursive resources could be used by workers and employers to influence the power, agency and control in workplace environments and the labour process, and the implications such attempts might have for social suffering. It concludes with an agenda for future research exploring these issues.

Keywords

Labour Process Theory, mental illness, social suffering

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Introduction

Mental illness is a significant issue for workers, workplaces and societies. Recent research suggests 27% of the adult population had experienced at least one form of mental disorder in the past year, with depression identified as the leading cause of disability (World Health Organization, 2017). In Australia, depression is estimated to affect one in five people and anxiety is estimated to affect one in four (Beyond Blue, 2019). Work-related mental stress claims are the most expensive form of worker's compensation claims in Australia (Safe Work Australia, 2013), exceeding $AUD500 million per annum (Safe Work Australia, 2018). In 2012, depression alone cost Australian employers approximately $AUD8 billion in illness-related absences and presenteeism (Dollard et al., 2012). Conversely, improving the psychological health of workers and psychological safety climates in organisations could save an estimated $AUD32 billion (Dollard et al., 2012).

In recent years, academics, governments and peak community organisations (e.g. Australia's Black Dog Institute and Beyond Blue, the UK's Mental Health First Aid England and Canada's Great West Life Centre for Mental Health in the Workplace) have given increased attention to relationships between work, workplaces and mental health. Academic investigations from a wide range of disciplinary perspectives have addressed two broad themes: how workplaces harm mental health, and how work and workplaces can enhance mental health.

Research examining how workplace conditions cause or exacerbate mental ill-health draws from disciplinary traditions including medicine, psychology and occupational health. Seminal work such as Karasek and Theorell's demand–control model (1990) has examined the harmful mental health impacts of job strain, which results from a combination of high job demands and low control over how the job is done. Low job control and high job strain are both significantly associated with subs
et al., 2009; Inoue et al., 2010). Work on psychosocial sa
safety-related workplace policies, practices and cultural no
health also suggests these impacts largely through [AQ: 2]
the social relational aspects of work (Dollard and Bakke
examined the ways in which workplace arrangements and c
employment, work intensification, heightened performance
assment influence psychological health. 'Lean' organisatio
fragmentation, standardisation and individualised work
increase the incidence of symptoms of mental ill-health (Carter et al., 2013). Precarious employment is associated with depressed mood (Han et al., 2017), and an increased risk for suicidality (Min et al., 2015) and mental health conditions requiring medical treatment (Moscone et al., 2016).

AQ:2
Please amend sentence to read "..impact workers' mental health largely through their influence on job design and the social relational aspects of work"

Other work, drawing largely from psychology, has examined how employment and work environments promote mental health. Employment is generally better for mental health than non-employment (Llena-Nozal, 2009) and can be a crucial influence on recovery from a mental health condition (Andren, 2014; Doroud et al., 2015). Employment appears to promote recovery via provision of routine and structure, social connectedness and belonging, hopefulness and purpose, sense of identity, and empowerment (Leamy

et al., 2011). Other benefits include improved quality of life and well-being, providing structure and routine to day-to-day life, contributing a sense of meaning and purpose, promoting opportunities for social inclusion and support, and provision of financial security (Beal et al., 2005; Eklund et al., 2012; Hitch et al., 2013). Research in positive psychology and positive organisational behaviour has examined how workplace interventions can promote psychological well-being and positive psychological states, finding that interventions can sustainably enhance mental well-being and reduce depressive symptoms (LaMontagne et al., 2014). Related work in medicine, psychiatry and public health has examined how workplaces can promote mental health by facilitating early intervention and help-seeking when people experience mental ill-health through initiatives such as mental health literacy training in workplaces (Bovopoulos et al., 2018) and suicide prevention programmes. Other research in psychology (Shann et al., 2018) and human resource management (Martin, 2010) has examined ways to reduce the stigma associated with mental health issues in workplaces. **[AQ: 3]**

