Exploring the Role of Employers and Managers in Supporting People with Long-Term Conditions in the Workplace

A thesis submitted to the University of Manchester for the degree of Doctor of Philosophy (PhD) in the Faculty of Medical and Human Sciences

2013

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<tr>
<td>CFS</td>
<td>Chronic Fatigue Syndrome</td>
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<tr>
<td>DDA</td>
<td>Disability Discrimination Act (UK)</td>
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<tr>
<td>DoH</td>
<td>Department of Health (UK)</td>
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<tr>
<td>DWP</td>
<td>Department for Work and Pensions (UK)</td>
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<tr>
<td>EI</td>
<td>Emotional Intelligence</td>
</tr>
<tr>
<td>ESA</td>
<td>Employment Support Allowance</td>
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<td>GP</td>
<td>General Practitioner (UK)</td>
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<td>GT</td>
<td>Grounded Theory</td>
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<tr>
<td>IM</td>
<td>Impression Management</td>
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<tr>
<td>IPS</td>
<td>Individual Placement and Support</td>
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<tr>
<td>LTC(s)</td>
<td>Long Term Condition(s)</td>
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<tr>
<td>MH</td>
<td>Mental Health</td>
</tr>
<tr>
<td>MIXED</td>
<td>Organisations with both manual and non-manual duties/workers</td>
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<tr>
<td>MSD</td>
<td>Musculoskeletal Disorder</td>
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<tr>
<td>NHS</td>
<td>National Health Service (UK)</td>
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<tr>
<td>ORG.</td>
<td>Organisation</td>
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<tr>
<td>RTW</td>
<td>Return to Work</td>
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<tr>
<td>SA</td>
<td>Situational Analysis (for Grounded Theory analysis)</td>
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<tr>
<td>SA</td>
<td>Sociological Ambivalence</td>
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<tr>
<td>SMEs</td>
<td>Small to Medium Enterprises</td>
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<td>UK</td>
<td>United Kingdom</td>
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<td>WCA</td>
<td>Work Capability Assessment</td>
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<td>WRAG</td>
<td>Work Related Activity Group</td>
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ABSTRACT

Background: Evidence from the employee perspective frequently suggests that unsupportive managerial relations present a considerable barrier to those with long-term health conditions (LTCs) both on their ability to sustain employment and manage their condition at work. However, little is empirically known about employers’ and managers’ experiences of supporting those with LTCs, or indeed about their perception of their supportive role in the social context of the workplace on which employees suggest they depend for workplace success. This presents a disparity in understanding the contribution of the management role in influencing the (re)entry process to employment for those with LTCs. This is important to explore in light of ongoing objectives by the UK Government to move people with LTCs off incapacity benefits and back into the labour force, as any successful return to work will largely be influenced by employers’ and managers’ readiness to support them.

Method: A qualitative approach informed by Grounded Theory principles to guide data collection and analysis was taken for this 3½ year study (September 2009 to March 2013). 40 semi-structured in-depth interviews were conducted with employers and managers from a range of organisations in the North West of England and analysed thematically. Findings were interpreted in relation to a framework of sociological theories of emotion and work.

Results: Regardless of industry type, sector and size or condition, several themes emerged which contributed to a sense of burden and tension for participants in supporting those with LTCs. These included discerning legitimacy and tangibility of conditions, having difficult conversations with employees and the influence of the employees’ personality on support. More significantly, all bar one participant typified their role as one of a difficult ‘balancing’ act of additional and often incompatible demands, pressures and feelings arising from managing a complex and emotive situation many considered non-normative to their everyday role. This was typified by feelings of conflict and emotional discomfort, interpreted as ambivalence, stemming from contradictions between and within the normative expectations of their social roles and appropriate feeling rules. For example between the obligations of the professional ‘public’ managerial role in providing value to the organisation, and philanthropic concerns for the welfare of the employee concomitant with their personal ‘private’ role as an individual. Interpreted from a combination of both spoken word and ‘unsaid’ gestures, is the emotion management conducted by managers to cope with negative feelings of ambivalence in a culture which favours rationality over emotionality.

Conclusion: Overall, findings indicate that participants in this study concur with the employees’ perspective as to the importance of socially supportive managerial relations. However, it is theorised that managing the emotions of ambivalence serves to undermine manager’s capacity to translate intention to provide support into tangible action, and hence is reflected in the employee’s perception of unsupportive relations. It is suggested that this research could be used to inform the development of a potential intervention to support managers in their pivotal role in the return-to-work process, being beneficial for all stakeholders - the Government, employees and employers alike.

The University of Manchester
Name: Donna Louise Bramwell
Degree Title: Doctor of Philosophy (PhD)
Thesis Title: Exploring the Role of Employers and Managers in Supporting People with Long-term Conditions in the Workplace
Date Submitted: 2013
DECLARATION

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ACKNOWLEDGEMENTS

‘A journey of a thousand miles begins with just one step...’
(Lao Tzu, 604 BC - 531 BC)

My PhD studentship began with just one step and has taken me on a journey of what seems like a thousand miles. It has been a long, hard journey and I am grateful to many who have helped me along the way and provided support through thick - and mostly thin! Especially:-

- To my husband for all his support, I could not have done it without you. We have been on a journey together.
- My mum for being there for me and for very much appreciated childcare.
- To my children for putting up with an ‘absent’ mummy for the last few years. For letting me work when I should have been with them. I am sorry for all the disrupted holidays but short-term pain equals long-term gain...remember that for your own academic careers!
- To my best friend Den, who has kept me on the straight and narrow, who would not let me give up even when I was in the depths of despair. Her support has been unwavering and so has the reiki!
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- To Tracey and all the school mums, who have propped me up on many occasions.

I would also like to say special thanks to my supervisors Dr Caroline Sanders and Professor Anne Rogers for their invaluable support and advice over the past few years.

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Thank you Caroline for giving me that one step onto my journey of a thousand miles...
THE AUTHOR

I have come to academia late in life after completing a BA Hons in Psychology with Sociology in 2007 as a (very) mature student. Prior to this I have had a varied career in Human Resources and Management Development where I gained qualifications in Personnel Management and Business Studies. I have worked for various large organisations covering a range of industries including banking, finance, transport and most latterly for a large multi-national communications corporation where I was employed in European Marketing.

I also have three children, the youngest of whom arrived during the first year of my Undergrad Degree, which was an interesting challenge. Having children has lead me down the path of being involved with the NCT (National Childbirth Trust) and for many years I conducted voluntary work for the organisation, working for the benefit of new parents on a local level across Cheshire. This ultimately led to my volunteer work for the East Cheshire NHS Trust, Maternity Services Liaison Committee. This role involved responsibility to visit community Post Natal groups across the area to gather feedback and report on, new mothers experiences and perceptions of the maternity services provided by the Trust.

My undergraduate studies ignited a passion in Medical Sociology and spurred a personal interest in the intersection of the lived experiences of individuals, their health and the health care system. In particular, my interests in the sociology of health and illness encompass experiences of long-term conditions, the patient-practitioner relationship, health and the internet, and the self-management of illness in relation to both the health service and an individual's life circumstances. A personal motivation for this study is the passion to give individuals a voice in expressing their experiences with regard to health, work and wellbeing in today’s disquieting climate of austerity. I feel that my previous career alongside my voluntary work and interest in the sociology of health and illness therefore placed me in a good position to conduct this research.
CHAPTER 1: Introduction to Thesis

1.0 Introduction

The need to understand the role of employers and managers in supporting those with long-term conditions (LTCs) is important in the context of ongoing austerity measures introduced by the UK Government in 2010. Welfare policy objectives to get those with LTCs back into the labour force and off key incapacity benefits, signify that more people will be working whilst coping with a long-term condition (LTC) – and for longer. However, the successful retention and rehabilitation of those with LTCs in the workplace is essentially dependent upon the employers1 and managers who employ them, and on the capacity of those employers to be supportive. Given this, surprisingly little work has been conducted to date which explicitly explores this fundamental aspect of the ‘back to work’ journey. This is an interesting disparity given that there is an existing body of literature from the employee perspective which frequently cites the supportive nature of workplace relations as being influential in both enabling them to work and to manage their health condition at work (for example; Gallant, 2003; Lysaght and Larmour-Trode, 2008; Munir, Randall, Yarker, and Nielsen, 2009).

Amir, Strauser and Chan (2009; p74) encapsulate this dilemma by noting that the majority of the focus on rehabilitation, research or otherwise, is on the ‘supply-side’ i.e., from the point of view of the individual with the disability (p74), rather than examining the ‘demand characteristics’ i.e., the employer (p74). This limited perspective represents a vacuum in comprehending those characteristics from the demand-side which have the capacity to facilitate or hinder successful (re) entry into the workplace for those with a LTC.

Considering that people often do not work in isolation and that the success and meaningfulness of their working life with a chronic condition is contingent on practical and social support from other people in the working environment, this presents a limitation in understanding the wider picture. Indeed, it represents a

1 The word employer is used as an umbrella term throughout this thesis to define those companies where there are few or no layers of management within the company hierarchy, and where the employee directly reports to the company owner.
less than holistic view of the situation which is important to ascertain for all
stakeholders concerned – the Government, the employee, the employer alike – in
achieving a successful employment outcome. Barnes and Mercer (2005) argue
that this holism is necessary to overcome traditional perceptions of work for
those with a disability, which perpetuate disadvantage for disabled workers in
mainstream employment. This is echoed by Lewis, Dobbs and Biddle (2013) in
their qualitative review of the UK Government’s WORKSTEP programme, in
which they cannot stress enough, ‘the wider message that both demand-side and
supply-side issues matter profoundly in disability and employment’ (p13).

As a step towards holism, this thesis therefore presents an examination of 40
employers’ and managers’ experiences and perceptions of managing those with
a LTC, focusing on the social context of working relations, which employees
suggest is critical to a successful working life with a LTC. Whilst it is widely
acknowledged that work is good for your health and wellbeing, it is important to
explore how this can be achieved for those with LTCs from the employer’s and
manager’s perspective, as any successful return to work will be largely
influenced by their readiness to support such an employee.

1.0.1 Definition of Long-Term Condition(s)

In defining the term LTC used for this research and for the purposes of this
thesis, it is noted that the terms LTC, chronic illness and disability are often used
interchangeably. Whilst there appears to be no one unified amalgamation of the
meaning of the terms, current definitions are conceptualised around the chronic
(longer-term) nature of certain conditions. For example, the Department of
Health (DoH, 2010, p4) in the UK define a LTC as ‘a condition that cannot, at
present be cured; but can be controlled by medication and other therapies’.
Conditions are taken to mean illness or disabilities which alter an individual’s
state of health and wellbeing (Blaxter, 2010). The DoH (2010) gives examples
of LTCs as heart disease, stroke, severe mental health conditions, epilepsy,
arthritis, chronic obstructive pulmonary disease and diabetes (not exhaustive).

Moreover, under the UK Disability Discrimination Act 1995 and latterly the
Equality Act 2010, a person is deemed to have a disability if they ‘have a
physical or mental impairment that has a ‘substantial’ and ‘long-term’ negative
effect on their ability to do normal daily activities.’ (OPSI, 2010, p4). In this instance substantial is defined as more than minor or trivial and ‘long-term’ is defined as being over 12 months or more. By implication, this definition of disability therefore encompasses certain LTCs captured under the DoH (2010) definition above.

It is apparent from these definitions that clarification is required between what it means for an individual to have a LTC and/or a disability and which is the most appropriate definition/terminology to be associated with their health and wellbeing – which is outside of the scope of this thesis. Therefore in the absence of a unified definition, the term LTC was used as an overarching concept in this research and throughout this thesis to encompass conditions (or illness however defined) and disabilities that would fall under both of the above definitions. It does not include those conditions (or illnesses) that are considered to be acute or of short term in duration such as the common cold.

1.1 **Context and Justification for the Research**

Changes to the UK medical certification ‘sick note’ legislation combined with a re-focussing of the social contract of the UK welfare state from being a ‘crutch to a ladder’ (Department for Work and Pensions (DWP), 2005, p3), in terms of the payment of key out of work benefits, signify a major change to the way health, work and wellbeing is conceptualised in the UK (see Chapter 2 of this thesis). Suffice to say, this highly controversial period of policy change – where cuts to welfare and a media perpetuated ‘scrounger’ rhetoric are considered particularly punitive for disabled people (Jolly, 2013) - provides an important back-drop to this study, and underpins the relevance of this work in the current climate of austerity.

There is a clear shift away from traditional notions of illness and work, where previously individuals were discouraged from working when ill, to now being actively encouraged to continue where possible (Department of Health (DoH), 2008, Dame Carol Black Report). Combined with the estimates that by 2025, the lives of over 18 million people will be affected by long-standing illness (DoH, 2010), and that nearly a third of all lost working time is attributable to
chronic conditions, it is indubitable that more people are, and will be, working whilst coping with a chronic condition (DoH, 2008).

Moreover, there is ongoing focus on self-care for management of LTCs in the National Health Service (DoH, 2005a) whereby individuals are encouraged to play an active role in managing their own symptoms to improve quality of life. The emphasis on empowering individuals to self-manage LTCs in their daily lives must also by implication, include managing their condition at work. For those re-entering the workforce after a period of worklessness or for those new to the labour market, this will be a daunting prospect.

However, while it is widely acknowledged that work is good for your health and wellbeing and that being employed is the desired outcome for all stakeholders concerned; the individual, the employer and the Government alike (Waddell and Burton, 2006) it must be questioned at what cost? The push for employment raises a concern that individuals with a LTC will be placed in jobs that are inappropriate for their circumstance, neither suit their expectations or skills (Riach and Loretto, 2009), or that they may have to remain in unsuitable positions. Thereby risking further damage to health status or an unnecessary slide towards the ‘revolving door’ (Bevan, 2010a, p1) of work and welfare, counter to government aims.

In addressing this situation, it is desirable to understand all stakeholders’ perspectives of the role of work. However, current research is weighted on the side of employees (Chan, Strauser, Gervey and Lee, 2010), so the significance of work for employees with LTCs and the situational barriers/facilitators they face in the workplace have already been explored. In contrast, there is a dearth of qualitative literature exploring employers’ and managers’ experiences and perceptions of managing chronic illness at work, and more specifically the social context of the work environment that adds to, or detracts from, support for employees managing a chronic condition. Further, Cartwright and Holmes (2006) suggest that the social aspect of working life is often overlooked by employers, who perceive their role as providing employment and nothing more.
The importance of this study therefore lies in exploring the social significance of the supportive role of employers and managers in managing LTCs in the workplace. As Munir, Leka and Griffiths (2005a, p1404) contend:

'successful management of chronic illness is associated with receiving practical and social support specific to the illness - this can only happen in the workplace if the provider of the support - the employer, is in possession of how the chronic illness affects the employee at work'.

Ascertaining all stakeholders’ perspectives to ensure successful, productive retention and rehabilitation of individuals in the labour force may be mutually beneficial on many levels, not least from a long-term health and economic perspective. In this respect, economic and financial gain is beneficial for the employee (through receipt of payment for their work), the government through prevention of unnecessary claims for incapacity benefit, and organisations through improved sickness absence levels.

1.2 **Aims of Research**

The primary objective of this research is to explore employers’ and managers’ views and experiences of supporting employees with LTCs in the workplace. Previous research from the employee’s perspective suggests that a successful working experience is defined by the ability to return to, and remain in, work whilst coping with a LTC (e.g. Westmorland, Williams, Strong and Arnold, 2001; Lysaght et al, 2008; Munir et al, 2009; Yarker, Munir, Bains, Kalawsky, Haslam, 2010). Further, employee research identified those circumstances which facilitate or hinder this successful outcome, such as line manager/employer attitude, communication and social support. This study therefore aims to contribute to understandings of the influence of the management role in enabling employees with LTCs to be recruited into and retained in the work force and will:

1. Explore employers’ views and experiences of employing and/or working with individuals with LTCs, and perceived barriers and enablers to successful working.

2. Compare and contrast how management and views vary according to illness type (e.g. cancer versus back-pain), across occupational hierarchies (e.g. manual/ non-manual) and sectors (e.g. private/ public).
3. Explore how occupational status and sickness absence management policies influence the management of LTCs and how these in turn shape workplace relations.

To fulfil the aims of the research, the study sought to answer the following questions:

1. What are the experiences and perceptions of employers of people with long-term conditions in the workplace and how do these shape the working environment, workplace relationships, and the management of sickness absence?

2. How do employers view the working experience for those managing a LTC?

3. How do employers’ experiences and perceptions of illness vary according to occupational status, type, size and nature of industry and organisation?

1.3 **Thesis Structure**

This thesis presents a qualitative study informed by Grounded Theory (GT) principles and is structured so as to take the reader on a journey through the research process which is detailed in Figure 1: Thesis Outline, next page. Results from the study are presented in Chapters 5 and 6 and draw attention to how socio-emotional factors experienced by participants (employers and managers), influence the provision of social support for those with LTCs. This is discussed in Chapter 7, where findings of the study are interpreted with reference to existing literature and in relation to the theoretical framework presented in Chapter 3. Implications and proposed suggestions for further research are considered in Chapter 7, as are the strengths and limitations of the study. Finally, concluding comments with regard to the findings of this study are presented at the end of Chapter 7.
Chapter 1: Introduction

Presents the impetus for the study and central argument for the importance of understanding demand-side characteristics i.e., employers and managers voices, in the successful working experience of those with LTC’s. Presents the aims of the study and explains the structure of the thesis.

Chapter 2: Background

Positions the study in broader context. Presents the political agenda, LTC demographics, and work and wellbeing drivers underpinning the significance of the research. Discusses literature review findings and presents orientating concepts emergent from the grounded theory process. Emphasises the importance of socially supportive relations for employee’s with LTCs and provides evidence for central argument.

Chapter 3: Theoretical Framework

Details the extant sociological theories of emotion and work used to situate and interpret the findings of the study detailed in Chapters 5 and 6. This framework is integral to the development of overarching theory and discussion that follows (Chapter 7).

Chapter 4: Research Methodology & Methods

Details the philosophical and methodological positions underpinning the qualitative/GT approach to study design. Details data collection and analysis methods. Goes through results relating to GT coding stages, provides an explanation of how data was interpreted to generate substantive core categories. Presents two key categories which constitute the overarching theme of Balancing Differing Needs.

Chapter 5: Tightrope Walkers

Details second substantive category that participants experience external pressures and conflicts in response to balancing the demands of their professional ‘public’ role and the employee.

Chapter 6: Getting Personal

Details second substantive category that participants experience internal pressures and conflicts in response to balancing the personal interests and values of their ‘private’ individual social role in supporting employees with LTCs.

Chapter 7: Discussion – Theoretical Integration

Findings are interpreted and discussed with reference to the background literature detailed in Chapter 2 and the theoretical framework presented in Chapter 3. The finding that many participants experience feelings of emotional disquiet stemming from the conflicts between and within the demands of their public and private roles can be explained by Merton and Barber’s (1963) theory of Sociological Ambivalence, and Bolton’s (2005) typology of Emotion Management in the Workplace (which utilises Hochschild’s Feeling Rules (1983). The relevance and contribution of findings are discussed with reference to the research argument. Implications for all stakeholders; the employee, employers and UK Government alike are discussed, including suggestions for future research. Finally, strengths and limitations of the study are identified before concluding comments of the thesis are presented.