AQ: 3
Shann, Martin, Chester and Ruddock, 2018

Critical explorations of relationships between workplac experiences and psychological health that are linked to bro and critiques have been rare in these bodies of work (for exceptions, see Gruhl, 2010; Negri, 2009). However, they are now emerging and addressing calls for more development of multi-level conceptualisations of mental health and psychosocial work environments that link individual-level, meso-level (e.g. group and organisational) and macro-level (e.g. labour market) factors and impacts (Martin et al., 2014). For example, Strong (2015) and Davies (2015) have critiqued the ways in which strategies used to monitor and influence workers' states of happiness convert emotions into another element of human capital that employers can influence and exploit in the labour process, and create workplace inequality. Lowe (2015) has linked the impacts of job design and social relational aspects of work on the psychological health of workers to a broader critique of the neo-liberal workplace and the alienating and exploitative aspects of capitalism. Additionally, Karasek (~~2019: 1~~) defined and rapidly growing social problem of 'unhealthy an ns' causing the deterioration of psychosocial well-being in th my.

Please amend Karasek reference to Karasek (2014) as per edits in reference list

We propose that both critical and r f inter-relationships between work and mental health could l onceptualisations of social suffering and Labour Process The is defined as 'collective and individual human suffering associated with life conditions shaped by powerful social forces' (Benatar, 1997: 1634), including personal inter-relationships, cultural systems, and political, bureaucratic and institutional social structures. It is a concept designed to focus attention on, build an understanding of, and document how, suffering is caused and conditioned by the social world (Kleinman and Wilkinson, 2016). We propose that examining how workplace conditions and experiences influence the social suffering of individuals experiencing mental health issues would enable new explorations of the ways in which workplace conditions and experiences *contribute to* social suffering, and how they could *alleviate* social suffering experienced by individuals experiencing mental ill-health. LPT examines the social relations between employers and workers and how dynamics of control, power and structural antagonism influence these relationships. We suggest that, as such, LPT offers a useful conceptual lens for considering how these

dynamics mediate relationships between workplace conditions and social suffering related to mental illness, including the effectiveness of strategies intended to alleviate suffering.

In the next section, we discuss the concept of social suffering and articulate how it can offer new insights into the relationships between workplace conditions and experiences of mental illness. We then examine how perceptions and narratives around mental illness act as discursive resources to influence people with mental illness and their power and agency, focusing specifically on how this occurs in the workplace and the labour process. We then explore how workers experiencing mental health issues might potentially leverage such discursive resources to give them more power to alleviate their suffering, and how control and power dynamics in the labour process might influence the effectiveness of such attempts. We then discuss how employers might also leverage discourses and perceptions about mental health in workplaces to influence the labour process, and the implications such attempts might have for social suffering. We conclude by discussing opportunities to enhance theorising and research about the relationships between workplace conditions and mental illness using conceptualisations of social suffering and LPT.

Social suffering as a lens for examining workplace experiences of mental illness

Social suffering is a specific form of human suffering that arises from social contexts. Human suffering can be defined as 'the state of severe distress associated with events that threaten the intactness of person' (Cassell, 2004: 32) and 'as a visceral awareness of the self's vulnerability to be broken or diminished at any time and in many ways' (Black and Rubinstein, 2004: S22). Andersen et al. (2014) identify four types of human suffering: physical, mental, existential and social. They equate physical suffering with pain; mental suffering with cognitive and emotional suffering; existential suffering with distress around life's meaning; and social suffering as 'suffering whose sources are social collectives and/or social institutions'. This reflects Cassell's contention that human suffering occurs because '*our intactness as persons, our coherence and integrity, come not only from intactness of the body but also from the wholeness of the web of relationships with self and others'* (2004: 38). Thus, suffering can be understood as a range of distressing experiences that result when intactness feels threatened or compromised. *Social* suffering thus frames understandings of the ways in which social forces and dynamics cause, affect or can alleviate the distressing experiences of human suffering.

Notions of social suffering can be used to understand micro-level, meso-level and macro-level forms, sources and consequences of human suffering. For example, in the social sciences, social suffering has been used to examine suffering as a micro- and individual-level experience grounded in social structures, history and culture (Kleinman and Fitz-Henry, 2007), and as 'the result of what political, economic and institutional power does to people, and reciprocally, how these forms of power themselves influence responses to social problems' (Muderedzi and Ingstad, 2011: 176). More specifically, the concept of social suffering enables fine-grained examinations of 'cultural responses, including bureaucratic responses, that can intensify social suffering as structural violence' (Hansen

and Sait, 2011: 95). Structural violence is 'the negative impact – beyond their control – of social structures (political, religious, cultural etc) on the lives of individuals and groups' (Muderedzi and Ingstad, 2011: 176 **[AQ: 4]**) ndings of social suffering frame responses to it because 'how ng becomes that experience, for the observers and even for th hat we represent and how we represent it refigure what we will, to will not, do to intervene' (Kleinman et al., 1996: xii). Research has shown, for instance, that beliefs about social suffering can result in empathy gaps towards sufferers (Norgden et al., 2011) and witnessing the social suffering experienced by a stranger triggers different brain mechanisms to witnessing suffering experienced by someone to whom we are connected (Meyer et al., 2013).

AQ:4
please amend to p. 178

Disciplines such as psychology, medicine and health recognise that concepts of suffering and social suffering offer valuable insights into causes and experiences of mental illness. In psychology, the mental, emotional and social suffering that results from mental illness are central pillars of many forms of psychotherapy. Psychodynamic therapy, for example, focuses upon helping people see how they use recurring patterns of thinking and behaving to avoid distress or cope with experiences of it (Shedler, 2010). In medicine and health, advocates argue that theories of social suffering have particular utility for understanding mental health-related issues and situations as they enable acknowledgement that the sources and effects of mental health conditions such as depression 'are located at least in part in the social worlds' and that 'political and professional processes powerfully shape' responses to them (Kleinman et al., 1996: xii).

These distinctions between mental health conditions and their social causes and consequences are also found in work examining the inter-relationships between workplace conditions and mental illness framed around the social model of disability. Whereas the 'functional limitations' or 'individual deficit' models of disability focus on the physical and psychological limitations of disabled people (Mik-Meyer, 2016), the social model of disability adopts a 'social barriers' view and theorises that it is societies and social systems that 'disable' individuals whose physical or mental characteristics differ from others. It separates the bodily and psychological variations by which a person differs from others (designated their 'impairment') from their 'disability', defined as the 'contextual factors that mediate the experience of impairment' (Foster, 2018: 191), including the 'social consequences of being labelled "disabled"' (Barnes, 1999: 149). Studies framed around the social model of disability have examined 'how "brutal" workplace practices can be' towards people with impairments, and how workplace policies and practices targeting impaired individuals can disable rather than assist or empower them (Mik-Meyer, 2016: 986). However, scholars have consistently called for more investigation of the experiences that impaired people have in workplaces and labor markets so as to enhance understanding of how these social structures and processes 'disable' people with impairments (Barnes and Mercer, 2005; Fevre et al., 2013; Foster, 2007).

Examining the social suffering associated with workplace experiences of mental illness aligns with and extends social models of disability by enabling finer-grained distinction between, and understanding of, the social suffering which results from a person's mental health impairment, and that which results from their (contextually mediated) disability. It facilitates deep critical reflection about what is causing an individual to suffer, and new insights into 'the complexity and multiplicity of the social restrictions faced by

people diagnosed as "mentally ill"' (Mulvaney, 2000: 585). This includes the ways in which modern work causes suffering and the underlining structures and mechanisms through which this occurs. It also draws more focus to the ways in which social actors in the workplace contribute to or could alleviate suffering associated with mental ill-health. Examining the social suffering associated with health conditions enables recognition that suffering caused by a disorder extends into a sufferer's social networks, which in turn enables greater consideration of the people in those social networks as influencers of help-seeking and utilisation of assistance, and as people also needing interventions and support (Kleinman, 2010). In a workplace context, this could include consideration of the impacts of a person's mental illness on their managers and colleagues, an area which has to date received very little attention in the business and management literature (for exceptions, see Martin et al., 2015, 2018).