Chapter 7: Conclusion

Figure 1: Thesis Structure and Outline
CHAPTER 2: Welfare Reform, Health and the Social Context of Work

2.0 Introduction

In this Chapter I continue to contextualise and provide background to the study. As previously stated, this thesis is being written at a time when concerns surrounding the United Kingdom (UK) Government’s strategy to move people off incapacity benefits and into work are, and continue to be, highly controversial (Baumberg, 2011). This is significant in shaping the focus of the study, where political and conceptual changes relating to work and illness in the UK underpin the impetus for this research. I will present an overview of these changes in this Chapter, detailing the shift in focus from traditional notions of illness and work through to current conceptualisations of (in)capacity for work. This is placed in the context of the sociological and psychological meaning of work in everyday life outlined here. This will be elaborated further by including a brief consideration of who has responsibility for management of illness in the workplace and an overview of self-management of LTCs.

I will then go on to present findings from the initial literature review which led to identifying the research topic – that of the absence of the employers’ and managers’ voice in understanding what makes work ‘work’ for those with LTCs. In contrast, there is a wealth of literature detailing the employee experience of working with a LTC. This indentifies three frequently cited barriers to employment success with a LTC and which are attributable to the social context of work:- employer perceptions and discriminatory attitudes, issues around disclosure and stigma and most frequently, supportive relations - where positive and negative relations at work are influential in self-management of chronic conditions and retention in the labour force. The social context of work therefore provides the orientating concept for this study, presented at the end of this Chapter. This aspect of work has been little explored for those with LTCs from the perspective of those who employ and/or manage them.
2.1 The Meaning of Work

Why should we be concerned about work and wellbeing? What makes this research meaningful? Work is a fundamental aspect of human life daily life. For many, work whether paid or voluntary, formal or informal\(^2\), constitutes a significant proportion of daily life (Warr and Wall, 1975). One only has to think about the influence of work on one’s own life to understand its far reaching effects on lifestyle, housing, family, social networks, health and financial security for example.

Suffice to say, work is bound up with both individualist and societal creation of personal identity and social roles (Wolfensberger, 1998; and Parsons, 1951) in that people of working age tend to become known by the nature and type of work that they do (Jenkins, 1996). In this way, work can be viewed as a part of an individual’s identity (Roulstone, 2004) and is said to be one of the central defining aspects of them as a person (Noon and Blyton, 1997). Maytal and Peteet (2009) proffer that it could be said, ’what you do is who you are’ (p108). To think about the importance of work we only need to consider that one of the first questions asked in any initial encounter with a new person is...‘and what do you do?’

Work is often seen as a means to an end, exchanging labour to earn money for subsistence (Grint, 2005). Wresniewski, Dutton and Debebe (2003) suggest that individuals make sense of their work through the meaning ascribed to it by others, which is communicated via a process of ‘interpersonal cues’ (p95). Conversely, Strangleman (2012) taking a sociological perspective, claims that work no-longer shapes identity or holds meaning for people in an age of economic employment uncertainty. Nevertheless, work consumes not only time but physical and emotional energy (Blustein, 2008) and considering the proportion of daily life engaged in work, it is not surprising that work is ‘central to individual identity, social roles and social status’ (Waddell and Burton, 2006, p7). Consequently, much time has been invested in research around the impact of chronic illness diagnosis on self and identity throughout the lifecourse such as

\(^2\) For the purposes of this thesis a sociological definition of work will be used (Grint, 2005) whereby work is taken to mean formal ‘paid employment’ (p9). However, work can encompass non-formalised unpaid activity such as domestic duties and voluntary roles but this is not the focus of this thesis.
that of Charmaz (1995), Yoshida (1993) and Bury (1982). But it must be questioned, how does the importance of work translate in the context of coping with a LTC? In Grewal, Joy, Lewis, Swales and Woodfield’s (2002) study of disability in Britain, the majority of respondents felt that ‘being unable to work was a defining feature of being disabled’ (p159).

Unfortunately, the psychological and sociological importance of work is often overlooked in the routine of everyday life, despite, as Marmot, Siegrist and Theorell (2006, p101) observe, that ‘in adult life, employment and the quality of work define one of the most important psychosocial environments’. Current research suggests a positive correlation between employment, health, and wellbeing (Ross and Mirowsky, 1995) where specific research into the psychosocial work environment and its influence on health has been widely documented (e.g. Joyce, Critchley and Bambra, 2009). Related studies (i.e. Marmot, Stansfield, Patel, North, Head, Brunner, Feeney and Smith, 1991; Kuper and Marmot, 2003) have generally built on the findings of the 1967 Whitehall Studies which examined the working environment of civil servants to ascertain the socio-economic reasons for sickness absence. However, empirical evidence such as this concentrates on the causal affects of the work environment on health and well-being (i.e. from an occupational health perspective), rather than, as suggested earlier, examining the effects of the psychosocial work environment on someone working with an established illness.

One of the most comprehensive studies conducted into the psychosocial work environment is that of Waddell and Burton (2006) to inform the UK Government Health, Work and Wellbeing Strategy (DWP, 2005). Waddell and Burton examined the psychosocial aspect from the experience of working with or without a LTC, and concluded that work is good for health on many levels, including self worth, self-esteem, physical and mental well-being alongside being therapeutic, economically rewarding and ‘reducing the risk of long-term incapacity’ (p9). The relevance of this study therefore lies in exploring employers’ and managers’ perceptions of their role in providing a psychosocial work environment which is conducive to those with a LTC, thereby reducing the risk of long-term incapacity as posited by Waddell and Burton (2006).
2.2 **Policy, Politics and Health – A Time of Change**

2.2.1 **Health and Welfare**

To contextualise the salience and impetus for this research, it is pertinent to provide a little background to the demographic health of the nation and historical welfare reforms that underpin the drive for greater employment for those with LTCs.

Waddell and Burton’s (2006) study was conducted partly in response to the UK Government’s growing awareness of the rising incidence of chronic conditions occurring both nationally and globally (World Health Organisation (WHO), 2011). The realisation that the prevalence of LTCs in the UK is set to rise by 23% over the next 25 years (Black and Frost, 2011) due to a nation that is both ageing and growing\(^3\) has prompted Government action to mitigate the longer term economic impact to health, social and welfare provision.

The publication of the Government White Paper, Choosing Health: Making Healthy Choices Easier (DoH, 2004) led to the Government’s commitment to improving the health of the working age population through the Health, Work and Wellbeing Strategy (DWP, 2005) and from a health care perspective, the journey to understand LTCs and how best to improve lives (DoH, 2005b) had already started. However, given that it is estimated that by 2025 the lives of over 18 million people will be affected by long-standing illness (DoH, 2010), and that nearly a third (32%) of all lost working time is attributable to chronic conditions (CBI/Pfizer, 2011), it is clear that more people are and will be, managing their daily lives whilst coping with a LTC (DoH, 2008).

From an economic perspective, this is a concern for the UK Government where those of working age considered unfit to work are, in the majority of instances, eligible to claim for financial support from the State benefit system. The consequence of a nation living for longer with longer-term ill health therefore presents an unsustainable financial burden on the limited welfare budget through individual claims for financial assistance. The UK Government therefore recognised a need for an overhaul of the welfare benefits system to account for

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\(^3\) The GB median age is forecast to increase from 39.7 in 2010 to 42.2 in 2035 and the population to grow by over 10 million to 71.2 million by 2035 (Black and Frost, 2011).
the changing demographic landscape of the country. Acknowledging there are benefits to be had for both the individual as advocated by Waddell and Burton (2006), and the Government through lucrative cost savings to the welfare bill of moving people off incapacity benefits and into work.

2.2.2 Welfare Reform Pre-Austerity Measures (2010)

The drive to get people into work is not a new concept and people have always been incentivised to work by providing means tested benefits that would supplement income rather than replace it. This is especially relevant as social security benefit has evolved from initially providing financial protection for those unable to work due to industrial injury, to encompassing all citizens with some work limiting incapacity (Ford, 2008). However moves to get people back into work began in earnest under the direction of the Thatcher Government in the 1980s and 90s – again with the aim of reducing the welfare bill. In 1983 the responsibility for paying sickness benefit (or pay) was also passed over from the Government to employers for the first 28 weeks of absence, in an attempt to raise awareness of the cost benefit to employers (and the Government) of keeping people in work (Middleton, Brittain, Ashworth, Vincent, Walker, 1994).

A tougher stance towards eligibility for longer-term sickness benefit post 28 weeks was introduced by the incoming New Labour Government in the late 1990s, which also included more stringent assessment criteria for disability/LTC claimants through the introduction of welfare–to–work programmes. This was also in recognition that benefits were easy to get on but harder to get off. The foundations of this are rooted in an ideological shift of the original vision of the post-war social contract of the UK welfare state, in which the Government aimed to transform it from a ‘from a crutch into a ladder’ (DWP, 2005, p3), helping people help themselves to better social and economic lives.

Unfortunately, the implementation of new systems proved less successful in helping those with a disability/LTC into the labour market, prompting the Government to make further proposals for Welfare Reform. This included the

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4 According to the Financial Times Lexicon (2014, p1) the term ‘austerity measures’ refers to ‘official actions taken by the Government during a period of adverse economic conditions to reduce its budget deficit using a combination of spending cuts or tax rises’. The ‘Age of Austerity’ was a phrase coined by the UK Prime Minister, David Cameron (Summers, 2009, p1), to denote the period of fiscal restraint commencing in 2010 arising from these measures.
appointment of a Health, Work and Wellbeing Director (Dame Carol Black – see Section 2.2.4) to work in partnership with employers, General Practitioners (GPs) and employees to ‘deliver more effective rehabilitation’ (DWP, 2006, p6) and an overhaul of the incapacity benefit system to encourage and support those who are capable, into employment.

To this end, the Welfare Reform Act 2007 (Office for Public Sector Information (OPSI), 2007) and Government White Paper 2008 (DWP, 2008a) saw the introduction of revised assessment procedures for incapacity benefit claims, and from October 2008, new claimants are given Employment Support Allowance (ESA) if eligible. ESA is a two-tier system and benefits are paid according to whether there is some or no capability for work. These reforms have major implications for those claiming incapacity benefits, as payment of ESA is contingent on satisfying a medical Work Capability Assessment (WCA) (Directgov, 2010). Those (re)assessed as ‘fit to work’ are moved onto Job Seekers Allowance and expected to take the necessary steps towards employment. Individuals assessed as being unable to work are given unconditional support, those assessed as a having limited capability for work are placed in a work related activity group (WRAG) (OPSI, 2013) where work activity is expected given the right support. Those individuals currently claiming incapacity benefits will be moved over to ESA by 2014 (DWP, 2008a) with a further plan to move 1 million people off incapacity benefits and into the labour force by 2015 (DWP, 2008a).

2.2.3 Welfare Reform in Austerity (2010 - )

A change in the political climate since the start of the study has brought a subsequent air of urgency to the subject of disability/LTCs and work, in that objectives to reduce the amount paid out in incapacity benefit claims have been highly publicised as one of the incoming Coalition Government’s significant cost cutting measures in the age of austerity.

The cost benefits to the UK economy of moving people off incapacity benefits are substantial. Around 300,000 people per year fall out of work and into the benefits system due to ill health, which is considered unnecessary (DWP 2013a). The total cost of working age ill-health to the Government is over
£60 billion per year (benefit expenditure, lost tax revenue, NHS costs) with the current cost to the UK economy generally estimated at over £100bn per annum (Black and Frost, 2011). There are 131 million working days lost each year through sickness absence with an estimated cost to British employers of around £9 billion per annum (DWP, 2013b). Further, at the end of August 2012, 2.52 million people were claiming ESA/incapacity benefit or severe disablement allowance costing the State £13 billion per year (DWP, 2013c).

The desire to reduce these high costs (DWP, 2010a) saw the incoming Chancellor, George Osborne, look to immediately and significantly reduce the welfare bill (Porter, 2010), taking the controversial decision to accelerate the rate at which existing claimants of Incapacity Benefits were reassessed for ESA through the WCA as mentioned in 2.1.2. This ignited much panic for those with disabilities/LTCs, as the WCA assessment conducted by the private healthcare company ATOS, was already courted controversy prior to this decision (Kennedy, 2012).

2.2.3.1 The Work Capability Assessment (WCA)

The WCA has proved to be extremely controversial, with ATOS being criticised for conducting assessments that are medically unsound (Gentleman, 2013), giving pay-for-performance incentives to their employees for ‘fit-for-work’ assessments and for costing the UK economy £170m per annum (BBC News, 2013). A report published by the Citizens Advice Bureau Scotland (2010) is particularly critical of the government initiative, suggesting that the medical assessment system is ‘unfit for purpose’ (p1) leading to many thousands of genuinely, seriously ill and disabled individuals being pressurised to find work or risk losing benefits. Similarly the group ‘We are Spartacus’ (2012) have voiced concerns about the design and damaging impact of the WCA not taking into account certain conditions’ symptoms and the use of medication in the work context, a concern shared by the National Aids Trust (2010) who also point to the fluctuating nature of conditions such as HIV.

Disability Rights UK (2013) along with other specialist groups such as the Mental Health Foundation, MIND and the MS Society, also share the concern that in the push for employment, people will be expected to work when this is inappropriate. Raising concerns that individuals with a LTC will either be
placed in jobs that are inappropriate for their circumstances, neither suiting their expectations or skills (Riach and Loretto, 2009), or that they will have to remain in unsuitable positions. Thereby risking further damage to health status or an unnecessary slide towards the ‘revolving door’ (Bevan, 2010a, p1) of work and welfare, counter to government aims.

Professor Paul Gregg who designed the new system for re-assessing incapacity benefit claims has himself had to step into clarify the situation, suggesting that the Government exercise caution and implement the system as it is intended, to support people back into the work force, rather than hastily assessing people to reduce costs. Gregg (2010) argues that incapacity benefit reform will be undermined by this haste. Detrimentally leaving those with disabilities on the wrong type of benefit for longer and hence incurring further cost to the UK economy, whilst at the same time they will be receiving no specialist help in moving them nearer to the jobs market.

The Government’s keenness to reduce long-term worklessness and create a ‘welfare system for the 21st Century’ (DWP, 2010b) is therefore a topic of intense national interest. Recent figures suggest that following assessment, 52% of claimants who had completed the ESA claims process were medically assessed fit to work and no longer entitled to the benefit (DWP, 2013d) and a further 21% assessed as capable of working with help and support. This suggests that the bulk of claimants with some form of disability or LTC are therefore ready to enter the labour force and to work. The question is whether employers are ready to receive and support them, and under what circumstances.

2.2.4 The Dame Carol Black Report (2008)

The focus on assessing for fitness for work is part of a ground breaking cultural shift in the way that health, wellbeing and capacity in relation to employment is conceptualised in the UK. Recommended by the Health, Work and Wellbeing Co-ordinator following an examination of the health of the working age population (DoH, 2008), previously held notions of incapacity and illness in relation to work have been redefined to concentrate on capacity for work rather than incapacity. Black’s refocusing of traditional notions around illness and work replaces inability to work with ability to work, centring on what an
individual *can do* and in what capacity, rather than what they *cannot do*. Dame Carol Black’s vision is of ‘creating a society where the positive links between work and health are recognised by all, where health conditions and disabilities are not a bar to enjoying the benefits of work’ (DoH, 2008, p7).

The Dame Carol Black Report (DoH, 2008) is significant to this study in that the reshaping of perceptions of fitness for work signifies an enabling approach to employment, rather than equating LTC/disability as a permanent barrier to work. Indeed the Report led to an overhaul of the UK GP medical certification or ‘sick note system’ inline with this approach, prompting the introduction of the new GP Fit Note in April 2010 which details the employees’ capacity for work (DWP, 2009a). This heralds a new way of thinking for health practitioners, employees and employers alike, as traditional assumptions often equate symptoms and disability with incapacity for work, which is not necessarily the case (Waddell, 2006).

### 2.2.5 The Fit Note – ‘Sick but fit or fit but sick?’ (Pinder, 1996, p135)

Conventionally, matters of employment and illness in the UK meet the medical profession at the primary care level. It is generally the role of the GP to decide if an individual is well enough to work or should be issued with a medical certificate (or sick note) legitimising the sick role (Parsons, 1951), allowing time off work or placing them along the route of long-term sickness. Traditionally, the focus of medical certification of illness was centred on what an individual *could not do* with regard to capacity for work, or implied that they should not return to work until they are 100% fit (Sawney, 2002). The introduction of the ‘Fit Note’ system concentrates on getting people back into the workplace sooner, placing emphasis on early intervention, rather than encouraging patients to remain absent from the labour market, either short term or long term. As Black (DoH, 2008) points out, there is strong evidence that an extended period of absence is detrimental to the return to work process, as the

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5 Parsons (1951) concept of the sick role perceives illness as being deviant from an individuals normal functioning in society such that they are unable to perform or meet the responsibilities of their usual social roles. Individuals are given the right to be exempted from and withdraw from social responsibilities i.e., to assume the sick role, and are not to be blamed for their illness. However, legitimacy of their illness is dependent on meeting obligations to try and get well and to seek appropriate help from the medical profession.
longer an individual is off work the less likelihood there is of them returning. Figures show that for those out of work for 20 weeks or more the chance of them returning to their previous job is only 25%, ‘and worklessness comes at great personal and financial cost’ (Black and Frost, 2011, p7).

To address this phenomenon, the Black Report (DoH, 2008) also advocated the creation of an early intervention ‘Fit for Work Service’ (p72) based on the biopsychosocial model of disability, providing a multi-disciplinary, individually tailored approach to return to work. It is timely to note here that the move towards the biopsychosocial model of disability has also been another conceptual shift within the field. The World Health Organisation (2002) suggests there has been a paradigm shift from the purely medical model, to an integrated biopsychosocial model of human functioning and disability.

Traditionally, conceptions of chronic illness and disability have been informed from within the health issue or medical framework/model (Barnes and Mercer, 2003) and more latterly through the lens of the social model of disability. Conceptualised in 1983 by Michael Oliver, the social model of disability has been the key theoretical model upon which much research, discussion and government policy has been based. The model is primarily concerned with the construction of disability in society, and is informed by sociological theories of deviance (Merton, 1938; Parsons, 1951) in that inability is seen as not within ‘normal’ expectations of society. The model rejects the individualisation of disability, ‘it does not deny the problem of disability but locates it squarely within society’ (Oliver, 1996, p32).

However, Waddell (2006) advocates the merits of the biopsychosocial model over the medical and social models of disability such that it is individual-centred and acknowledges the biological, psychological and social dimensions that contribute to a health problem. Waddell suggests that a ‘lack of understanding of the contribution these factors make to incapacity, actually perpetuates illness and disability and impedes recovery and return to work’ (p37). The biopsychosocial model in relation to work (Figure 2) is particularly relevant for this research where employees suggest coping with a LTC is contingent on personal, social and situational (i.e., environmental adaptations) support in the workplace.
Figure 2: A biopsychosocial model of disability, with corresponding work related contexts
(Adapted from: Preventing incapacity in people with musculoskeletal disorders. Waddell, G. (2006, p58)

As Waddell (2006, p64) asserts, ‘biopsychosocial problems need biopsychosocial solutions.’ However the biopsychosocial model as classified by Waddell and Burton (2006) above, does not address the employer’s voice in rehabilitation interventions. It is generated from the employee’s requirements, but can these issues really be addressed without understanding employer’s perceptions and experiences?