'Mental illness' as a discursive resource

We now examine how perceptions and narratives about mental illness can operate and be leveraged as discursive resources to 'disable' or empower individuals experiencing mental ill-health. Discursive resources are linguistic devices (e.g. phrases, expressions) which act as 'tools that guide interpretations of experience and shape the construction of preferred conceptions of persons and groups' (Kuhn et al., 2008: 163). In doing so, they contribute to the operation of discourses as systems for forming and articulating ideas which establish relationships between knowledge and power that then shape and even subordinate other levels of social reality (Alvesson and Karreman, 2000).

While the historical passage of discourses around mental illness is complex and multifarious (Craig, 2014), the tendency in the past was to identify mentally ill people as either 'mad', blessed, or possessed. People who were 'mad' were also morally flawed, and were sinful, had character flaws, or were lazy (Borch-Jacobsen, 2001; Lewis and Whitley, 2012). Alternatively, they were blessed with a spiritual gift: exemplars of excellence, saints or ascetics on the path to purification or worldly detachment (Kleinman, 1988). Otherwise, they were possessed; under the sway of demonic or satanic forces (Borch-Jacobsen, 2001). With the emergence of modernity and science, and changes in the power of psychiatric and pharmaceutical knowledge (Lewis and Whitley, 2012), the discourse has progressively shifted to frame people experiencing mental illness as sick, rather than choosing to be wicked, or being chosen by the unseen forces of good and evil (Borch-Jacobsen, 2001). They have a disease or injury – in a similar category to people suffering pneumonia or a broken arm.

As discursive resources, these characterisations of mentally ill people shape conceptualisations of both their agency and power. Attributing a person's 'madness' to indulgence of character flaws and sinfulness, frames them as having brought their state of ill-health on themselves and perpetuating their own suffering by continuing to indulge in the choices and behaviours which brought this to pass. In contrast, attribution to demonic possession frames a mentally ill person as a tragic and passive victim of forces beyond their control, reliant on the agency of others to alleviate their suffering by, for example, exorcising the demonic cause. Biomedical framings of mental health combine all three elements. The focus of biomedical models on the physiological elements of mental ill-health frames a

mentally ill person as hostage to their biochemical processes and reaction: experiences of depression attributable to serotonin, and anxiety resulting from cortisol. Critical authors (e.g. Glass, 1989; Greenberg, 2010; Szasz, 2003) argue that biomedical models also silence and de-privilege the voices of those who suffer mentally, prioritising instead the voices of medical and clinical experts. As the emphasis on biomedical explanations of mental health have increased, so has the relative power of such experts. For instance, in recent years the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2013), the classification taxonomy used by mental health professionals to diagnose, treat and research mental health disorders, has been amended to lower the threshold of what is considered a diagnosable mental health condition and increase the number of diagnosable illnesses (Rosenberg, 2013). This expands the purview of mental health professionals and means people with a wider sweep of conditions are becoming pathologised in biomedical terms (Harrist and Richardson, 2013). Clinical diagnosis can alleviate and legitimate suffering when being formally identified as having a mental illness 'gives a name to the suffering we feel and a hope that with a label can come relief' (Rosenberg, 2013: 1). However, it can also exacerbate suffering for those who feel their diagnosis is an inconsistent or inadequate reflection of their experience. Biomedical and clinical definitions of mental illness also reframe perceptions of agency in a person's recovery from mental ill-health. For example, biochemical explanations of mental ill-health correspondingly privilege biochemical forms of treatment, such as the use of serotonin uptake inhibitors to treat depression. They also reframe perceptions of the person's power and agency over their own recovery around their degree of compliance with clinically based regimes for recovery, such as whether they are willing to utilise pharmaceutical remedies for their condition or are 'medication resistant'.

Utilising LPT to examine mental illness as a discursive resource in the labour process

We now consider how perceptions and narratives about mental illness can also act as discursive resources in the workplace to shape experiences and conceptualisations of mentally ill people and influence their social suffering. Using LPT, we consider specifically how perceptions and narratives influence power dynamics in workplace environments and the ways in which narratives about mental illness and mentally ill people might be *leveraged* as discursive resources by both employers and employees.