Turning back to the Fit for Work service and the introduction of the Fit Note, there are those that discuss the adjudicating role of the GP in the recent reforms, which places increased responsibility onto them as gatekeepers of capacity and incapacity to work (Ford, Ford and Dowrick, 2000). In this respect, The Employers’ Forum on Disability (Government Select Committee for Work and Pensions, 2003) see the health service as a barrier for both employers and patients, suggesting that understanding the realities of work are outside of the role of GPs. This is echoed in an evaluation of the Fit Note system by the DWP (2012) which reported that employers believe GPs lack specialist knowledge about occupational health and ‘detailed information about job roles’ (p1). Suggesting that this hinders their provision of practical fitness for work advice for employees and hence their employers, with some advocating ‘more direct contact between employers and GP’ (p1). Riach and Loretto (2009) on the other hand perceive of the benefits of the re-conceptualisation away from inability,
suggesting it will help deconstruct discriminatory labelling, which currently constructs barriers to work and imposes identities around the notion of capability. The Fit Note system will get people back to work but will employees be perceived as sick-but-fit or fit-but-sick? (Pinder, 1996, p135).

The promotion of the early intervention approach towards avoiding long-term incapacity for work (Campbell, Wright, Moseley, Chilvers, Richards, Stabb, 2007), also denotes that employers and managers will be presented with new challenges with regard to managing sickness absence (see 2.2.6 below) and presenteeism\(^6\) for those with LTCs. Correspondingly, results of a survey of British employers published by the Human Resources Magazine (Woods, 2010) reported that they think the Fit Note will create more problems than it will solve, with only 22% of those surveyed believing that it will reduce sickness absence levels.

2.2.6 Sickness Absence Management and Patterning

Given the high cost to British employers, there is understandably a growing body of research discussing sickness absence and ways of tackling it in the workplace (Whitaker, 2001). Understanding sickness absence reasons and patterns at source can act as an early intervention mechanism in getting people back to work who might have otherwise slid towards long-term sickness (Shiels, Gabbay and Ford, 2004; Edwards and Gabbay, 2007). Figures suggest that sickness absence costs the British economy an estimated £15bn in lost economic output. In 2011, 131 million days were lost due to sickness absence (ONS, 2012), 30.4m days of which were estimated as being non-genuine in nature (CBI/Pfizer, 2011), with sickness absence levels higher for women than for men in both public and private sectors, although most absence is minor in nature and limited in duration such as cough, colds, gastrointestinal infections. Both work and non-work related mental health conditions such as stress and anxiety (CIPD, 2012), are most commonly identified as causing long-term absence, but cancer and chronic back pain are also important contributors.

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\(^6\) Dew and Taupo (2009) define the phenomenon of presenteeism as ‘workers turning up to work despite ill-health conditions’ (p1), going on to suggest that the reasoning behind it is multi-faceted, such as the belief in responsibility and moral obligation towards fellow workers, alongside financial and psychosocial implications.
To address these concerns, the Government have recently published their review and strategy for tackling high levels of sickness absence in the UK (DWP, 2013a) which recommends greater drivers and support for employers to keep people in work. This resonates with the fact that employers perceive that the most effective absence management policies are punitive, utilising disciplinary procedures and return to work interviews, but feel that the Government could do more to support them through improved partnerships with health professionals and GP's etc., (CBI/Pfizer, 2011). Casting a critical eye over the strategy (DWP, 2013a) it suggests that if the employment relationship is no longer working people should look for alternative suitable employment. However, this does not seem realistic given the current climate of high unemployment. This is especially relevant as noted by one GP when discussing the Fit Note system, that in a ‘quarter of the cases they see, poor relationships at work are behind the sickness absence’ (Bayley, 2013, p1). Improving relationships by understanding what influences support for LTCs at work may be more economically beneficial than going through work placement programmes or turning back to benefits – again counter to Government aims.

2.2.7 **Individual versus Collective Management of Illness**

Interestingly, Government intervention in tackling sickness absence in the UK prompts the question of who has the responsibility for ensuring health and wellbeing, self-management of chronic illness and adaptation in the work place – is it the individual or the organisation or even the Government? It is apparent in the literature, that there has been a strong shift in focus from collective (societal) consideration of disability in the workplace to understanding the requirements of the individual, commensurate with the biopsychosocial model of disability and illness, especially when addressing rehabilitation schemes and workplace interventions (e.g. Detaille, Haafkens and van Dijk, 2003; Gregg, 2008).

However focusing on the individual is counter to the UK Government's policy of Health and Wellbeing at Work (DWP, 2005), where the key themes are centred on stakeholder collaboration and collective management of health in the workplace along the lines of the social model of disability. This appears even more contradictory when welfare reform perpetuates individualism, both by
using the medical model to determine an individual’s functional capacity for work (Grover and Piggott, 2007) and, by providing support to individuals to overcome their limitations rather than looking at how their limitations can be facilitated in and by the labour market (Grover and Piggott, 2007). Further observed is the contradictory nature in which employers place the onus on employees to manage illness and to overcome negative pre-conceptions of LTCs (Chan et al, 2010), without necessarily acknowledging their own role in supporting personal illness management or in perpetuating discriminatory attitudes (Grover and Piggott, 2007). Sickness absence levels and turnover could possibly be reduced were this issue more explicitly understood by employers.

2.2.8 Self-Management of Chronic Illness and Work

Alongside the holistic context of support for LTCs, one of the fundamental notions underpinning this research is that of personal self-management of LTCs and adjustments to coping with a LTC on a daily basis (Lorig and Holman, 2003). There is a current focus on self-care for management of LTCs in the National Health Service (NHS) (DoH 2005c) whereby individuals are encouraged to play an active role in managing their own symptoms to improve quality of life. The emphasis on empowering individuals to self-manage LTCs in their daily lives must also, by implication, include managing their condition at work.

Again, this raises the question about individual versus collective management of illness in the workplace and the contradictory nature of messages stakeholders receive about this issue. It is one of the aims of this research to understand how the collective social ecological landscape of the workplace adds to, or detracts from, support for individual LTC management. Indeed, whilst research into self-management of chronic conditions grows, there appears to be little specific examination of the connection between the role of employment (social, personal and situational context) and self-management.

Townsend, Wyke and Hunt (2006) posit that employment is a helpful self-management strategy, indicating that the contextual negotiation of symptoms in daily life, building on the trajectory model as theorised by Corbin and Strauss.
is important to individuals in the preservation of identity and normality. Alternatively, Cunningham, Wolbert and Brockmeier (2000) suggest that, especially in the employment domain, gaining perspective on illness as one part of life, rather than the centre of it, and perhaps focusing on skills to manage coping with daily life with an illness, is more important than focusing on managing the illness itself.

Despite this, it is widely acknowledged that social support is a major influence in successful self-management of chronic conditions (Gallant, 2003) and that there is much to be gained by understanding the influence of an individual's social network in relation to self-management (Sanders and Rogers, 2008). However, it should be noted that social support is not confined to immediate social networks of friends and family which is a dominant focus of research (Vassilev, Rogers, Sanders, Kennedy, Blickem, Protheroe, Bower, Kirk, Chew-Graham and Morris, 2011). This is understandable given the proven influence of strong, proximal relationships (dyadic and otherwise) on individual health and self-care behaviour (Smith and Christakis, 2008). But work relationships, strong or weak, proximal or distal, are also pivotal to successful self-management of chronic conditions for individuals in the workplace (Gallant, Spitze and Prohasha, 2007; Munir, et al, 2005). This is therefore important to consider in light of the drive to move those with LTCs back into the labour force and off incapacity benefits.

### 2.3 Controversy, Politics and Media Criticism

However, all is not running smoothly with the introduction of the welfare initiatives under the ongoing period of austerity (post 2010) which, as acknowledged by the UK Government, have been ‘controversial from the outset’ (Kennedy, 2012, p1). Criticisms levelled at the Government over the introduction of welfare benefit changes and in particular the cultural shift towards ability rather than inability underpinning the ATOS medical WCA (see section 2.2.3.1) are being debated in a very public arena. The resulting media hyperbole on these changes and its effect for both potential employees with LTCs/disability and their employers, serves to reinforce the salience of this research as discussed below.
The consequence of widespread media coverage, whilst highlighting the plight of those on the receiving end of the benefit cuts, also serves to demonise them. As Jolly (2013) argues, austerity measures have not only been financially punitive for disabled people ‘but also socially as media representation of ‘scroungers’ and ‘skivers’ is increasingly synonymous with disability’ (p1). For example, in February 2012 The Sun Newspaper ran a ‘Beat the Cheat’ campaign to urge people to report those they believe are fraudulently claiming incapacity benefits. Therefore promoting the scrounger rhetoric, a term implying that there are those receiving benefits unnecessarily and ‘taking something for nothing’ from the economy. This was exacerbated by inflammatory media reporting of Prime Minister - David Cameron’s statement on the Welfare Reform Act 2012 (Number10.gov.uk, 2012) which aims to reduce those ‘who languish on the dole and dependency….marking the end of the culture that said a life on benefits was an acceptable alternative to work’ (p1).

Media narrative has seen negative discourse around the scrounger rhetoric therefore permeate British culture and language. A rise in hate crime against disabled people in the UK, thought to stem from negative perceptions and hostility towards those with LTCs and disability incited by the rhetoric, is being reported through major disability charities such as The MS Society, Scope and MIND (Walker, 2012). However, it is well known that many of those with a LTC/disability actively want to work (DWP, 2012) for all the psychosocial reasons outlined in 2.1 of this Chapter.

Given that many more individuals with a LTC/disability will be actively seeking work following their WCA, it is questioned if the rhetoric of ‘skivers’ and ‘scroungers’ will have a bearing on employers’ and managers’ attitudes towards, and perceptions of, those with a LTC/disability and therefore their role in supporting them in the workplace (Garthwaite, 2011). It is important that those with LTCs (re)entering the labour force are supported and welcomed into organisations because as Smith (1996) argues, the negative psychological and social effect of entering employment, to then leave shortly after due to a detrimental experience, could make individuals reluctant to try again - which is counter-productive for all stakeholders. Yet there is very little research available which examines this phenomenon from the perspective of those with the capacity to facilitate sustained employment (Gates, 2011).
With this in mind, I will now go on to provide a brief overview of the literature which demonstrates the perceived importance of the social context of work for employees with LTCs.

2.4 The Employee’s Perspective of Working with a LTC

Literature reviewed at the start of the study was based on the initial intent for the PhD project which was to explore the social significance of employment in contributing to, or detracting from, support for personal LTC management. Searching for literature was complicated by the variance in terminology used to describe LTCs. This was problematic when searching for relevant studies as, as previously noted, the terms LTC, chronic illness and disability are often used interchangeably. Consequently, the literature on employment and LTCs is to be found across a broad range of disciplines and as such it is not possible to comprehensively review this within this thesis. Hence, I will examine that which focuses on the barriers to work which are considered detrimental to a successful working life as perceived by employees with a LTC. This will illustrate the importance of the social context of work for employees and further demonstrates how the empirical focus of this research was orientated towards exploring the employers’ and managers’ perceptions and experiences of this phenomenon.

In general the literature broadly falls into condition specific examination of work for example, working with a condition such as multiple sclerosis (Messmer Uccelli, Specchia, Battaglia and Miller, 2009), diabetes (Detaille et al, 2003), asthma (Adams, Pill and Jones, 1997), low-back pain (Mitchell and MacDonald, 2009), rheumatoid arthritis (Lempp, Scott and Kingsley, 2006), and other conditions such as epilepsy (Jacoby, Gorry and Baker, 2005) and inflammatory bowel disease (Calsbeek, Rijken, Dekker and Berge Henegouwen, 2006).

There is a considerable body of literature focusing on mental health and musculoskeletal conditions (MSD) being the two main causes of sickness absence from work and on-flow to ESA in the UK (DWP, 2013c). Figures from the Department for Work and Pensions in February 2013 indicate that the

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7 As defined in Chapter 1 - Section 1.0.1 of this thesis.
number of ESA recipients claiming for conditions related to Mental and Behavioural Disorders were 45.5% of the total caseload of 1.6 million people, with claimants claiming for MSD constituting 14% of total caseload. Given the current emphasis on reducing the levels of sickness absence and incapacity claims for mental health conditions, there is a plethora of Government (Perkins, Farmer and Litchfield, 2009; DWP, 2012) and mental health organisation initiated research such as The Sainsbury Centre for Mental Health (2007), which aim to address the phenomenon.

It is also noted from the literature that research into how smaller companies tackle LTCs and sickness absence is generally lacking. Indeed, Graeme Henderson of the UK Department of Health stated during a seminar on work and wellbeing (PPE, 2010), that how sickness absence is dealt with in smaller to medium enterprises (SMEs) is the unknown, although SMEs employ over 13.7 million people and constitute over 99.9% of all UK enterprises (BIS, 2009). The North West Public Health Observatory (2009) similarly pick up on the issue for investigation, as evidence suggests that most progression to incapacity benefits is by individuals from smaller employers.

Interestingly there is a wealth of research from the Scandinavian countries and from the Netherlands, where there is a positive emphasis on employment of those with LTCs equating to high employment rates. The literature would suggest that this favourable emphasis is attributable to many factors, not least to governmental policy regarding discrimination and stricter sanctions than in UK law (Burstrom, Whitehead, Lindholm and Diderichson, 2000), but also to employer attitudes to employing people with illness and general societal attitude to marginalised groups. This more proactive stance, which is not necessarily part of the UK employment culture (Cunningham, James, and Dibben, 2004) has been noted, and researchers such as Gregg (2008) are using these examples to inform UK Government policy.

Another observation is the wealth of literature generated in the United States with regard to disability and employment. Again, much of this is attributable to governmental policy and the introduction of the American with Disabilities Act in 1990 (Lee, 1996). Whilst much of the American literature is relevant to UK employment culture with regard to rehabilitation and barriers to work, certain
socio-cultural aspects are inevitably not transferable to UK workplaces and this remains to be explored.

Three distinct themes ran through the literature covering what is known about working with a LTC. These were; barriers to successful working, issues around disclosure and stigma, and employer perceptions and discriminatory attitudes. Findings from the literature trended towards similarities in barriers across illness conditions, suggesting that although specific conditions tend to be heterogeneous, there are generic barriers applicable to all.

2.4.1 Barriers

It was noted that the literature examined illness and work through a negative lens, and it was felt that the negative undercurrent running through them was almost an expectation or hypothesis. Indeed Allaire, Li and LaValley (2003) in their examination of work barriers experienced by persons with arthritis, purposively recruited participants who had experienced problems or anticipated problems in the work environment. The majority of studies reviewed tended to examine the role of illness in employment experiences and predominately evaluated this in terms of ‘barriers’ to work, rather than examining the issue from the opposite perspective i.e. the role of employment in illness management.

This suggests that rather than seeing the person with an illness, as Cunningham et al (2000) found in their study of gaining and retaining employment with mental illness, the illness is seen as being the person. Cunningham et al (2000) go as far as to say, ‘if the person is the illness, where is there room to be a worker?’ (p492). A general observation of the literature reviewed would be the use of negative discourse surrounding disability and the word ‘barrier’, which implies negative connotations of work. In contrast, Waddell (2006) refers to obstacles to rehabilitation which has more positive connotations.

Barriers at work and to gaining employment were often expressed in terms of perceived versus actual barriers (Koletsi, Niersman, van Busschbach, Catty, Becker, Burns, Fioritti, Kalkan, Lauber, Rossler, Tomov, Wiersma, 2008) and material versus non-material (Baanders, Andries, Rijken and Dekker, 2001). A brief thematic analysis using these categories identified that material barriers are viewed in terms of adjustments to the working environment, such as furniture
modifications and job accommodations (Lacaille, White, Backman and Gignac, 2007), flexibility in working hours, changing job duties and using specialist equipment (Jackson, Furnham and Willen, 2000). Non-material barriers to work covered symptom management such as fatigue, pain, and those that ‘trespass on daily life’ (p125), as one respondent described the fatigue from nocturnal toilet use in inflammatory bowel disease (Calsbeek et al, 2006). They also covered inability to fulfil the requirements of the job (Jacobsen, 2001) and social challenges i.e. exclusion and relationships, resentment and tensions from colleagues (Barnes et al, 2005; Wilson-Kovač, Ryan, Haslam and Rabinovich, 2008).

Patel, Greasley, and Watson (2007) studying musculoskeletal conditions, found that respondents perceived barriers in returning to work due to physical pain, employers’ limited understanding and support, worry about letting employers and fellow workers down and unpredictability of symptoms. The thought of a perceived barrier is often very damaging, for example for those who meet with consistent barriers, work will become negatively associated therefore leading to negative expectations of work, and hence a possible downward spiral towards worklessness (Smith, 1996).

In UK Department of Work and Pension (DWP) studies into people claiming incapacity benefits (Grewal et al, 2007; Goldstone and Meager, 2002; Kemp and Davidson, 2008) respondents felt that their health condition was a major barrier in gaining or remaining in employment. Salway, Platt, Chowbey, Harris and Bayliss (2007) corroborate this finding, with respondents from a study into long-term ill health, ethnicity and poverty feeling that their illness prevented them from doing any kind of work. One respondent remarked, ‘I wouldn’t employ me!’ (p43).

In summary, the three most often cited barriers are:

- Unsupportive relations
- Issues around disclosure and stigma
- Employer perceptions and discriminatory attitudes
2.4.1.1 Unsupportive Relations

One of the most consistently mentioned barriers relates to the lack of social support and the importance of having a supportive working environment in order to remain employed. As previously discussed in Section 2.2.8, having a supportive environment is one of the fundamental contributors to successful self-management of LTCs (Gallant, 2003; Townsend et al, 2006). Employee’s with LTCs often stress that social relations are pivotal to the success of the return to work process and for subsequent sustained employment, such that support is at the heart of a successful working life for those with LTCs (e.g. Frieson, Yassi and Cooper, 2001; Lysaght et al 2008; Lysaght, Fabrigar, Larmour-Trode, Stewart and Friesen, 2012; Aas, Ellingsen, Lindoe, Moller, 2008). For workplace coping, social support, both outside and inside work (Roulstone, Gradwell, Price and Child, 2003), was considered essential to successful employment with a LTC.

Employees reported that support from managers and co-workers was one of the main enabling factors to work in a study of workers with rheumatoid arthritis, diabetes mellitus or hearing loss (Detaille et al, 2003), and that ‘to succeed with a disability you need support’ (Foster, 2007, p75). Interestingly, Kemp et al (2008) found that employees with mental health conditions were twice as likely to say their employer was unhelpful than were employees with a physical disability. This finding is supported by Glozier, Hough, Henderson and Holland-Elliott (2006) who concluded that co-worker attitudes towards nursing staff returning to work following psychiatric illness were ‘significantly more negative’ (p525) than those returning with diabetes. Glozier et al (2006) suggest that this is in part due to the potency of illness labels driving co-worker negative attitudes.