Labour Process Theory

The labour process has been described 'as that activity in which the capacity to work is turned into concrete labour, together with the relevant relations between managers and workers' (Edwards, 2010: 32). LPT concentrates on 'the organization of the labour process and the way in which the frontier of control is created and sustained' (Edwards, 2010: 33). Its historical articulation, development and debates have been well described by several authors (e.g. Thompson and Smith, 2010) so will not be repeated here. [AQ: 5] A significant body of case study research and scholarly debate underpins LPT an

AQ: 5
This reference should stay as Thompson and Smith, 2010. We have now removed the Thompson and Smith 2010 b reference from the reference list so that only this reference is included.

thrive, notably through the annual labour process studies conference [A
associated 27 edited books (see www.ilpc.org.uk/).

In recent years, LPT scholars have articulated a set of core characteris
labour processes for use as a 'conceptual toolkit' (Jaros, 2005) for inves
that affect capitalist labour processes and to provide a useful heuristic or reference point for 'considering the dynamics and developments of workplace social relations' (Thompson and Vincent, 2010: 64–65). These characteristics have been specified to varying levels of detail, but Thompson and Vincent (2010: 48) summarise them as comprising the following propositions: [AQ: 7]

1. Because the labour process gene entral part of human experience in acting on the world and reproducing the economy, the role of labour and the capital–labour relationship are privileged in . . . [AQ: 8]
2. There is a logic accumulation that compels capital to constantly re production of goods and services. This arises from competition b ists and between capital and labour.
3. Because market mechanisms alone cannot regulate the labour pr control imperative as systems of management are utilised to reduce the indeterminacy gap.
4. Given the dynamics of exploitation and control, the social relations between capital and labour in the workplace are of structured antagonism.

The focus of LPT on the structured antagonism and control dynamics in relationships between capital and labour offers opportunities to consider more specifically how perceptions and narratives around mental illness could operate as discursive resources within the labour process. We discuss below how workers experiencing mental illness might potentially leverage an identity as 'mentally ill' to influence their workplace power and social suffering, how the structured antagonism of the labour process might mediate the success of such attempts, and how employers might leverage narratives around mental illness to influence their control of the labour process.

Worker utilisation of 'mental illness' as a discursive resource

In countries such as Australia, anti-discrimination and workplace health and safety legislation and workers' compensation regimes confer on workers legally protected rights to identify themselves as having a mental illness and to claim worker's compensation if their mental health impairment is caused or exacerbated by their workplace or work-related experiences. In this context, identifying oneself as mentally ill hypothetically enables a worker who is experiencing mental illness and attendant suffering to exercise agency and affect the dynamics of power and control which influence their situation. Where these experiences result from behaviours such as bullying or harassment, they can also help redress feelings of powerlessness and dis-empowerment by others. Additionally, when such experiences have resulted in a compensable psychological injury, workers' compensation can help to redress or limit additional forms of suffering resulting from

AQ: 6
Please amend to "the annual International Labour Process Conference"

AQ: 7 Yes, the following points comprise a direct quote from p. 48 of this reference.

AQ: 8
As this is to be presented as a direct quote (please see response to AQ:7), this sentence should read..."are privileged in our analysis"

their injury, such as economic hardship that results from their injury, negatively affecting their capacity to work.

However, as Rundle et al. (2018) identified in their recent analysis of Australian workers' compensation legislation, legal, institutional and cultural structures embedded in these legislative processes can actually contribute to the suffering and disabling of mentally ill individuals. In all Australian states and territories, a worker wishing to claim compensation must prove that (a) they have suffered a *diagnosed* psychological injury, which (b) resulted from their employment, and (c) did not arise from 'reasonable management action' undertaken by their employer (for a detailed explanation of the 'reasonable management action' provision, see Rundle et al., 2018). But in several key ways, these provisions actually disempower and de-privilege the mentally ill worker. The diagnosis of a psychological injury depends upon a determination by a clinical expert that the worker's experiences and suffering conform to diagnostic guidelines, an 'epistemic injustice' (Lakeman, 2010) that undermines the credibility of a sufferer's own testimony while prioritising the interpretations of professionals. Employer exemption from liability for injuries resulting from reasonable management action privileges the voices and power of employers over that of the worker because an employer who can show that the injury arose from actions considered 'reasonable' by the courts is not considered liable. Consequently, the issue of what caused the injury is privileged over the injury that was caused or the suffering that resulted for the worker. In several states and territories, the definition of 'psychological injury' specifically excludes those caused by reasonable management action. This means that, in the eyes of the law, a worker whose mental illness was caused by such an action is considered *not to have suffered any injury at all*. Thus, an employer's power to demonstrate that their action constituted reasonable management action negates the worker's power to have their experience and their suffering identified, recognised or redressed, and can cause additional social suffering by de-legitimating their claim to have been injured or to have suffered.

Identifying one's self as experiencing mental illness resulting from workplace pressures can also provide a mechanism for workers to gain recognition for their suffering and re-frame perceptions of their situation. Shifting their identification from 'healthy but underperforming' to 'mentally ill and not coping' may offer a way for suffering employees to push back against forms of work or workplace expectations that they find immiserating. This may, in turn, help them assert more control over their workplace experiences and narratives about the impact of those experiences on their person. Moll et al. (2013) have written about employees strategically disclosing mental illness by choosing when, and to whom, they will reveal their mental health problems.

Claims of mental illness may also be a discursive resource that workers can *collectively* use to resist managerial strategies and re-balance power dynamics. Identifying a worker as being, or potentially being, mentally ill, may provide a mechanism for line managers to block organisational attempts to simply 'get rid' of someone who is not coping and provide a buffer for the person to recover and re-gird themselves for the workplace. Moll et al. (2013) detail cases where groups of employees drew cloaks of secrecy around suffering individuals to protect them in the workplace.

Nevertheless, few workers are likely to willingly embrace being identified, by themselves or others, as experiencing mental illness because such disclosures can trigger

other changes to the power they can subsequently exercise. Research points to a cascading effect of someone identifying as mentally ill at work (Anderson et al., 2014). Their disclosure may protect them from formal labelling as 'poor performers' but can also then trigger a therapeutic and biomedical treadmill that assigns them an externally imposed workplace identity and affects their capacity to work, and which can enmesh them in processes over which they have little control. In Australia, for example, claims that mental illness is affecting a person's capacity to perform their job triggers consideration of whether they are able to continue performing their current duties or require adjustments to current working conditions that can range from modified duties, period of leave, and the development of recovery-at-work or return-to-work plans (Safe Work Australia, 2019). These processes can involve medical and psychiatric professionals, managers, return-to-work coordinators, workplace health and safety officers and workers' compensation providers. In such contexts, medical professionals hold the social and legal power over the worker's diagnosis and treatment. This extends to the power to determine and define the worker's recovery from their mental illness, including definition of if, when and to what extent that has occurred. These judgements inform, in turn, determinations by the worker's employer and other stakeholders as to whether the worker can undertake any of their regular duties during their periods of illness and recovery, and the supports and adjustments available to facilitate that. Thus, these determinations can influence the suffering which might consequently result for the workers from either continuing to participate in their workplace environment while ill, or, conversely, being excluded and socially isolated from that environment. **[AQ: 9]**

AQ: 9
Complete reference should be:
Andersen, Nielsen and Brinkmann, 2014

The stigma of mental illness can also cause m s of being (Glass, 1989), and of attendant social suffering. In l is increasingly casualised and precarious, the effect of havi ill' can be devastating on long-term employment, job prospect Henwood, 2014). Some have in fact proposed that 'the stigmatization of psychological **[AQ: 10]** disabilities remains the final frontier in the elimination of prejudice and s citing evidence that 'a third of the British population does not believe th mental health problems should have the same right to a job as anyone else 2013: 291). Thus, the structured antagonism of the labour process, including that of associated workplace health and safety and workplace compensation regimes, can result in the very disclosure intended by the worker (or well-meaning others) to bring recognition of their suffering causing that suffering to increase.