Koletsi et al (2008) attempted to identify the most effective components of IPS and Vocational Service schemes for a purposive sample of mental health patients. The resulting narratives highlighted that service users felt that significant barriers in being employed with a LTC were their worry of being unable to do the job properly or the fear that they may have problems with colleagues and employers. One patient mentioned that her ‘colleagues were harassing her and that her boss did not allow time off for sick leave’ (p966).
2.4.1.2 Disclosure and Stigma

‘Illness is at once both a very personal and a very public phenomenon’ (Nettleton, 2006: p72) – and in this sense disclosure, stigma and support are inextricably linked. Almost all the literature surveyed mentioned stigma and disclosure as an issue for those working with a LTC. Stigma, whether enacted or perceived (Goffman, 1968), is a significant barrier to work especially for those with mental health conditions (The Royal College of Psychiatrists, 2008; Sainsbury Centre for Mental Health, 2007; Scheid and Anderson, 1995).

Disclosure and stigma are bound up in almost all aspects of support for managing a LTC at work. The dilemma to disclose or not could mean the difference between getting support or not, but the decision to disclose is complex (Munir, Jones, Leka and Griffiths, 2005b). It is contextual and highly individual, requiring lengthy consideration of the benefits versus the problems, such as help with work tasks, flexibility and co-worker support (Gignac and Cao, 2009), negative impact on interpersonal relationships at work and loss of self-efficacy for example (Lacialle et al, 2007).

Jacoby et al (2005) make a worthy observation in relation to epilepsy in that there is almost an expectation of discrimination, an ascribed stigma. They make the point that the UK Disability Discrimination Act (DDA) encourages disclosure, however those who do disclose risk enacted stigma and discrimination. In essence, people with LTCs are ‘damned if they do, damned if they do not’ with regard to disclosure.

The literature also suggested that the decision to disclose is often driven by the visibility, or invisibility of symptoms. Vickers (1997) describes the traumatising conditions for those who are required to conceal their condition in the workplace until they are forced to disclose. However, given that this review has identified that social support is one of most important factors in successfully working with a LTC, there is ambiguity in how sufferers obtain this support if they conceal their illness. This is further contradicted by Grytten and Maeside’s (2006) study into the embodiment of multiple sclerosis and disclosure, which suggests that sufferers possibly chose to conceal their illness to ensure the continuance of social belonging.
However, the findings of Munir et al (2005b) into working with various conditions such as diabetes, asthma and heart disease do not support this argument, and it was found that disclosure was related to individual self-management strategies in that the importance of support from line management and co-workers overrode the need for preservation of image and identity. Special support and work dispensations for those with conditions which do not present outward symptoms, such as epilepsy and inflammatory bowel disease, may illicit strong reactions from co-workers who perceive that the individual is not ill. This returns us to the sick-but-fit or fit-but sick dilemma, the ramifications of which will become more prevalent as the new Fit Note system becomes widely used.

2.4.1.3 Employer Attitude and Discrimination

One of the prevailing themes running through the majority of the literature reviewed was the undercurrent of employer attitude. A frequently cited barrier to employment or difficulties with being employed was the attitude of others. Goldstone et al (2002) allude to the fact that there may be some measure of ‘political correctness’ in employer responses when questioned about their attitude towards, and policies for, recruitment and retention of employees with LTCs. This was evidenced through questions that elicited the contradictory nature between what employers would theoretically do when recruiting or attempting to retain an employee with a chronic illness, and what actually happens in practice. This is commensurate with the findings of (Unger, 2002) in a relatively comprehensive review of barriers to employment, which questioned company policies and experiences of employing people with LTCs or disability. Lee (1996) also questioned the continued hesitation of employers in recruiting disabled employees and looked to the reluctance of employers to make workplace adjustments and accommodations as a possible cause.

Again perceived versus actual discrimination is equally damaging. Grewal et al (2002) provide a detailed examination of discriminatory attitudes in a study of

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8 Definition of phrase ‘politically correct’ according to the Oxford English Dictionary Online (2013): ‘Conforming to a body of liberal or radical opinion, especially on social matters, usually characterised by the advocacy of approved causes or views, and often by the rejection of language, behaviour, etc., considered discriminatory or offensive.’
experiences of disability in Britain, and found that 38% of respondents felt that they had received unfair treatment from their employer and/or manager (p174). These findings are consistent with those of Patel et al (2007) into musculoskeletal pain, where patients felt that employers and co-workers have a negative attitude towards them, even before returning to work, and especially when the condition has no visible symptoms as discussed above.

Schur, Kruse, Blasi and Blanck (2009) point to company (corporate) culture and climate as being very influential on the disabled employee’s experience. This accords with the earlier findings of Wilson-Kovacs et al (2008), who describe the ‘under the radar’ (p451) organisational culture and behaviour with regard to discriminatory attitudes and practices encountered by disabled employees. This brings in theories of organisational behaviour where the normative effect of custom and practice and tradition dictate corporate culture in respect of informal, as opposed to formal behaviour (Dawson, 1996). The creation of attitudes and behaviour in the organisational environment can be viewed through the social constructionist lens (Harlan and Robert, 1998) whereby organisations absorb and reflect the culture of the larger society. This is a concern given the proliferation of the current scrounger rhetoric as discussed in Section 2.3. Following this train of thought, Wilson-Kovacs et al (2008), suggest that ‘work cultures can have deeply rooted prejudices’ (p713).

To a certain extent the UK Disability Discrimination Act (OPSI, 1995) provides legislative protection against discrimination in the employment market (Bambra, Whitehead and Hamilton, 2005) and was welcomed by disability activists, employers and employees alike. It is noted however, that there is a growing body of literature critically appraising the DDA, which suggests that it has yet to be effective in reducing discrimination and increasing employment rates for the disabled (Pope and Bambra, 2005; Roulstone, 2005; Jackson et al, 2000). Similarly, employer willingness to comply with the DDA is also questionable.

The Industrial Relations Society Annual Survey (IRS) (2009) found that many organisations are unwilling to make permanent job accommodations and, even more surprisingly, only 62.3% said they would observe the requirements of the Disability Discrimination Act (OPSI, 1995), in making reasonable adjustments (IRS, 2009). Jackson et al (2000) tend to imply that disabled persons will
continue to experience unequal and underemployment treatment in the workforce, due to prevailing employer attitudes towards employees with LTCs.

Following a study into institutionalised discrimination, Larwood, Gutek and Gattiker (1984) concluded that managers should take the lead in making non-discriminatory decisions so that others in the organisation will follow. Larwood et al (1984) call for managers to be rational in resisting outside influences and external pressure to discriminate. They argue that the cycle of institutional discrimination will be broken by resisting the desire to be seen to be fitting in with the desires of others within the organisation.

2.5 **Identifying the Gap: The Focus of the Research**

As evidenced, there are a wealth of studies that capture the employee’s experience and perspective of working with a LTC. Employers’ and managers’ experiences and perspectives are notable in their absence, as are the ways in which sickness absence and other related phenomena are dealt with in real life situations.

It is noted that there is a considerable bias in the literature therefore, by not including these perspectives. This disparity in the dyadic employee/employer relationship presents a limitation with regard to understanding the holistic experience of an individual in the workplace. Schur et al (2009) in the USA also note this gap in knowledge, and feel that marrying an examination of corporate culture to uncover unconscious assumptions and subtle organisational values with the lived experience of employees will unlock the door to understanding why disabled employees are successful in certain companies and not others. Stephan Bevan of the Work Foundation (2010b) in his review of inflammatory conditions such as psoriatic arthritis and work ability, implies that employers consider only the physical demands of the job that need to be met and overlook the psychosocial aspects of the return to work process.

The limitation most often expressed and identified in studies looking to improve the employability of those with LTCs is this need for holism. This requires demand-side or employer involvement and not sole concentration on ‘individual level factors and supply-side issues’ (Joyce, Smith, Henderson, Greig and Bambra, 2009, p7). Gewurtz and Kirsh’s (2009) meta-synthesis of disability in
the workplace highlights the need for further research into the employer’s and co-workers’ experiences and understanding of disability at work. Gewurtz et al (2009) also argue that there is a need to examine the role of organisational structure with regard to social relationships and the supportive environment in developing effective interventions in integrating people with disabilities in the workplace.

This review of the literature, whilst brief, uncovered some interesting limitations in the corpus of existing knowledge around the social context of work and the related barriers to employment suggested by those with LTCs. These are:-

2.5.1 Barrier: Unsupportive Relations

Given that the majority of literature cited social relations and the general social environment in the workplace as one of the most important factors in returning to and maintaining employment, there was little research which specifically examines employment experiences of support for self-management of chronic illness. This was neither from the manager’s or employer’s perspective, or indeed from within the framework of social support at work generally.

Research in this area has tended to be informed by the causal effects of work on health and the mediating effects of social support in buffering in-work issues known to cause health problems. Examples of this include the relationship between social support and stress, where stress has causal implications in the aetiology of cardiovascular disease (Johnson and Hall, 1993; Marmot et al, 1991).

This disparity presents a significant limitation with regard to understanding the holistic experience of an individual in the workplace. Townsend et al (2006) effusively argue for the social context of self-management, social support and its implications for self-management in daily life and it is widely understood that support increases coping ability (Gore, 1978). However, this poses the question of how employees are expected to adhere to the Governmental aim of increased self-care, when for the majority of their daily life they are not supported in doing so. This area is under researched, which coalesces with the majority of studies where participants suggest they feel they need employer and colleague support to be able to make work ‘work’ (see Section 24.1.1).
Taskila and Lindbohm’s (2007) study into the return to work of cancer survivors found that there was no research into social factors in the context of this condition, and little on employer interventions with regard to willingness to accommodate return to work. Taskila et al (2007) highlight the importance of social factors in the working environment but suggest that more research is required to understand their role as a significant factor in continued work ability. Similarly, qualitative studies specifically examining the meaning and type of social support in the workplace with regard to chronic illness are minimal. Those available have not accounted for perspectives from differing workplace relationships and/or environments, such as the distinction between formal and informal relationships i.e.; those with co-workers and supervisors/managers, which are prerequisites for job satisfaction (Ducharme and Martin, 2000).

The emphasis on social network support, both internal and external to work (Cohen, 2004), is essential for successful coping strategies but, whilst the positive aspects with regard to LTC management at work have already been noted, social relations can also be viewed as a barrier in small organisations (Eakin and MacEachen, 1998). This could be detrimental to health if employees feel they cannot, for moral reasons, ‘let the boss down’, or feel they cannot ask for work adjustments. Similarly if illness develops the transition to ‘problematising health’ (p905) from previously unconditional working relationships, could mean strained relations and an unpleasant working environment.

According to Eakin and Clarke (2003), the social ecology of small workplaces is much different to those encountered in larger organisations. Structurally there is insufficient bandwidth to move employees to different jobs should this be required. The nature of smaller organisations fosters more informal relationships (Eakin et al, 1998) such as those with line managers, and often promotes social closeness in the organisation.

Devins and Hogarth (2005) note that the entry period into employment, specifically the first couple of weeks, is the most critical for new recruits, especially for those with a background of long-term unemployment. They suggest that employers should focus more on retaining employees by improving the induction process once in situ rather than on the recruitment process itself.
Devins et al (2005) imply that employees are more likely to stay in a job if their employer is attentive and aware of their emotional needs, going extra lengths to smooth the transition into employment. Although it is commonly known that the longer an individual is absent from the work force the harder it is to re-enter it (DoH, 2004), this ideological stance must be contextually evaluated in light of both the nature and type of work and the illness.

Conversely, Eakin et al (2003) contest the notion that an early and safe return to work is psychologically beneficial for employees because of negative social experiences which ultimately contribute to the disability. However, Eakin et al’s (2003) study of workers in SMEs did not mention any underlying reasons for worklessness and it can only be assumed that the participating employers based their responses on healthy unemployed individuals. If this is the case, then improving the psychosocial element of the induction period will be doubly important for those entering work with a LTC.

However, Wilson-Kovacs et al (2008) posit that there is a lack of knowledge of chronic conditions by employers and human resource professionals. Commensurately, there is a need for employers to understand the concept of self-management. Indeed, from a study into the influence of employer support on employee management of chronic health conditions at work, Munir et al (2009) concluded that line managers play a pivotal role in self-care by providing direct support and increasing self-efficacy.

Nordqvist, Holmqvist and Alexanderson’s (2003) study into sick listed laypersons’ views of employers, suggests that employees perceive that social relations at work are one of the most important aspects of what keeps them in the workplace. Interestingly Nordqvist et al (2003) captured narratives which expressed the importance of a positive atmosphere in the working environment but that once a negative environment arose, it dominated and quickly became to be the norm. Respondents in the study talked about workplace atmosphere and the notion that when colleagues discuss negative comments or ideas, they then spiral into a general negative atmosphere. Berry and Meyer (1995) suggest that situational context is an important factor in workplace atmosphere. They proffer that the feeling of discomfort aroused when working with those with a disability,
especially conditions with visible symptoms, promote negative responses and attitudes which filter into the working environment.

Tarasuk and Eakin (1995) discuss the cynicism of co-workers and the limits to their patience over time after being initially supportive, taking on extra work tasks or helping more which is likely to invoke tension in the workplace. This is salient when examining issues of legitimacy of illness especially for conditions with medically undiagnosed symptoms or invisible symptoms (Vickers, 1997). Poon (2006) and Perlow and Weeks (2002) advance the notion that co-worker support is culturally specific such as in collectivist cultures, whilst Repetti and Cosmas (1991) refer to the gendered nature of workplace relations, suggesting that women are more influenced by social relations at work. Repetti et al (1991) also report that the quality of the relationship with supervisors rather than with co-workers is important to job satisfaction but that likewise, social relations within the common social environment at work were also an important determinant of job satisfaction.

The same point is made by Ahlstrom, Hagberg and Dellve (2013) in their study of Swedish women workers returning to work after a prolonged period of sickness absence. Sixty-five percent of their 349 participants were in some way dissatisfied with their employer’s efforts in helping them return to work. Thus, they found a direct correlation between work ability and socially supportive conditions in the workplace where socially supportive work environments increased job satisfaction, demonstrating the importance of supportive conditions at work.

2.5.2 **Barrier: Stigma and Disclosure**

The UK Government has recognised that one of the main underlying barriers to successful workplace integration is discrimination, characterized through stigma (Goffman, 1968). In their framework for mental health (DWP, 2009b) the Government outline various initiatives to overcome these issues such as raising awareness through mass media campaigns and strengthening anti-discrimination legislation. However, Beatty and Kirby (2006) in a discussion of how stigma influences workplace relations, argue that stigma ‘cannot simply be legislated away’ (p1).
For the majority of those with a LTC, evaluation by others - whether perceived or actual - is a bitter pill to swallow (Vickers, 1997), especially where underlying beliefs about sameness and difference (Roulstone, 2005) with regard to identity proliferate. Stories of legitimisation and credibility are pervasive and employees often feel that they have to ‘prove’ their illness (Beardwood, Kirsh and Clark, 2005, p33) to be believed. Employees interviewed by Beardwood et al (2005) returning to work following work related injury, sought to move beyond employer’s negative, stereotyped assumptions in supporting them to return to the workplace. Although in the reality of the workplace, Beardwood et al (2005) found that this was not practically experienced by employees.

Suffice to say, the moral dimension of illness and work with regard to disclosure is bound up in Parsonian notions of legitimising illness and the sick role (Parsons, 1951 – see footnote 3 this Chapter), and returns us to the sick-but-fit or fit-but sick dilemma (Pinder, 1996, p135 – see section 2.2.5 this Chapter).

2.5.3 Barrier: Employer Attitude and Discrimination

In their recent survey of the Government’s WORKSTEP programme which provides support into employment for those on long-term incapacity benefits, Purvis, Law and Lowrey (2010) report that many claimants had experienced discrimination and bullying in the ‘open’ employment market. Benoit, Jansson, Jansenberger and Philips (2012) large-scale study into the employment of Canadian blind persons points to a possible causation for this, concluding that employers’ attitudes and perceptions towards those with disabilities led to misconceptions about their abilities to perform jobs. This finding is interesting in light of current negative media portrayals discussed in 2.3 above, of those with LTCs/Disability in the UK, which may play a role in shaping stakeholders’ perspectives (Garthwaite, Bambra and Warren, 2013).

Cunningham et al (2004) in a study of the gap between employer policy and action, coalesces with previous studies from the employees point of view, which suggest that line managers lack knowledge and awareness of, and the skills to, deal with LTCs. Cunningham et al (2004) also found that line managers in their study were little aware of the mutual benefits to retaining an employee with a LTC in the workplace influenced by their concerns over the employee’s ability
to contribute to organisational objectives and effectiveness. Moreover, Tarasuk and Eakin (1995) found that damaged relationships at work through lack of manager and co-worker legitimisation of employee illness (resulting in the loss of a supportive and welcoming working environment), was detrimental to job security and impeded recovery and return to work.

Moral evaluation tends to underpin the perception and attitudes towards those who are employed and ill or have a disability in some way (Dodier, 1985; Wynne-Jones, Buck, Porteous, Cooper, Button, Main and Phillips, 2011), but the process of moral evaluation is often not explicit or influenced by the opinions of the medical profession. As Dodier (1985) points out, the moral position of the person with the illness is assigned by others in the organisation, which has a profound effect on continuing employment. Fevre, Robinson, Lewis and Jones (2013) clearly found this to be the case in their study of ill-treatment of employees with disabilities, rationalising that the stigmatising and discriminatory attitudes of line managers and supervisors made them responsible for the largest share of ill-treatment. This correlates to the nature of the socially supportive work environment, which directly affects those managing a LTC in the workplace (Wynne-Jones et al, 2011).

2.6 Theoretical Concept: The Social Context of Work and LTCs

As indicated in this Chapter, little research exists which explicitly explores the social meaning of work for employees, either health related or not, from the employers’ perspective. However, as evidenced, employees with chronic illness cite the importance of the social context of work as being influential in adding to, or detracting from, support for personal LTC management (Gallant, 2003). This is often conceptualised in terms of the supportive nature of workplace relationships, which can have both an ameliorative or detrimental effect on personal management of a LTCs and on successful work experiences. Cartwright (2010) in an exploratory study of NHS ward and facilities staff, found that the social meaning of work directly related to sickness absence levels and job satisfaction, where greater social meaning correlated to low-absence levels, positive psychological health and increased job satisfaction.
Social relations are also indicated as pivotal to the success of workplace rehabilitation for those with chronic conditions. As posited by Soklaridis, Ammendolia and Cassidy (2010) in a study of low back pain and return to work (RTW), the RTW process can be more successful and barriers removed if the ‘social context in which it occurs is taken into account’ (p1565). Tuljin, MacEachen and Ekberg (2009) suggest that tensions arise when there is a lack of communication and involvement of all workplace actors (colleagues, managers, occupational health etc.) in the RTW process which was also found by Soklaridis et al (2010). Aas et al (2008) go as far to say that ‘social support is crucial’ (p344) for those who are vulnerable returning to after long-term sick absence, further asserting that ‘social support might be the most important characteristic of a supervisor’ (p344). Jackson, Botelho, Welch, Joseph, Tennestedt (2012) attest to this, suggesting that talking with others about health conditions is an opportunity to gain emotional and instrumental support and help with symptom management, especially with stigmatising conditions such as urinary incontinence.

However, Wilson-Kovacs et al (2006) proffer that there is a lack of knowledge of LTCs by employers and human resource professionals. Indeed, Munir et al (2005a) argue that employers need to know how a chronic illness affects an employee in order for them to provide social and practical support specific to the illness in order to enable the employee to successfully manage their condition at work. There is also a need for employers to understand the concept of self-management. From a study into the influence of employer support on employee management of chronic health conditions at work, Munir et al (2009) concluded that line managers play a pivotal role in self-care by providing direct support and increasing self-efficacy. Despite this, Cunningham et al (2004) identified that there may be tensions at the micro-organisational level between disciplinary procedures and the desire of line management to be supportive and sympathetic. In essence, supervisors and line managers may wish to be supportive but are constrained by the disciplinary policies of the organisation. This leads to asking, how does this fit in with self-management, flexibility and necessary absence? This is a phenomenon which requires further research.
2.6.1 Employee-Employer/Manager Relations

Ultimately employees with LTCs are reliant on the goodwill of their employers and managers for fostering a socially supportive climate at work and for successful adjustments, which as Foster (2007) claims is a matter of ‘personal lottery’ (p79). However, it should be acknowledged that this is but one aspect of the management role which is by nature complex. It encompasses many tasks and is typified by the need to attend to many different situations and demands for example managing budgets and productivity, leading teams and projects - people management therefore being one amongst many (Peach-Martins, 2009). In this context it is easy to see that the social aspect of work may be over looked in favour of more pressing demands driven by the type of organisation and its structure. However, given that the line manager is, as the British Occupational Health Research Foundation (2013) suggest, ‘in a unique position to provide ongoing support to the employee through, and beyond, their return’ (p2) being crucial in the return to work process, little research exists which examines how this can be facilitated within their role. Indeed little is know about their role in the process in general.

This is echoed by Amir et al (2009) who identified emotional, personal and organisational concerns of line managers in their role as a supporter of employees returning to work after cancer. Suggesting that further research is required to explore stakeholder difficulties in the return to work process, where a smooth, stress free transition back into work is contingent on the employee and manager working effectively together. Higgins, O’Halloran and Porter (2012), following a systematic realist review of the management of long-term sickness absence, concluded that those responsible for managing sickness absence should consider contextual factors that might impact on interventions such as the ‘quality of relationships between managers and staff’ (p330). Waddell (2006) suggests that a ‘lack of understanding of the contribution these (psychosocial) factors make to incapacity, actually perpetuates illness and disability and impedes recovery and return to work’ (p37).

Bevan (2003) similarly believes that absence management and return-to-work processes are likely to be ineffective, no matter how well designed and managed they are, where line managers are ill equipped to support and manage
employees. This is counter to the aims of Government welfare reform and the suggestions of the Dame Carol Black Report (DoH, 2008), which are predicated on the migration of those with LTCs/Disability into a labour market that is ready to support them.

2.7 Chapter Summary

In this Chapter, I have outlined the key political drivers underpinning the study and contextualised the importance of work for those of working age at a time when concerns surrounding the UK Government’s strategy to move people off incapacity benefits and into work are highly controversial. I have presented the findings from a review of the existing literature which highlighted that there is wealth of research from the employee experience (supply-side) of working with a LTC. This literature identifies that the social context of work is pivotal to the successful retention and rehabilitation of those with LTCs in the workplace. Further, that it is conceptualised in terms of the ameliorative and/or detrimental nature of socially supportive workplace relations on the rehabilitative process.

However, employers’ and managers’ (demand-side) experiences and perspectives are notable in their absence (Amir et al, 2009), as are the ways in which sickness absence and other related phenomena are dealt with in real life situations. Given that employee research suggests that social support is at the heart of a successful working life for those with a LTC/disability, this represents a disparity in comprehending those aspects from the demand-side which have the capacity to facilitate or hinder successful (re)entry into the workplace. This is important in light of the re-conceptualisation of fitness for work in the UK and ongoing welfare reforms as described in this Chapter.

It is for this reason I have chosen to focus on this ‘gap’ and to explore the employer’s and manager’s role in supporting individuals with LTCs. The importance of this research therefore lies in understanding how LTCs are perceived and managed at work, again with the emphasis from the point of view of all parties concerned. Consultation with all stakeholders is important in increasing workplace social support which is critical to workplace rehabilitation (Hill, Lucy, Tyer and James, 2007) – and where the employer’s role is key (Waddell, Burton and Kendal, 2007). As Frank, Brooker, DeMaio, Kerr,
Maetzel, Shannon, Sullivan, Norman and Wells (1996; p67) assert, to make return to work policies and interventions successful it will require ‘all stakeholders on-side’. To do this however, there is a priority to understand where all stakeholders are coming from.

In the next Chapter I go on to outline the outcome of a return to the extant literature consistent with the concept of theoretical framework generation. This is commensurate with the methodological approach taken for this study which is informed by the principles of Grounded Theory.
CHAPTER 3: Theoretical Framework

3.0 Introduction

The background literature presented in the previous Chapter oriented this research towards exploring the social context of work, which employees suggest is pivotal to a successful working life while coping with a LTC. In this Chapter I present the sociological literature which forms the theoretical framework for the interpretation of findings of the study detailed in Chapters 5 and 6. This framework is integral to the advanced relational analysis, development of overarching theory and discussion that follows (Chapter 7) which is located in the social context of the workplace in supporting those with LTCs.

Conducting a study using elements of Grounded Theory (GT) methodology requires a dynamic process of bringing together a priori knowledge and knowledge gained by returning to the literature to discover extant theories about the evolving abstract theoretical concepts as they begin to take shape around the emergent substantive core categories (Charmaz, 2006). This Chapter therefore presents sociological theories of emotion and work which I use to situate and integrate the key emergent theme for this study, which is that managing those with a LTC incurs a socio-emotional consequence. In reflecting on this key theme in the literature, several theories of emotion and work (which take the perspective that emotion is relational, being the product of social interactions between individuals and ‘others’), became increasingly salient and have provided a useful conceptual framework for interpreting the key findings of this study. Two key theories have been drawn upon:


- Merton and Barber’s (1963) theory of Sociological Ambivalence
3.1 **Emotion in the Workplace**

Before going on to present workplace theories of emotion and those of work, emotion and health, it is firstly prudent to provide a brief introduction to the discipline of the sociology of emotions from which these theories stem.

3.1.1 **The Sociology of Emotions**

The subject of emotions has only been a substantive area of study in sociology for around 40 years, with 1975 being quoted by Kemper (1990) as the ‘watershed’ year for its advancement in the field. This latent sociological focus on emotions seems casual given that as Turner and Stets (2005) remark, emotions are viewed as pivotal to the viability of social and cultural structures, being the ‘glue’ that binds people together and upon which human beings are reliant to form social bonds (p1). Bendelow and Williams (1998) suggest that this neglect is rooted in dismissive Western thought around the view of emotions as ‘private irrational inner sensations’ (pxii) being the antithesis of scientific rationality. Although interestingly, this concept was discussed much earlier by the classical sociologist C. Wright Mills (1951) who was the first to comment on the socially structured nature of workers’ emotions in his observations of the plight of white-collar workers in middle-class America. Indeed Bendelow et al (1998) build on the tenet of Mills’ Sociological Imagination (1959) by further suggesting that emotion research provides a link between the personal and the wider social structure of ‘public issues’ (pxiv).

Research in this sub-discipline of sociology has since gathered momentum, with many theorists preferring to take a micro-level approach to studying emotional experience at the social psychological, social interactional level of the individual (Thoits, 1989) where emotions are the product of ‘social influences’ (p319). There is a less frequent approach to studying the macro/structural-level of emotional experience (Thoits, 1989) which focuses on the socio-cultural construction and dimensions of emotions (p334) as being more than ‘personal possessions’ (Middleton, 1989, p187).

Turner (2009, p343) suggests that sociological theories of emotion broadly fall into the following approaches; evolutionary/biological theories, symbolic interactionist theories, dramaturgical theories, ritual theories, power and status
theories, stratification theories, and exchange theories. Unfortunately there is no scope in this thesis to embellish these further other than to say that the dramaturgical approach introduced by Goffman (1959) is integral to Bolton’s (2005) Typology of Emotion Management in the Workplace described in Section 3.3 of this Chapter. Bolton’s work has been specifically chosen because it accounts for Goffman’s work on the micro-analysis of social interactions which draws on the analogy that the way people act, interact and present themselves in social life is akin to being on a stage complete with scripts, roles, and parts (Kivisto and Pittman, 2008), which is a useful concept by which to examine the interactive role of managers in providing social support.

Whilst there is now no shortage of emergent theory from the discipline it also follows that there is no shortage of the definition of the term – from either a sociological, biological or psychological perspective – and especially as there are over 600 words in the English language to describe emotions! For this study, Thamm’s (2007) sociological definition of emotion is used. Thamm (2007) suggests that emotions are an amalgamation of cognitive appraisal of a situation using the relevant socially pre-conditioned scripts with the social dimension. Emotions are therefore defined as ‘the process of actors appraising and responding to real or imagined focused social situations’ (Thamm, 2007, p16).

It is beyond the scope of this thesis to further detail how emotion is categorised from either a psychological, biological or a sociological perspective (Turner and Stets, 2007). Suffice to say that the absence or presence of emotion is dependent on social context and social structural conditions which Gordon (1990, p146) further defines as ‘persisting patterns of social relationships that instigate emotions’. As Layder (2004) notes, relationships by definition contain more than one person and that individuals are generally part of the wider social sphere. The implications of this being, Thamm (2007) asserts, that emotions are generated by the social structure of the context rather than the social context itself, which is particularly salient for this study. Further Bolton (2005) notes that, ‘emotions are social things and that humanity is expressed, shared and supported in a myriad of ways as part of the interaction order’ (p5). To this end, this is a relevant framework for considering the interactional struggles of employers’ and managers’ experienced as a consequence of the nature of their
role and the structural dynamics of the workplace, which is returned to in
Chapter 7 of this thesis.

3.1.2 Emotion in the Workplace - Returning to the Literature

In keeping with the ideology of grounded theory, extant theories were not
considered until iterative analysis and interpretation of the data was underway
and possible theoretical concepts had begun to emerge from the data. As will be
outlined in Chapter 4, these initially followed paths questioning empathy and the
nature of relationships at work before returning to see that participants were
really conveying their emotional difficulties in managing those with LTCs.

Literature from all disciplines was reviewed and considered as offering some
insights into the emotional landscape of the work environment. Again, as with
the initial literature review, the cross-disciplinary nature of the subject matter
presented a difficulty in searching for literature that links separate research on
health, emotions and work. It is therefore interesting to note that there appears
to be little interdisciplinary work in this area, a commonly observed
phenomenon. In their recent introduction to a special edition of the Journal of
Social and Personal Relationships on Health, Emotion and Relationships, Butler
and Sbarra (2013) liken this to a puzzle, suggesting that the pieces of which need
integrating at their intersections in order to advance the understanding of the
links between health, emotion and relationships.

With regard to theoretical perspectives, the literature highlighted that
perspectives of emotions lie broadly within the two spheres of psycho cognitive
and social sciences or as Lupton (1998) terms them; ‘emotions as inherent’ or
‘emotions as socially constructed’ (p10). I take a pragmatic approach to
acknowledging that emotions result from a combination of these (as per
Thamm’s (2007) definition) neurological cognitive functioning and socio-
cultural construction, but take a structuralist perspective of emotions for this
study as it is concerned with the social structural context in which emotions are
aroused and experienced, as mentioned above.
Sociological Theories of Emotion in the Workplace

The intersection of emotions and the workplace is of growing interest for sociological research and search terms in this area bring up a wealth of work from key thinkers in the field. Barbalet (2002, p8) posits that emotions deserve a sociological focus because ‘sociology attempts to explain social phenomena and emotion is a social phenomenon’.

Where once traditional organisational research tended to bypass emotional aspects of the workplace, focusing instead on the organisation as a dehumanised, lifeless static entity (examining production, labour processes, structure etc), later years have seen a shift toward researching those that ‘do’ or constitute these things i.e., the employees (including employers and managers). Acknowledging Fineman’s (2003) assertion that ‘all organisations are emotional arenas where feelings shape events, and events shape feelings’ (p1), there is a rising awareness that people are at the centre of organisations and that these people are not bland automatons to be observed and measured. Likewise, that with people come emotions which are at the very heart of workplace interactions and hence organisational success.

The rise in popularity of emotion research is due in part to the introduction of the concept of emotional intelligence (Goleman, 1996). Emotional Intelligence (EI) is defined by Goleman (1996) as a set of skills which focus the individual to awareness and understanding of emotions, thereby enabling them to harness this knowledge to enable them to use and manage emotions, and those of others, for their own/mutual benefit. This concept has been readily adopted in the corporate world, which has seen the value to organisations of ‘soft-skills’ for leadership, training and human resource management (Hughes, 2005). Further capitalising on the notion that ‘emotionally competent’ managers, as Goleman (1998) terms them, are more effective in achieving desired outcomes for the organisation than those who bring only hard, technical skills to the job.

It could be said that the majority of social science research on emotions in the workplace stems from Hochschild’s (1983) ground-breaking work on emotion management in customer service orientated organisations. Indeed Hochschild was in part responsible for the 1975 surge in emotion research as Kemper (1990)
alluded to and mentioned earlier. Laying down the gauntlet to the sociological world with a paper that took issue with the fact that sociologists had shied away from emotion research because emotions were perceived as neither rational nor measurable, Hochschild (1975) argued for this neglect to be rectified by suggesting that, ‘if we are to bring sociology closer to social reality, we will do it poorly if we close an eye to feeling. We must open the other eye and theoretically organise what we see.’ (p281).

To this end, Hochschild has had the most profound effect in bringing emotions back, not only to sociology but to the workplace. Her study of airline staff (1983) examining how flight attendants manage their emotions and feelings when dealing with customers, led to the notion that employee feelings can be and often are, commercialised for organisational gain. This in turn resulted in Hochschild devising the most influential theories in the field, those of feeling rules, emotional labour and emotion work as follows:-

3.1.3.1 Hochschild’s Feelings Rules and Emotional Labour

Hochschild (1983) coined the term feeling rules to define the concept of how people know what, for how long and which emotions they are supposed to feel, or should feel, in response to specific social situations, for example displaying the right emotion when hearing bad news or at a special occasion such as a wedding. Feeling rules, as explained by Lively (2007) ‘are socio-cultural norms that govern both the display and experience of emotion’ (p570). Elias (1994) postulates that feelings are communicated by cultural scripts which are determined by the structure of relations to others and by history.

Feeling rules, according to Hochschild (1983), are part of our private emotion system and guide our feelings appropriately in all social interactions. It is when there is incongruence between inappropriate (actual feeling) and appropriate (ideal feeling or what ought to be felt according to socio-cultural feeling rules), that individuals become conscious of the scripted nature of emotions. Further, according to Hochschild (1983), people engage in active management of their emotions so as to correspond to these norms and disparities by controlling what they display through surface acting and by manipulating their memories and thoughts through deep acting.
In the world of customer facing work, Hochschild (1983) posits that the private
world of feeling rules is brought into public life and used by organisations as a
commodity. Organisations have long since realised the benefits to their profit
margins of having friendly staff who can act as though the customer is ‘king’
(p86). Here, Hochschild (1983) coined the term ‘transmutation of the emotional
system’ (p19) to describe the ways that individuals suppress and manipulate their
personal private feelings acts into public feelings acts for the benefit of others,
for instance when being obliged to smile and respond positively to an awkward
customer.

In using their private emotional system individuals have agency over their
emotional display and/or resulting actions, bringing an element of evenness to
social exchanges with friends and family for example. However, in jobs
requiring customer contact, employees are often told how to feel and to express
their feelings by their organisation, requiring them to ‘act’ and respond to
customers in the ‘right’ prescribed way.

In this sense, social exchanges become unequal according to Hochschild (1983).
The customer can do or say what they like according to their own private feeling
rules, but the employee must use rules imposed by the company - which may or
may not accord with their primary socialised private feelings about their job, the
customer or the organisation. Fineman (2003, p20) suggests that emotional
work is the effort individuals put into making their feelings outwardly
acceptable to others by continually checking and scripting them. In essence
employees conduct emotional work to manage outward displays to customers –
suppressing and managing the private and public emotional systems so as to
provide service with a smile ‘from the inside out’ (p121) to the customer.

Hochschild (1983) terms this act of emotion management, conducted as part of
an individual’s paid job and commodified by the organisation, emotional labour.
Companies need employees to conduct emotional labour at work in order to get
the job done. In this respect, Hochschild also acknowledges that emotional
labour is not only the preserve of those who interact directly with customers but
that the concept is applicable to other areas of work and other
industry/organisation types, regardless of how commercialised they are (Brooks,
2009). The concept of emotional labour has spurred many questions for further
research, amongst them what are the psychosocial costs and consequences for employees of continually presenting authentic (self) versus inauthentic (self) displays of emotions? However, whilst Hochschild’s theories are enduring in the field, the very notion of emotions that are authentic and inauthentic to self has drawn criticism from those who argue, from the far end of the relativist spectrum, that self is a shifting concept (Gergen, 1991) being contextually determined by ‘specific social domains and relationships’ (Ashforth and Tomiuk, 2000, p184). This calls into question what Hochschild terms authentic emotions because feelings of authenticity are, from the social constructionist perspective, salient to the particular context and hence there is no fixed true self. Despite this as Hochschild (1983) points out, when the private emotional system is propelled into a commercial setting it is transmuted, successfully or not, into the public. Hochschild (1983) therefore observed that ‘a profit motive is slipped under acts of emotion management’ (p119) and in this situation, who benefits and who pays?

In conclusion, Weiss (2002) observes that in all the revived focus on research into emotions at work little attention has been paid to the causes of workplace emotional experiences. In completing this PhD study one of the causes (or antecedents) of emotional experiences at work has been identified. This is the emotion experienced by managers arising from supporting employees with a LTC – which is hitherto under researched. Further, as far as the author can ascertain, there is little published research in this area. Interestingly in a special edition of the journal Motivation and Emotions (2002) which included 6 articles on the topic of antecedents of emotional experiences at work, there was no mention, in any article, of employees or other persons’ health as being a possible antecedent.

### 3.1.4 Emotion in the Workplace and Health

To date existing research in this area is limited to the consequences of working with a health condition for the individual, or where work is a causal factor of ill health such as work related injury or stress. There is much work in the sociology of health and illness literature which examines the experiences of other peoples illness but from within proximal, intimate relationships, i.e., spousal experiences (Flor, Turk and Berndt Sholz, 1987; Radcliffe, Lowton and
Morgan, 2013; Ross and Mirowsky, 2013), or those of significant others such as family and friends (Richardson, Ong and Sim, 2007; Umberson and Montez, 2010). In contrast, there is a paucity of literature which examines the experiences of other people’s illness from within distal, instrumental relationships, such as those encountered in the workplace i.e. manager’s experiences of their employee’s illness.