AQ: 10
Please include "and learning" here as per the original quote

Employer utilisation of 'mental illness' as a discursive resource

We now turn to discuss how employers may use mental illness as a discursive resource to reframe perceptions of mentally ill workers and divert attention away from the ways in which workplace conditions cause social suffering related to mental ill-health. Employers may leverage mental illness as a discursive resource to divert attention away from the ways in which the workplace conditions cause suffering and mental ill-health by attributing these experiences to personal circumstances rather than system-wide pathologies. People experiencing mental illness as a consequence of work-related factors present a potential threat to employer control because of the questioning prompted by

their demonstrative expressions of not coping and what their suffering may 'awkwardly' suggest (Szarz, 2003). In such situations, labels and narratives of mental illness become invisibility cloaks for miner's canaries that employers want to conceal.[AQ: 11]

One way in which employers can seek to individualise experiences and suffering caused by working place conditions is through institutional characterise coping with traumatising and dehumanising workplace e 'normal' part of the job, such as those found in the professions of me policing. These narratives lead to individuals who experience work-re ness to be characterised by employers and co-workers as 'weak', 'not not a 'real' member of the profession. This perpetuates professional an cultures that individualise and dismiss mental illness and exacerbate the social suffering that results. In some Australian policing organisations, for example, officers who commit suicide are excluded from remembrance services that commemorate officers who die while serving (Jewell, 2014). Such practices deny the suffering that officers experience as a consequence of their workplace demands, and the suffering their work-related mental illness causes for loved ones, friends and communities, but also perpetuate conspiracies of silence within the profession about the systematic pressures and psychological demands of the labour process (Verity, 2014).

Workplace interventions such as resilience and mindfulness training that provide symptomatic and individualised 'fixes' for psychological distress and mental ill-health also individualise mental illness and suffering. As Foster noted: 'the purpose of workplace resilience strategies it seems is to toughen up individual employees to better withstand the seemingly "inevitable" demands of the current capitalist crisis' (2018: 189–190). These strategies are likely positive for helping some employees better cope with workplace stress but they focus on 'fixing' the individual, rather than the system (Gilbert et al., 2017). They may also lead to worker experiences of mental ill-health being framed as resulting from a personal failure to 'master' or utilise the training, and thus also an outcome of personal power and agency, rather than continued experience of workplace conditions that negatively impact their mental well-being and which they lack the power and agency to change.

Opportunities for future research

Examining issues such as those we have outlined above provide a range of valuable opportunities to use 'social suffering' and LPT to extend theorising and research about interactions between workplace conditions and mental illness. The first of these are opportunities for multi-level theorising and research. Since social suffering and LPT both conceptually link individual, meso-level and macro-level elements of social processes, they could usefully frame studies that generate new insights as to how macro- and meso-level conditions of the labour process influence the micro-level experiences of workers, including the forms of suffering they experience. This could include studies which examine how such experiences are mediated by power dynamics in the labour process, such as how workplace conditions and experiences affect people experiencing mental ill-health by influencing their feelings of empowerment and powerlessness. Such studies could, in turn, enable more exploration of how changes to factors at each level

AQ: 11 Full reference for Szarz (2003):
Szasz T (2003) Psychiatry and the control of dangerousness: on the apotropaic function of the term "mental illness." *Journal of Medical Ethics* 29: 227-230.

might exacerbate or ameliorate suffering, in themselves and specifically by influencing power relationships.

Multi-level studies could also examine how *discourses* operating at each level influence people experiencing mental illness in workplace settings, such as how macro-level (societal) discourses are enacted at the meso (organisational) level in workplaces and can generate change or affect the lived experience and suffering of workers at the micro-level. For example, studies could examine how being identified and managed as a 'mentally ill employee' influences individuals' experiences of their workplace and of social suffering. They could also investigate managers' responses to disclosures of mental illness and how their responses and actions affect mentally ill workers and the broader workplace environment. This would enable greater understanding of the uses, and limits to use, of discourses about mental illness to influence control dynamics and suffering in labour relationships.