Similarly the links between social support and health are well known, where supportive relationships have a positive (and potentially negative) influence on physical health and mortality outcomes (Berkman and Syme, 1979; House et al, 1988; Uchino, 2006). Again, most of this literature emphasizes the supportive nature of close strong social ties on health, such as those with intimate partners, where use of the term ‘relationship’ implies closeness. As shown by Uchino, Cawthorn, Smith, Light, McKenzie, Carlisle, Gunn, Birmingham and Bowen (2012) however in their study of social ties and quality of health, this is a matter of individual subjectivity where ambivalent relationships such as with those people considered friends but not in contact, can also be considered as close.

Building on the known benefits of social support to health, research into individuals’ social networks and their influences on health (Smith et al, 2008) and on capacity for self-care for LTCs, is on the ascendancy. In line with the UK Government’s policy agenda on LTCs (DoH, 2005b), attempts by Vassilev et al (2011) to understand the influence of the interrelations and diversity of an individuals broader social network in helping them to manage their condition, has identified that work colleagues are part of an individual’s Personal Community in providing support. However, to what extent /effect remains to be explored. Work in this area has notably highlighted the wider social context in which self-management of chronic conditions occurs and that a range of network ties (both strong and weak) are utilized in self-management work (Vassilev, Rogers, Blickem, Brooks, Kapadia, Kennedy, Sanders, Kirk and Reeves, 2013) and in health behaviour in general (Langlie, 1977). Certainly, a study by Munir et al in 2009 into the influence of employers support in self-management of conditions at work, found that managers have a direct role in better self-management, defining emotional and social support as integral to this.
Whilst many theorists mention the emotional consequences to self of living with chronic illness and discuss the emotion work that an individual conducts in outwardly managing the illness for both self and others (Bury, 1982; Yoshida, 1993, Charmaz, 2000; Sanders, Donovan and Dieppe, 2002), there was until recently, little academic or medical profession recognition of the emotional dimension of living with a LTC (Turner and Kelly, 2000). Freund (1990) has done much to bring health into the equation by ‘exploring the relevance of the sociology of emotions for the sociology of health and illness’ (p452). Suggesting that the connection is through the body where physical aspects of emotions (as well as the cognitive) and resultant health consequences, would be fertile ground for sociologists in the field of health and illness to explore.

Freund’s (1990) embodiment of emotions is a pervasive argument further embraced by Williams et al (1996) who view emotions as reconnecting the dualist Cartesian split between mind and body. Williams et al (1996) proffer their suggestion as a way to ‘rethink the biology/society relationship’ (p47). Moreover, Williams and Bendelow (1996) exhort emotions as the missing link in medical sociology, viewing them as ‘mediators of micro-macro relations’ (p47) because of their centrality to the individual experience of sickness and health. Unfortunately, as Francis (2007) observes, researchers in the field have yet to fully embrace the interactionist approach and study of emotions and health continues to follow the division. Studies tend to follow either the biomedical positivist route of psychology and health, or the social constructionist route examining the effects of emotion, usage, and social role in health related situations as outlined next.

What research exists in the field of emotions, employment and health focuses on the negative effect of emotional labour, emotion work and management, on individual employees’ health and wellbeing. Findings from these studies, predominantly examining service and customer facing occupations, look to the detrimental consequences of continuous emotional labour on health and wellbeing of the individual. Invariably, most of these studies concentrate on findings of burnout and stress on the individual. For example, Weinberg and Cooper (2007) discuss burnout in terms of the continuous emotional draining of individuals in occupations requiring a high level of contact with other people and their problems. Zapf (2002) alternatively points to the negative
psychological cost to employees of managing emotional dissonance, where the stress of conflicting emotions in dealing with others gives rise to emotional exhaustion and burnout. Conversely, Brotheridge and Grandy (2002) found that, whilst exhaustion and burnout was associated with surface acting, deep acting led to a positive feeling of personal accomplishment in a range of ‘people’ orientated jobs, such as nursing and human resources.

What is interesting is that emerging extant sociological concepts of emotions allied to illness in the workplace are minimal, where emotion work and managing emotions in the workplace have been little explored when the antecedent is other people’s health. What literature is available focuses on research between an individual employee of an organisation, usually in the public healthcare sector, and the emotion work conducted in the line of their duties as with paramedics and GPs (Meier, Back, and Morrison, 2001; Nettleton, Burrows and Watt, 2008; Williams, 2012) and nurses and health care assistants (James, 1992; Lee-Treeweek, 1997; Hayward and Tuckey, 2011; Smith, 1992; Gray, 2009; Bone 2002 and Bach, Kessler, Heron, 2012). Work has also been conducted in hospitality areas where employees must manage their emotions as the front line face to customers and clients, and where there is a financial consequence to the emotional labour for instance; fast-food workers (Talwar, 2002) and hotel workers (Fuller and Smith, 1991; JungHoon and Chihyung, 2012) and banking (Chau, Dahling, Levy and Diefendorff, 2009; Banks, Whelpley, Oh and Shin, 2012).

Beyond this, research into the individual experience of emotions and health at work concentrating on ‘emotions as distress’ or stress (Francis, 2006: p600) is plentiful. Again, it is outside the scope of this PhD thesis to detail this plethora of literature but as Francis (2006) points out ‘stress is not merely a biological function but is as a direct result of factors in an individual’s social environment’ (p600). Thoits (1990) notably suggests that stress arises from a discrepancy between an individual’s actual feelings and the feeling or normative rules of a situation, and that they seek to mitigate stress by managing their emotions or coping with them. It is from this context that sociologists tend to examine stress through the lens of coping and the resources to cope i.e., how people cope with stressful life events and what helps them to do this. Thoits (1986, 1995) is pivotal here in introducing to the field the concept of ‘emotion focused coping’
which as she asserts, is similar to the concept of emotion management, and that coping can be assisted by socio-emotional support. Thus it follows that Thoits work could provide an interactionist connection between the concepts of emotional labour/work in the workplace, emotional distress and ‘ultimately health’ (p604).

Finally, as the following separate Chapters from the Handbook of the Sociology of Emotions demonstrate; - Lively’s (2007) chapter on Emotions in the Workplace and Francis’s (2006) chapter on Emotions and Health – there is a disconnect between the two dimensions. Both chapters call for diversity, cross disciplinarity and to broaden the theoretical horizons beyond the overreliance on those theories well trodden such as Hochschild (1983). This notion is particularly interesting given that as Lyon (1996) comments, ‘feelings arise in the context of social relations’ (p70) and that emotion provides the link to health and the social world through the body. Yet the concept of health, emotions and the workplace or social-relational bases of illness as Lyon (1996) would suggest, have yet to be brought together and examined from the perspective of those supporting ‘other’s’ health in the workplace. As recently noted by Butler and Sbarra (2013), research into the interplay between emotions, health and relationships is diverse, scant and lacking, and is ripe for challenging.

3.1.5 **Emotions and the Role of the Manager**

The fact that there is little research into managers’ and employers’ health associated emotions in the workplace is not surprising given that the conventional perception of managers is that they are, by virtue of their role, rational and emotionally distant (Sachs and Blackmore, 1998). This is an interesting dichotomy given that the purpose of their role is generally to manage others for the benefit of the organisation and as Burkitt (1997) postulates, ‘emotions are to do with the social relations and interdependencies between people’ (p52). Where are their emotions therefore? For this reason, it is pertinent to briefly mention currently held ideas about emotions in the management role because managers rely on social relations with others, both within and without the workplace. If emotions are generated through social interactions, then it stands to reason that employers and managers will
experience emotions evoked in response to illness of those within that relationship.

Nevertheless, the traditional conceptualisation of the managerial role is one in which emotionality is eschewed in favour of rationality, where emotionality is seen as anathema to ‘clear headed decision making’ (Hughes, 2005, p604). Although this is potentially a myth in itself as Flam (2002) argues, because making decisions inherently involves making choices which are informed by emotions that aid decision-making. The emphasis on rationality equates to the tight control of managers’ emotions in the workplace, which if incorrectly expressed are considered deviant from normative expectations (Ashforth and Humphrey, 1995). Indeed, emotions have traditionally been considered outside of the expected behaviour patterns associated with the manager’s role, where the sociological definition of role encompasses the expected behaviour patterns, characteristics and identities associated with a particular status (Biddle, 1986).

Parsons (1951) noted that in the course of their duties, professionals need to maintain affective neutrality by not letting feelings show or letting them interfere with ‘the way they carry out their duties’ (p307). This was specifically advocated for the doctor/patient relationship and the obvious sensitivities involved in the medical encounter, although this has now come to embody the meaning of professionalism (Friedson, 1970) across all professions. Nettleton et al (2008) illuminate this concept from a study of GP feelings towards treating patients which found they are expected to conduct their role with ‘professional rationality that eschews feelings, emotions and sentimentality’ (p19).

Ashforth and Humphrey (1995), in their reappraisal of emotions in the workplace, write that rationality was advocated in organisations to defend against the ‘perceived dysfunction and pejorative connotations of emotions’ (p101). The seeds of this were articulated by Weber in 1968, who put forth the notion of ‘rational legal bureaucracy’ (p975), suggesting that organisations are more successful if they are dehumanised and emotional elements eliminated. Although this detrimental perspective of emotions and the over rationalisation of organisations is being challenged, especially with the proliferation of Emotional Intelligence into managerial discourse as mentioned earlier in this Chapter, Brotheridge and Lee (2008) voice the concern that remnants of it still exist.
today. They suggest that in contemporary management ‘lore’ (p114) traditional views of the rational manager are still out there even though there is now growing awareness of emotions as integral to, and embedded in, organisational life.

Brotheridge and Lee (2008) also imply that in today’s organisation managers are expected to be able ‘to do it all’, to manage their emotions and those of others whilst maintaining relationships which are the foundation of managerial work. On the one hand, managers have a responsibility to act ‘as agents of the employer who are accountable for the performance of the workers they manage’ (Bellaby, 1990, p48), and retain authoritative control over employees in order to achieve organisational goals and objectives. Whilst on the other, managers have a personal social role underpinned by their socio-cultural feeling’s rules which they bring to the workplace. And as Burkitt (1997) points out, emotions are at the heart of all working relationships and relationships are essential to organisational success and hence are central to the managerial role.

To Waldron (2000) the fact that relationships at work ‘constitute a unique context for emotional experience’ (p65) provides a wealth of opportunity for further investigation, as is the emergent recognition of the importance of emotions in the managerial role – both as a consequence for themselves and those they manage. This includes moving beyond notions of the reciprocal nature of emotions as a commodity (outwith emotional labour) but applying the concept of emotion management in other contexts. Such as when supporting the health of employees, or experiencing ambivalent feelings arising from normative expectations of the management role. I therefore draw on the following theories which will explain my analytical evaluation of the concepts and locate my findings in current literature. To this end, extant theory which connects to the findings of this study as presented in Chapters 5 and 6 is outlined below.

### 3.2 Emotion Management in the Workplace - Bolton’s Typology

Devised in 2005, Bolton’s typology of Emotion Management in the Workplace provides an explanatory frame in which to situate the findings of this study. It is Bolton’s intention to put the subject of emotions back into the analysis of organisations and ‘place the actor as the central focus in an analysis of the
emotional organisation’ (p4). Bolton writes that organisations, especially those in the service sector, have fallen prey to Ritzer’s concept of McDonaldisation (1983). In this respect, suggesting that the mechanisation, routinisation and predictableness of work in customer facing sectors has led to the organisational control and ownership of employee emotions through the implementation of rules governing social interactions with customers. Consequently, organisationally dictated emotions are assuaged and personal, private feelings suppressed in pursuit of achieving company aims. However, as mentioned earlier, although there is growing recognition that ‘organisations do have feelings’ (Bolton, 2005, p45) and that they have ‘invited them in’ (p42), Bolton feels that the ‘iron cage’ (p42) of emotional control as she terms it, continues to remain. In this sense Bolton (2005) argues that essential elements of organisational life are missed when the public and private worlds of employees continue to be divided in this way or ignored as incompatible.

Bolton’s typology therefore merges these boundaries drawing on Goffman’s dramaturgical theory (1967) and Hochchild’s (1983) work on emotional labour. Hence creating a typology that marries the concept of employees as social actors who manage their interactions with others depending on the type of situation and situational rules (Goffman, 1967), and the notion that employees manage emotions according to public and private feelings rules (Hochschild, 1983).

Conscious that research into emotions in the workplace is keeping pace with the ‘rush to re-emotionalise organisations’ (p64), Bolton has identified that this is being done at the expense of conceptualising emotions and what their presence in organisations actually means. By this, she recognises that research has focused on notions of emotional work and labour in certain sectors and professions as discussed in section 3.1.4 of this Chapter. Correspondingly, Bolton (2005) has also recognised that organisations have capitalised on the benefits of harnessing emotion for commercial gain in keeping the ‘customer satisfied’ (p66), but that these concepts have not been examined and deconstructed in light of the ways employees and managers as social actors, distinctively control and direct emotions in the workplace. For Bolton, the

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9 Bolton uses the term ‘employees’ to mean all those working in an organisation and throughout the hierarchy, from shop floor through to managers’ and employers’ and also includes those in non-service sector organisations. Thus Bolton’s theory is applicable and can be applied to employers’ and managers’ experiences explored in this study.
emphasis is on employees as social beings and all that this entails and brings to the working environment. This includes the social interactedness of the public and private worlds of the employee, where the employee has individual agency over their emotions, emphasising that not all emotion is controlled by the organisation. Further, Bolton recognises that a sociological understanding of the ways in which emotions are ‘managed, governed and regulated’ (p64) in the workplace is required. This provided the impetus for her typology of organisational emotionality which distinguishes ‘four distinct types of emotion work/emotion management in the workplace’ (p91) and three broad sets of feelings rules utilised by employees in order to ‘affect varied performances’ (p93) as follows:-

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<th>Feeling Rules</th>
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<th>Associated Motivations</th>
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<td>Stability</td>
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<td>Stability</td>
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<th>Consequences</th>
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<td>Alienation</td>
<td>Professional</td>
<td>Stability</td>
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<td>Contradiction</td>
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<td>Resistance</td>
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Table 1: A Typology of Emotion Management in the Workplace (Adapted from Emotion Management in the Workplace, Bolton, S. (2005, p93))

Bolton (2005) places much importance on the motivations behind employees’ adoption, or not, of feeling rules and recognises that employees have their own distinct motivations for enacting feelings rules in certain ways. Further, Bolton notes that these are individual to both the employee and to each and every emotion management performance. From the typology it can be seen that
managers draw on professional, organisational and commercial codes of conduct, and social feeling rules in their interaction with others in the workplace.

3.2.1 **Pecuniary Emotion Management:**

(Formal Feeling Rules, secondary socialisation)
This concept is akin to Hochschild’s (1983) term of emotional labour where there is commercial use of emotions. Employees must be the outward face of the organisation, suppressing or inducing personal emotions during ‘people’ interactions which are considered instrumental and conducted for material gain, i.e. maintaining the job and earning money. Employees’ performances during interactions may appear cynical due to the limited scope and lack of autonomy in their ability to personalise social interactions, by having to comply with display rules as imposed on them by the organisation. Bolton suggests that employees may feel obligated and ‘absent of feeling’ when acting to portray the desirable corporate image.

3.2.2 **Prescriptive Emotion Management:**

(Formal Feeling Rules, secondary socialisation)
Again akin to Hochschild’s (1983) term of emotional labour/work where there is commercial use of emotions but not necessarily. Feeling rules are closely prescribed by the organisation and/or the profession to which the employee belongs (i.e. doctors, lawyers, accountants) but are not necessarily prescribed by the organisation for commercial gain, as in the public sector. Prescribed feeling rules can foster a sense of belonging and involvement, becoming the automatic norm by being embedded implicitly in corporate culture. Employees either embrace this for materialistic gain, i.e., promotion or cynically ‘play the game’ enough to maintain their job. Professional feeling rules can be connected to social statuses when people are motivated to live up to the image, status and identity associated with the job i.e., doctors, lawyers. Those in caring professions such as doctors, nurses may perform and display feeling rules sincerely, with altruistic or status motivations behind them.
3.2.3 *Presentational Emotion Management*:

(Informal Feeling Rules, primary socialisation)

Presentational emotion management accords to social feeling rules where emotion work is carried out in response to the rigours of organisational life. Feeling rules are not formalised by the organisation but form in the informal spaces of employee social interaction, such as in coffee breaks of informal chats, occurring ‘off stage’ as it were. Bolton (2005) suggests that these unmanaged (by organisational rules) spaces are formed in resistance to prescribed feeling rules and are spaces for ‘being human’ (p133). They are the social side of life, where people can be true to themselves. Feeling rules foster informal friendships for example, which provide informal ways of fitting into the organisation, maintain the interaction order and result in feelings of belonging and security for the employee. Employees have the capacity here to use social feeling rules to perform acts of sincerity, to provide comfort to colleagues or by allowing themselves to show a kindness to customers.

3.2.4 *Philanthropic Emotion Management*:

(Informal Feeling Rules, primary socialisation)

According to Bolton (2005), philanthropic emotion management requires conscious effort on the part of the employee, drawing on social feeling rules to altruistically give more. Agency is allowed therefore the employee can consciously choose to go beyond organisationally prescribed rules to offer a little bit more to the customer for example. Bolton suggests that this can be seen as giving a gift to others via a performance which is sincere and based on the employee’s authentic self. The giving and receiving of a sincere act of kindness or help (gift), serves to increase the employee’s sense of satisfaction in the role and reaffirm their sense of self against the backdrop of organisationally prescribed performances.

Bolton (2005) postulates from her typology that there is a consequence to the social world surrounding employees, arising from the impact to their sense of self and the presentation of self elicited by ‘the type of feeling rules and associated motivations.’ (p94). Given this, Bolton perceives that organisational actors are highly efficient in managing emotions ‘who are able to present themselves in the appropriate manner according to the often implicit rules of the
situation’ (p133). It could be questioned, if as Bolton suggests there is an impact upon self, what cost is incurred by managers through being highly efficient emotion managers acting in multi-faceted roles. This is particularly interesting in light of Bolton’s suggestion that the typology can be used to ‘highlight the blurring of boundaries, the blending of different roles and the contradictions this can bring to people’s lives’ (p101).

The presentational aspect of Bolton’s typology and the impact to self is heavily influenced by the theories of Goffman (1959, 1967). Goffman’s theory has relevance for this study and as such will be briefly presented here.

3.2.5 **Performance/Impression Management**

Goffman’s (1959) dramaturgical theory, upon which Bolton draws in the ‘performance’ category of her typology, is important for this study as will be illustrated in the results chapters and discussion for this thesis. In brief, Goffman’s (1959) ground breaking theory is based on the micro-sociological analysis of everyday face-to-face social interaction. Goffman compared social interactions to those of theatrical performances, seeing that at the micro-level of interaction, the ways in which people act, interact and present themselves can be likened to being on a stage complete with roles, scripts and parts. Kivisto and Pittman (2008) broaden this notion by explaining that Goffman used theatrical metaphors to explain how understandings of reality are created and sustained, ‘by people working individually and collectively to present a shared and unified image of that reality’ (p272). The strategic ways in which people present themselves (Stets and Turner, 2006), either to be an authentic reflection of the reality they want to portray, or stage managed to manipulate the impression of themselves to others and hence other’s perception of them, is therefore of central interest to Goffman’s (1959) theory.

Impression management (IM) according to Giddens (2009), is used to compel others to react in desired ways but which may or may not be consciously acted. Goffman (1959) suggests that impression management during interactional performances is used to maintain and create a desired perception of one’s self, both to self and the other interactants, and is seen as an attempt by the actor to have control over their ‘selves’ as well as an attempt to control and manage the
social encounter (Rosenberg and Turner, 1981). Further, Goffman aligns role based IM to different regions of the theatre. Performances are contingent on audience reaction, therefore front region performances are those that are ‘on-stage’ where a ‘front’ is performed for the audience. Alternatively back region or backstage, the performer prepares for the on-stage performance but also takes off their ‘character’ and relaxes those things normally kept in check during ‘on-stage’ performances (Giddens, 2009). In essence, how people act is very much dependent on the role they are playing at the time (Giddens, 2009).

Rosenberg and Turner (1981) in expounding Goffman’s (1959) work on self write that actors try to sustain a desired self in social encounters by controlling perceptions of and information about themselves, but further explain that the social interaction is open to disruption and misinterpretation. Goffman (1959) provides a link to emotions here by suggesting that those who deviate from the correct cultural script – or fail to abide by routine feeling rules during social interactions - will experience ‘self-based emotions like embarrassment’ (Boyns, 2007; p270). In this case the social encounter is subject to disruption and compromise, as are the selfhoods of the participating actors (Stets and Turner, 2007).

Hochschild (1983) further links Goffman’s (1959) ideas about selfhood to emotions. However, the notion of a core self which can be inauthentic and authentic, is contested by many sociologists as according to Chriss (2002, p68), Goffman ‘never really specified what it is’, rendering a weakness in his theory. And of course the existence of ‘self’ is much discussed in relative terms by those seeing it as purely as a social construction (Gergen, 1991). To take up Hochschild’s (1983) link is to specify authentic self (or true self as she terms it) as being deep inside oneself, accessible through deep acting, which induces feelings which are real and natural. There is no IM, performance is authentic and sincere, as are the associated feelings. In contrast, Hochschild (1983) would equate inauthentic self to ‘surface acting’ (p37), which requires manipulation of impression and the use of body language so as to outwardly appear to be feeling something that is not being truly felt, there is a pretence being enacted.

To conclude, Stets (2012, p331) aptly notes that for Hochschild ‘the true self” resides in being able to express impulsively what we are feeling. When people
inhibit their true feeling in the workplace they experience ambivalence and emotional dissonance. This can be theorised using the following socio-emotional theory.

3.3 **Sociological Ambivalence**

Merton and Barber’s (1963) theory of sociological ambivalence (SA) is particularly amenable to theorising the findings for this study. It has been chosen because it appears to be a useful conceptual theory with which to enrich Bolton’s Typology of Emotion Management. Whilst Bolton’s (2005) theory explains the types of emotion management conducted by employees, it does not currently account for a key theme in this study which is that participants also experience conflict and contradictions arising from what Bolton (2005) terms, the blending of different roles and boundaries as outlined in 3.2 above. Therefore, I searched for theory to explain conflict between roles such that it can augment Bolton’s (2005) theory in-line with the findings of this study, which is discussed in Chapter 7 of this thesis.

Merton and Barber (1963) were keen to move away from psychological theories of ambivalence and turned to establishing ambivalence as a sociological construct as being the ‘product of conflicting norms and counter-norms associated with particular social positions’ (Hillcoat-Nalletamby and Phillips, 2011, p203). However, the psychological dominance of all things emotional (Barbalet, 2002) has been hard to leave behind, where ambivalence (or emotional deviance) occurring as a product of conflicting emotions, has resulted in the construct being little used as a conceptual tool by contemporary sociologists (Hillcoat-Nalletamby et al, 2011).

As the complexity of Merton and Barber’s (1963) theory is too great to cover at length in this Chapter, a succinct definition and explanation is therefore provided. In brief the theory accounts for the relational way in which ambivalence is created through the differing social roles conducted by, and social positions held by human beings and is concerned with the way ambivalence comes to be ‘built into the social structure of statuses and roles’ (Merton and Barber, 1976). Pratt and Doucet (2000) reporting on their work into ambivalent feelings in work relationships, further define it as emotional
ambivalence which is ‘the association of both strong positive and negative emotions with some target, such as a person or object/symbol’ (p205).

The structural sources of ambiguity according to Coser (1966) ‘can be found in situations in which a status holder faces contradictory normative expectations’ (p175). Merton and Barber (1963) assert that unlike the psychological definition of ambivalence, which centres on the individual feeling of being pulled in opposing directions, the sociological definition centres on the ‘incompatible normative expectations of attitudes, beliefs and behavior assigned to a social position’ (p6) or ‘opposing normative tendencies in the social definition of a role’ (p12). In his detailed analysis of Merton and Barber’s concept of SA, Donati (1998) reflects that social relations have prime importance in the theory, noting that:

a) the socially constructed nature of ambivalence which is both determined by and occurs within the structure of social relations and,

b) when linked to statuses and roles, they are reduced to role-relations and from this it can be seen that ambivalence is built into the structure of role-relations.

Merton and Barber (1963) propose that SA can be both restricted – referring only to incompatible normative expectations in one single role of a single social status (position), or extended to incorporate normative expectations of multiple statuses or social positions. Donati (1998, p105) distinguishes two sources of Sociological Ambivalence:

1) In the structural context of a particular status where a manager has both personal thoughts but at the same time has to share the values/objectives of the organisation.

2) In the multiple types of functions assigned to a status i.e., having to be being many things in one role i.e., a university professor with teaching, administrative and research responsibilities.

Merton and Barber (1963) further defined six types of Sociological Ambivalence, of which only three are relevant for this study, those of:
1) **Conflict within a single status (position) and social role:**

Ambivalence arises from contradictory demands when acting in the interests of oneself and the other person may not (and often do not) coincide, for example in the relationship between manager and employee.

2) **Conflict within a set of statuses an individual occupies:**

Conflict arising from the various statuses in an individual’s set of statuses (positions) i.e. between the professional role and the family or friend roles – a conflict of interests and values as when a lawyer is friends with their client.

3) **Conflict between the different roles in one single status:**

Conflict arises amongst the demands of the roles associated with a particular status as in the manager’s role where they have to manage people, budgets, productivity and time. Conflict may also be created when requested values, norms, attitudes and activities are incompatible.

However, where are emotions in SA theory? From a psychological perspective, the concept of emotional dissonance (Middleton, 1989) is used to describe the conflict in emotions arising from between what is actually felt (e.g. in the types of SA situations above) and what is considered normative. Thoits (1990) has also taken a sociological interest in the source of what she terms discrepant feelings, such as those created between what is actually being felt and those expected by feeling rules of a given situation. Thoits (1990) defined from this that people feel emotional deviance when the reality of the situation does not always fit clear normative ideals. Further suggesting that, similar to Merton and Barber (1963) a possible source of discrepancy is multiple role occupancy where holding and conducting many roles may result in contradictory feelings. Heiss (1990) similarly points to the notion of role conflict in his review of social role theory stating that, ‘various roles in the managers’ repertoires contain incompatible elements/expectations’ (p97). Finally, those with task orientated identities such as managers Thoits (1990) suggests, cope with the negative feeling of ambivalence by conducting emotion work and emotion management.
3.4 Chapter Summary

In this Chapter I have presented the theoretical framework for the study which is that of emotions in the workplace. This is important in the social context of work and for socially supportive relations where emotions at work are relational in cause. The characteristics of working relationships differ in many ways from those of personal relationships and subsequently the experience of emotions in the workplace differs too (Waldron, 2000). The manager’s role and emotional expectations of it in this instance are transitioned to cope with a non-normative role cause or antecedent of emotion (employee illness), which, as identified above, has been little explored in sociological literature of emotions in the workplace or the wider field of the sociology of health and illness.

By introducing the theories described above, that of Bolton’s (2005) Typology of Emotion Management in the Workplace (including Hochschild, 1983 and Goffman, 1967), and of Merton and Barber’s (1963) Sociological Ambivalence, a bridge has been built to the Results and Discussion Chapters of this thesis by providing the theoretical framework in which the resultant substantive themes have been interpreted and integrated. In the next Chapter I will go on to present the methodology and methods for the study.
CHAPTER 4: Research Methodology and Methods

4.0 Introduction

This chapter presents the methodological approach taken for the study and the research methods used. Firstly, I discuss my rationale for choosing a qualitative methodology and include a brief discussion of the epistemological location (Grbich, 2007) and associated principles which informed and shaped the research. I then go on to provide a brief description of the constructivist Grounded Theory approach (Charmaz, 2006) which informed the research. This includes the underlying principles and practices of the method, elements of which were utilised for data generation and analysis. Next, I consider quality and rigour in qualitative research and the ethical concerns of this study before moving on to detail the research method. I detail here how the study was conducted, from initial formation of sampling criteria through to participant recruitment, interviewing and data transcription. This is followed by a detailed description of the data analysis process for this study so as to illustrate and explain how the data was interpreted in generating emergent substantive themes (or findings) for this study. A reflection on using the Grounded Theory process concludes this Chapter.

4.1 Research Design

The matter of which methodological approach to take for a study is determined primarily by the suitability and appropriateness to which it can adequately answer the research question(s) (detailed in Chapter 1). Integral to the research design process, is to question whether the methods of data collection and analysis associated with that particular methodology are capable of achieving this aim (Green and Thorogood, 2009). In other words, the phenomena of interest to be studied should dictate the choice of method, not the method dictate the choice of phenomena (Flick, 2002).

In this case, the phenomenon of interest was pre-defined by my PhD Supervisors having formed the basis of an application for a joint University of Manchester and Medical Research Council funded PhD studentship, although a research
design had not been established other than that the nature of the topic is more empirically suitable for examination by qualitative methods. This gave me considerable scope to study the phenomenon of interest utilising methods most appropriate to address the aims of the research as identified from the literature review (see Chapter 2).

In-depth semi-structured interviews were deemed the most appropriate research method for elucidating employers’ and managers’ views and experiences. Interview questions aimed at exploring the underlying social processes of the managerial role in relation to supporting, social relations, perceptions and experiences of employing and working with employees with LTCs, were initially formulated around the aim of the study (see Chapter 1). Due to the nature of the management role and anticipated complications in gaining access to busy employers and managers, a research design using only one interview for data collection and for as limited a duration as possible (30-60 minutes), was considered optimal.

A large maximal variation of management experiences was sampled for to ensure a breadth of experiences. This included a mix of conditions, working roles (e.g. manual/non-manual), industry types (manufacturing/non-manufacturing) and workplace settings (including large and small, public and private) across the Greater Manchester/East Cheshire area. Such an approach was intended to allow the identification of generic themes, patterns and shared experiences that emerge from diverse groups (Patton, 1990).

4.2 **Research Approach**

Applying Flick’s (2002) analogy in 4.1 above to the phenomenon of interest for this study suggests that a qualitative approach is the most appropriate method by which to address the research questions, thereby supporting the aims of the study. This is because research employing a qualitative approach is interested in discovering how people experience things in the context in which they occur along with the meanings they ascribe to those things (Corbin and Strauss, 2008), as is the aim of this study. For Yin (2011) one of the attractions of qualitative research is that it is ‘real-world’ (p5). It captures participants’ views and perceptions about their experiences in the reality of their everyday lives.
Qualitative research explores those aspects of social life that are deep, complex and not quantifiable. Standing in contrast to quantitative approaches, qualitative research does not seek to measure or enumerate a phenomenon (Pope and Mays, 2006) or ask ‘how many’ or ‘how much’ (Green et al, 2009, p5) but seeks to give voice to unique human experiences. Alternatively, as Pope and Mays (1995) aptly suggest, qualitative research reaches ‘the parts other methods cannot reach’ (p1).

For precisely this reason, an additional justification for taking a qualitative approach to this study resides in the nature of the phenomenon under exploration, where researching people’s subjective perceptions and experiences of illness is considered a sensitive topic area and data are therefore difficult to ascertain. This is particularly evident in the workplace where imparting intimate information, such as when disclosing personal feelings and private experiences about others peoples illness (which would normally be kept hidden), can be seen as intrusive and potentially socially damaging. Lee (1993) suggests that taking a qualitative approach to researching sensitive topics is particularly befitting in situations that participants may perceive as ‘highly personal, threatening or confidential’ (p102) such as in this study. In these situations, Lee (1993) reinforces the potential of qualitative methods to reach those things hidden from view that other approaches would fail to draw out.

Gubrium and Holstein (1997) posit that a qualitative research methodology is appropriate to use when aiming to understand meaning and actions underpinning people’s everyday lived experiences. Such is the case in this study, which aims to explore the everyday social processes and actions underpinning employers’ and managers’ support of those with LTCs. Likewise, to understand how they make sense of chronic illness in the workplace and what it means to them. This is especially important to elicit where as suggested in the existing research literature, perspectives of employers and managers influence the provision of social support critical to a successful working experience for employees managing a LTC.

Taking a qualitative approach to exploring the phenomenon of interest is, according to Flick, von Kardorff and Steinke (2004, p3) to ‘describe life worlds from the inside out’. In order to do this, the qualitative researcher aims to
develop concepts and theory (Bryman, 2012) about the phenomenon of interest in order to better understand it. This occurs by investigating social phenomena from the perspective of the participants in their natural environment (in this case the workplace). The objective being to make subjective life experiences and the meanings attached to them knowable to the outside world by using theories constructed from inductive, interpretative analysis of the data participants impart. This data can be obtained by observing participants naturalistically rather than in controlled, artificially generated settings as in the research laboratory for example (Green et al, 2009), as well as/or by talking to and asking participants to tell their stories, as is the case in this study.

Denzin and Lincoln (2011) succinctly define qualitative research as consisting of ‘a set of interpretative, material practices that make the world visible’ (p3). To this end, data gathering and analysis techniques commensurate with a Grounded Theory (GT) methodology of interpretative, material practices, were used in this study. Variants of GT methodology - as originally defined by Glaser and Strauss in 1967- are widely used within the qualitative tradition, the principles of which are used to guide the research process from inception through data collection, analysis and ultimately to generation of conceptual theory about the phenomenon of interest. Elements of a variant to GT methodology as espoused by Charmaz (2006) were employed in this study, which was also guided by the perceptions and narratives of the people studied (Bryman, 2012) in leading to an interpretative theory about managerial experiences in supporting those with LTCs, emergent from the data. Thus, this research aims to complement existing quantitative studies in this area by bringing into the visible world the reality of what the employers and managers in this cohort experience, feel, mean and perceive about their role in supporting employees with a LTC.

4.3 **Epistemological Location**

From a philosophical perspective, the matter of what we accept as truth and how it is constructed, as well as what and how we know about the nature of reality (Grbich, 2007) depends on our worldview. This ranges on a continuum between realism (positivism) on the one hand through to relativism (constructionism) on the other. Where a positivist worldview espouses scientific empiricism and
objectivism, truth is deemed absolute and that there is a ‘reality out there (outside of our knowledge) to be studied, captured and understood’ (Denzin and Lincoln, 2011, p8). A constructionist perspective however, eschews objectivism such that truth in the form of meaning and reality is subjective and socially constructed from the interactions between humans and their world (Crotty, 1998), suggesting that in essence, reality is interactionally negotiated (Blumer, 1969) between people ‘and our understanding of it depends on an aggregation of our understandings’ (McClelland, 2000).

Worldviews or paradigms are traditionally equated to particular research approaches - positivist to quantitative, relativist to qualitative research. Although Crotty (1998) argues that in the postmodernist world, the qualitative/quantitative divide is better justified by whether your worldview aligns with objectivist or subjectivist ontologies – or both. However, the assumption that the objectiveness of positivism equates to pure, ‘value’ free research is now critiqued by those who subscribe to post-positivist or critical realist perspectives. Whilst there are many forms of critical realism (Maxwell, 2012), realists subscribe to a relativist epistemological view that no scientific research can be truly value free (Grbich, 2007). Pointing therefore to the fallibility of human knowledge, which is located in the interactive process of research, where researchers inherently bring their socio-cultural backgrounds and life experiences (Denzin and Lincoln, 2011) to bear on their scientific inquiries. Critical realists also generally subscribe to relativist epistemology in accepting that understandings of the world are inevitably interpretative and constructed through personal standpoints and perspectives (Maxwell, 2012). Where the critical realist paradigm diverges from the relativist end of the spectrum, however, is a realist ontological belief that reality exists independent of our constructions and perceptions of it (Maxwell, 2012) being independent of the human mind (Williams, 1999). A critical realist approach therefore espouses a middle way though the paradigms arguing that reality is multi-layered, residing not only in social constructions, but in the processes, causal mechanisms and structures, which underpin them (Denzin and Lincoln, 2011).

Whilst I feel that a qualitative, interpretivist approach is akin to my personal interests in exploring the experiences of others, I would like to suggest that my own ‘epistemological location’ (Grbich, 2007) retains an element of pragmatism
or choosing the best approach for the phenomenon to be studied. In this sense I agree with Seale’s (1999) call for pragmatism in social research which suggests that subscribing to a specific philosophical viewpoint may be restrictive and inhibit flexibility in how research is approached. Particularly where an appropriate ‘middle ground’ (p26) though the dualisms such as that of the critical realist position opens the door to the benefits of mixed-method approaches to research (Johnson and Onwuegbuzie, 2004). Similarly, Cresswell (2009) suggests that those who subscribe to a pragmatist philosophy focus on the intended outcomes of the research and are not committed to ‘any one system of philosophy and reality’ (p10). Methodologies and research procedures are therefore chosen that are best suited to the purposes of the research.

In seeking to explore employers’ and managers’ realities in supporting those with LTCs through an interpretative lens I therefore take a middle ground by acknowledging that this reality is value laden, there are multiple interpretations of it and that they are contextually, structurally and temporally bound. I also acknowledge that participant interviews are filtered through my interpretation of the event based on current knowledge of the literature, my own personal experiences and socio-cultural background. Further, I demonstrate careful interpretation of the data by reflecting on these elements to mitigate their influence on it, thereby enhancing plausibility of the subsequent findings. This tenet is also consistent with the choice of GT inquiry taken to guide data collection and analysis for this study, the principles of which prioritise the phenomena of the study and the co-construction of data and analysis through the relationships and shared experiences of the researcher and the participants (Charmaz, 2006).

4.4 **Grounded Theory Methodology**

In accordance with the above philosophy, the research procedures and principles of GT methodology were chosen as being a particularly suitable research strategy for the purposes of this study and its intended aim. Since GT methodology focuses on generating a theory ‘of a social process, action or interaction shaped by the views of a large number of participants’ according to Cresswell (2009, p13), it was considered a good fit for exploring the meanings
and actions ascribed to the ‘how’ and ‘what’ of employers’ and managers’ experiences and perceptions of LTCs in the workplace.