Studies such as these could also enhance the utilisation and usefulness of LPT. More understanding of inter-relationships between conditions, power dynamics and experiences of mental illness in the workplace could enable greater examinations of the exploitative nature of capitalist labour processes by generating new generate [AQ: 12] new insights as to how employers attempt to control the labour process, how resist work arrangements that undermine mental health, and how the us and identities related to 'mental illness' does and does not work to influe relations. From this perspective, the dynamics of social suffering, exploitative practices and strategies of control and resistance that underpin the structured antagonism of the labour process may become easier to identify and connect. Greater consideration of these inter-relationships occurs and could even, eventually, justify a variation on the fourth leg of core LPT to recognise that the social relations between capital and labour in the workplace are of structured antagonism due to the dynamics of exploitation, control *and social suffering.* Social suffering also offers a useful concept for grounding normative pronouncements by labour process theorists. Social suffering can act as the ground for social and moral inquiry because of its demonstrable, palpable and embodied character (Kleinman and Wilkinson, 2016). It also has an embodied intensity that facilitates moral and political intervention. Thus, social suffering may provide a normative ground for evaluating the effects of 'mental health discourses' in the workplace, and give labour process analysis an even stronger normative intent.

AQ: 12
Please amend sentence so to read "by generating new insights as to how..."

The second opportunity is to leverage critical realist (CR) research approaches, which have established traditions in research examining labour processes and framed by social models of disability. CR perspectives provide a powerful conceptual framework for understanding deep and causal relationships and mechanisms, and their effect on social outcomes. CR takes the ontological position that entities are 'real' if they have a causal effect (Fleetwood, 2005), so must always be investigated in context because they influence people and events in interaction with other entities. These include socially real entities (e.g. social and organisational structures, forms of social stratification) and conceptually real entities (e.g. discourses, symbols, values) that influence people's lived experiences, behaviours, decisions and identities. In CR terms, the labour process is only *relatively* autonomous from broader social and economic arrangements and thus must be examined in that context (Edwards, 1990). Thus, CR examinations are particularly

appropriate for theorising about and researching links between intra-personal experiences of mental illness, higher-level factors such as inter-personal workplace relationships, organisational conditions, labour market characteristics, ~~and~~ regulatory environments, and societal discourses about mental illness. **[AQ: 13]**

CR perspectives also offer potential to generate more sophisticated u workplace experiences of mental illness because they 'allow[s] a perso illness to make sense of their biological experiences, while equally ack experience within a social domain' (Bergin et al., 2008: 175). Theories a do not acknowledge that 'some people experience severe pain and disco of disorganised thinking, racing thoughts, fixed paranoid delusions, ina thought processes or perceptions of external thought control . . . [are] increasingly irrelevant for many people experiencing serious mental distress' (Mulvaney, 2000: 591). Thus, CR approaches enable the development of accounts and explanations which may resonate more fully with people who experience mental illness in workplace settings, and those who contribute to such suffering.

AQ: 13
Please remove the highlighted 'and' to improve clarity of sentence.

Conclusion

Workplace conditions and experiences have profound and wide-ranging impacts on mental health. Understanding more specifically how they impact the experiences, social suffering and power dynamics associated with mental health creates the capacity for positive change on many levels. At the individual-level, it provides more understanding and empathy for individuals experiencing mental health issues and new ways to empower them to alleviate their social suffering. At the meso-level, it can shed new light onto opportunities to develop workplace cultures and social structures which contribute to psychosocial safety and provide social environments that positively influence and support mental health. At the macro-level, it can generate new directions for adapting social, economic and labour processes in ways that more positively influence mental health, workplace experiences, and work environments. Additionally, it creates new opportunities to synthesise insights from diverse bodies of knowledge about the relationships between work, workplaces and mental health to improve knowledge, research and work environments.

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