Being specific to qualitative research, GT is defined as ‘the discovery of theory from data’ (Glaser and Strauss, 1967; p1), whereby theory building is idiopathic and generated from the data as it is analysed i.e. from the ground up (Pope and Mays, 2006) rather than imposing a formal a priori hypothesis on the data to be tested from the outset. As its name would suggest, GT methodology gives precedence to the development of theory as a product of data analysis (Charmaz, 2006) in that constructing a ‘grounded theory’ is the stated aim of the research journey. Gummesson (2002) in an interpretation of Glaser’s (1992) definition of GT analysis aptly sums up the essence of GT, as follows:

'take the elevator from the ground floor of raw substantive data and description, to the penthouse of conceptualization and general theory. And do this without paying homage to the legacy of extant theory.'

(p585)

GT is a complex and demanding methodology that has evolved significantly since its introduction by Glaser andStrauss in 1967. As such, conscious of limited space in this thesis, only a brief summary is provided. There are many versions and proponents of the methodology (Dey, 1999), which has moved on from its initial intent of bridging the divide between the quantitative and qualitative worlds at a time when positivism was the dominant paradigm of inquiry. Initially based on the language and standardisations of the positivistic world however, Glaser and Strauss sought to bring qualitative research to the world as a methodological approach in ‘its own right’ (Charmaz, 2006). They challenged the dominant view that qualitative methods were unsystematic, without rigour and generally inferior to quantitative methods in their pursuit of truth and knowledge. The basic premise of GT was therefore to move research away from the linear model of scientific experimentation, to offer an approach in which the parts of the research process are mutually interdependent (Flick, 2002). The basic processes of GT are therefore simultaneous data collection and analysis, memo writing, coding and categorizing data, constant comparative method, theoretical sampling, sensitivity, saturation and finally theoretical integration.
A much criticised permutation of GT as espoused by Strauss and Corbin (1990) followed, which deviated from Glaser and Strauss’s now classic theory with the addition of a coding paradigm to guide data analysis. This, Glaser (1992) averred, would result in the researcher ‘forcing’ a theoretical mindset/frame on the data rather than allowing it to inductively emerge, as is the intent of the process. Charmaz (2006) echoes the inductive sentiment by observing at the start of the GT research process that, ‘we cannot assume to know our categories in advance much less have them contained in our beginning research questions’ (p100).

Latterly, GT has taken a constructivist turn under Charmaz (2000, 2006) emphasising the interpretative nature of reality which is co-constructed during the research process. An interpretation of reality is constructed between the researcher and the participants where the researcher’s role/perspective is part of the process and not separate from it. In essence, Charmaz (2006) ‘sees data and analysis as created from shared experiences and relationships with participants and other sources of data’ (p130). Charmaz (2006) argues that theory is not ‘discovered’ in the data as posited by Glaser and Strauss but is co-constructed from it - social actor’s understanding of the world is socially constructed (Bryant and Charmaz, 2007) – therefore the phenomenon of interest is similarly addressed. Charmaz builds on the basic premise of GT as originally defined by Glaser and Strauss (1967) but integrates reflexivity and relativism throughout the research process (Charmaz, 2011). Charmaz (2011) does however, go to lengths to emphasise the pragmatist foundations of GT as leaving it open to a multiplicity of perspectives and traditions which is revitalised by taking a constructivist approach. It is elements of Charmaz’s (2006) version of GT that are utilised in this study (as described below).

Following this, it is worth noting here that given its complexity and variations, many researchers who claim to conduct a formal GT study are in fact only using ‘elements’ or ‘principles’ of the methodology (Murphy, Dingwall, Greatbatch, Parker and Watson, 1998). Similarly there are many who argue that to complete a study using GT in the truest sense would be time consuming, tedious and demanding, rendering it almost impossible to do (Hammersley, 1992). Silverman (2013) is more critical of GT suggesting that at worst it can lead to the generation of fairly empty categories and can ‘degenerate into a
smokescreen used to legitimise purely empiricist research’ (p249) where it is clearer about theory building than testing it. This is a particular limitation of the methodology noted by O’Reilly, Paper and Marx (2012) in their detailed examination of the use of GT in business research, where they believe that the independent and selective use of coding techniques from the other tenets of GT can result in ‘fragile connections to theory’ (p259). Moreover, Bryman (2012) is similarly cautious about studies conducted under the label of GT citing Richards and Richards (1991, p43) phrase ‘an approving bumper sticker’, which denotes that GT is often used as a way of conferring an air of respectability to qualitative research. In reality many researchers are using an adapted and refined version of the process (Donovan and Sanders, 2005).

Similarly, constructivist GT as defined by Charmaz (2006) provides methodological guidelines which are adaptable and flexible and can be adopted and used by researchers to suit themselves and their research situations. Here Charmaz (2006) advocates flexibility over prescribed rules in how to conduct the research process. For the current study, I have drawn mainly from the approach of Charmaz which accommodates pragmatism because it is not a rigidly standardised method but is adaptable and responsive to the ‘particularities of situations’ as suggested by Rogers, Popay, Williams and Latham (1997).

I concur with the view that substantive theory should be allowed to emerge from the data rather than being imposed upon it. Although this is problematic in theory, as it has to be reflexively acknowledged that even though I may wish to come to the research table ‘tabula rasa’ (Dey, 1993, p229) neutral of previous thoughts and biases, these will inevitably shape my interactions with participants and how I interpret the resulting data. As defined above, perceptions of experiences and the meanings attached to them are created through negotiated interaction with others (Blumer, 1969). Glaser and Strauss (1967) suggest attending to theoretical sensitivity, in a process of researcher reflection of what prior knowledge and theoretical background they bring to the study (see section 4.4.2 below).

Charmaz (2006) stresses the neutrality of the research methods, suggesting that elements of GT such as memo-writing, sampling and coding can be adapted and
adopted by any researcher and used flexibly. Birks and Mills (2011) have captured those elements which characterise a GT study and which set it apart from other qualitative methodologies, as per Figure 3:

- Concurrent data collection and analysis in an iterative process.
- Initial coding of data - categorizing of data with short labels to summarise the data.
- Focused (intermediate) coding - synthesis of the initial codes into the most significant categories that make the most analytic sense of the data - increases conceptual analysis towards selecting a core category(ies) which encapsulates the grounded theory.
- Theoretical (advanced) coding – specifies possible relationships between the categories developed in focused coding, generates theoretical concepts and weaves the story back together.
- Constant comparative analysis of data between, incidents, codes and categories - This technique allows for the comparison of salient themes across narratives, and will be particularly useful for this study in identifying themes in relation to the management role in supporting those with LTCs.
- Memo writing – the writing of memo’s throughout the research process to capture the researchers thinking and which are integral to the theory building process.
- Theoretical sampling – see Section 4.6.4 this Chapter.
- Theoretical sensitivity – awareness of subtleties the researcher brings to the meaning of data through their personal experiences and intellectual awareness.

**Figure 3: Salient Elements of a Grounded Theory Study**  
*(Based on Grounded Theory: A Practical Guide Through Qualitative Analysis, Birks & Mills (2011, p9-13))*

In addition (Charmaz, 2006, p11) suggests that those working through a GT process should analyse actions and processes rather than themes and structure, emphasise theory construction rather than description of application of current theories and search for a variation in the studied categories or process.

The research process for this study has been informed by these principles and guidelines. A description of how the study and analysis was conducted using these guidelines is detailed in Section 4.7.5 below along with the elements of the process that were used. As advocated by Charmaz (2006) the process was recursive in nature and was not followed linearly or prescriptively per se to take into account my own thought process and visual way of diagramming relational
concepts. Some of the stages overlapped and data was returned to and compared time and time again during the analytical process of defining categories and building theoretical concepts to ensure that they were indeed grounded in the data.

4.4.1 **Extant theory – The Literature Review in Grounded Theory**

There is some ambiguity as to the place of literature reviews in studies informed by Grounded Theory principles. The originators of formal GT methodology, Glaser and Strauss (1967) advocate that the literature review should be delayed until analysis is completed, allowing for theory to emerge from the data and not from extant data and thereby not contaminating the resulting emergent theory with those of extant thinking and pre-conceptions. Glaser and Holton (2007) further argue that researcher knowledge of existing literature and problems has the potential to block the process of unbiased discovery of theory from data.

However, by the very fact of being in the world, researchers bring their personal background and a priori knowledge to the study which, as theorists such as Charmaz (2006) and Layder (1988) argue, is not entirely possible to set aside in pursuit of unblemished theory generation. More recent theorists writing on the GT method such as Dey (1999) and Kelle (2007) therefore dispute Glaser and Strauss’s (1967) and Strauss and Corbin’s (1990) position on extant knowledge – or even the notion of only reviewing literature outside the topic area to avoid contamination. And have moved on to acknowledging the importance of knowledge brought to GT research in guiding meaning making, early enhancement of theoretical sensitivity’ (Birks and Mills, 2011: p22) and the place of reflexivity in this respect.

In this study I have attempted to remain open to what participants had to tell me about their experiences and concerns in supporting those with LTCs by not filtering the data through a pre-conceived extant theoretical framework. Extant literature was consulted as abstract theoretical concepts began to take shape around the substantive core categories emerging from the data analysis process, according to the constant comparison approach (Charmaz, 2006). I have acknowledged any reflexive thoughts arising from my personal background and prior knowledge in memos commensurate with the GT process.
4.4.2 Theoretical Sensitivity - Researcher Reflexivity

As Flick (2002) discusses, researcher reflexivity is an essential feature of qualitative research which is inherently fraught with issues relating to objectivity. Therefore, by bringing our own subjectivities into the foreground and including them in the process, we introduce an element of transparency and rigour into the resulting findings.

In considering my own contribution as the research instrument through which the participants’ experiences are collected and interpreted, I reflected on the knowledge and experiences I bring to the situation. My previous life prior to academia was very much with me in the study, which was perceived as both a help and a hindrance. As outlined in The Author section of this thesis, my background is in Human Resources, therefore I am accustomed to supporting employees and managers – instituting and offering advice on organisational policies and procedures with regard to sickness absence to both managers and employees. It was therefore difficult to set this knowledge aside during the interviews and not let it influence my questioning, responses and analysis. On the other hand, my experience allowed me to understand participants’ difficulties and challenges faced in their everyday management of illness in the workplace.

Similarly, if I had shared my own experiences with regard to illness and work, would participants have been more forthcoming? I suspect this would have altered their responses and non-verbal gestures in that they would have assumed that I did not need to understand the meanings behind their experiences. I also did not discuss my background in HR for fear of it skewing the interview. Only after did ‘I admit’ to it if it came up in the natural course of conversation. This study has involved me sitting on the ‘other side of the fence’ as it were, viewing the employees and managers perspectives.

It is also important to mention here that during the period of the PhD study I had personal experience of the phenomenon of interest under inquiry and as such, it is important to reflect on this and how it has shaped my research and subsequent findings. During the second year of my PhD study my husband was unfortunate enough to have a life threatening bowel illness. Whilst the initial illness was
acute, subsequent complications during the 3\textsuperscript{rd} year of my PhD and further life saving surgery, has led him down the path of living his life with a LTC. The impact of this on my studies can be summed up by our GP who commented that I am now living in, and can relate to, my PhD research ‘now that my husband has a LTC’. This is especially relevant given the difficulties my husband and I experienced in returning to the workplace and sustaining employment, which is reflected on in detail in Chapter 7, section 7.8.

4.5 \textbf{Quality and Rigour in Qualitative Research}

The question of quality and rigour in qualitative research constitutes an ongoing debate against the opinion that only those studies conducted using a positivist paradigm produce valid and reliable results, thereby being objective and generalisable to the wider population (Winter, 2000). Attempts to apply qualitative research to the scientific rigours of the quantitative perspective are problematic when considering the differences in their respective underlying epistemological and ontological paradigms about what constitutes truth and reality. In this respect, many would argue that attempting to establish what is truth based on the ‘multiple constructed realities’ of relativism versus the ‘single tangible reality’ (Lincoln and Guba, 1985, p295) of positivism are incompatible and not measurable or replicable as in the controlled, experimental world of the scientific (Winter, 2000).

Nevertheless, as Pope and Mays (2006) discuss, the need for qualitative methodology to be accepted as a credible and reliable research method rather than seen as a ‘soft option’ (Chapple and Rogers, 1998) against the backdrop of the rigours of the positivist paradigm, demands that the knowledge it generates should be subject to scrutiny in pursuit of rigour and trustworthiness. However, whilst the matter of whether the validity of the findings generated by qualitative research should be judged by separate criteria distinct to the qualitative paradigm, indeed if at all (Smith, 1984) or the same as those associated with the positivist tradition, it is generally agreed that some method by which to assess the quality of qualitative research is needed.
Criteria and checklists by which to judge the findings of qualitative research have therefore become common place in the methodological literature but have in themselves courted controversy. For example, it is not possible to apply the notion of replicability in the quantitative sense as a judgement criterion, as it is neither appropriate nor often possible in qualitative research (Chapple et al, 1998). Similarly, Wolcott, 1992 argues that 'understanding' is more pertinent to qualitative research than 'validity' where validity in the positivist paradigm relies on standardisation of the research process to mitigate contamination of participant responses. Many have highlighted the need for clarity on the criteria appropriate for qualitative research (Murphy et al, 1998) because ambiguity and diversity in qualitative methodologies and associated epistemological/ontological assumptions (Rolfe, 2006) make a unified set of quality criteria or what constitutes ‘good’ qualitative research (Flick, 2007) difficult to achieve.

However, whilst there is no one definitive set of criteria for evaluating ‘best practice’ in qualitative research (Tracy, 2010) there is a commonly held emphasis across the field for the ‘need to establish the trustworthiness’ (Donovan et al, 2005, p526) reliability and relevance of the research. In conducting a study using GT principles I have attempted to ensure the credibility of the research by adopting a stance of transparency in detailing and critiquing my methods of data collection, relational analysis and by being self reflexive to those things which may shape and influence the data (Gioia, Corley and Hamilton, 2013). Additionally I have adopted the evaluation criteria devised by Chiovitti and Piran (2003) which specifically aim to improve rigour in studies informed by (or using) GT principles and married them with those proposed by Lincoln and Guba (L&G) (1985) as summarised in Table 2 over.
<table>
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<tr>
<th>Standards of Rigour</th>
<th>Suggested Methods of Research Practice</th>
<th>This Study - Methods Used</th>
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| Credibility         | 1. Let participants guide the inquiry process  
2. Check the theoretical construction generated against participants’ meanings of the phenomenon  
3. Use participants’ actual words in the theory  
4. Articulate the researcher’s personal views and insights about the phenomenon explored by means of:-  
   (a) Post comment interview sheets used as a tool  
   (b) A personal journal  
   (c) Monitoring how the literature was used | Detailed in this Chapter:  
Use of informal semi-structured interviews, interview guide appended to include questions to check theory construction inline with participant meanings i.e., influence of employee personality. Researcher reflexivity and use of extant literature detailed (see Chapter 3). A diary was kept of analytical thoughts/diagrams/notes about the research process. Findings are verified using participant quotations (Chapters 5 & 6) |
| Auditability        | 5. Specify the criteria built into the researcher’s thinking  
6. Specify how and why participants in the study were selected | Detailed in this Chapter:  
Participant characteristics and sampling procedures. Clear audit trail of the research process including details of interview transcription, use of detailed fieldnotes and memo’s and discussion of process and emergent themes with Supervisors. Clear and detailed criteria by which the data was coded using the constant comparison approach. Written note cards provided a ‘double check’ system to compare consistency in coding generated off-line and in Atlas.ti. |
| Fittingness         | 7. Delineate the scope of the research in terms of the sample, setting, and the level of the theory generated  
8. Describe how the literature relates to each category which emerged in the theory | Detailed in this Chapter and Chapter 7:  
The theoretical framework identified is applicable to settings other than the immediate sample upon which it is based and can fit into contexts where LTCs are likely to cause social role conflict. Chapter 7 details analytical integration of the emergent substantive themes using extant socio-emotional theories applied to each core concept. |

Table 2: Eight methods of research practice for enhancing standards of rigour.  
Adapted from Chiovitti, R.F. and Piran, N. (2003, p430)
4.6 Methods

4.6.1 Introduction

This section of the chapter details how the study was conducted and outlines the sampling, recruitment and methods of data collection and subsequent analysis. Data collection consisted of one semi-structured interview to elucidate the employer’s and manager’s experiences and perceptions of their role in supporting those with LTCs. Individual interviews were conducted over a period of ten months from March 2011 to January 2012. Vignettes of hypothetical scenarios detailing various illness situations (Appendix 1) were available for those with no experience of LTCs in the workplace, although only one participant (P4, male, large private org.) took advantage of this. Demographic information such as age, position in organisation and gender was also captured on the Consent Form in order to be able to understand how, why and whether experiences/perceptions of LTCs differ across types of organisations and types of occupation. Interviews were audio-recorded with consent and the recordings transcribed to generate interview transcripts which were anonymised and formed the data for qualitative analysis.

The Atlas.ti qualitative data analysis software package was used to capture transcripts, field notes and memos etc, and to conduct initial coding and focused (intermediate) coding (Charmaz, 2006). Categorising the data through iterative coding served to expand and explain the interactive social processes inherent in the research situation as espoused by Birks and Mills (2011).

4.6.2 Recruitment and Sampling Strategy

A total of 40 participants took part in the study and were recruited from a range of organisation types, sizes and industries across the Greater Manchester and East Cheshire areas of the North West of England (Table 1). These geographical areas were chosen due to the concentration of a wide variety of suitable organisations within the locale. Criteria for inclusion in the study were employers and managers aged 18 and over who own or are employed in, a range of large and small to medium (SMEs) size organisations from across the private, public and third (charitable/voluntary) sectors. A demographic breakdown of the sample is detailed in Table 3 over.
### Table 3: Demographic Breakdown of Sample

Sampling ceased when saturation of categories had occurred and no new theoretical insights about them were emerging from the data. Sampling was mixed, being both purposeful and snowballing.

**Purposive** sampling occurred by purposefully contacting a range of organisations to satisfy the sampling criteria as defined in the sampling matrix (Appendix 2) and based on company size, industry type and sector. Suitable organisations were identified through liaison with business organisations such as Manchester Business School, the North West Development Agency, the North West Health and Wellbeing Co-ordinator (who both kindly supplied databases of companies in the North West for my use). A request for participants was also placed on social media such as Facebook, Linked-In and Twitter specifically targeted to reach the North West business community. The study was also publicised on the Small Business Federation website. Two business networking groups were also attended for the purposes of potential recruitment.

**Snowball** sampling occurred via purposefully selected individuals within the researchers’ own business connections, who in turn identified suitable participants via word of mouth. Interviewees were also asked if they could put...
me in contact with other potential participants, which is typical of this approach to participant recruitment (Bryman, 2012). Potential participants were approached directly by the researcher and asked to participate and also whether they knew of anyone else who would be suitable and willing to participate.

The initial sampling frame (Appendix 2) suggested a figure of around 48 participants, which is approximate in-keeping with the nature of qualitative studies (Pope and Mays 2006) and given the mix of sampling procedures being both snowballing and purposive. However, the numbers selected were intended so as to be representative of a cross section of organisations and to realistically reflect a wide range of experiences whilst being manageable to collect. Whilst many researchers suggest that there is no fixed guide for sample size for qualitative studies, Strauss and Corbin (2008) advocate that at least ten interviews are necessary for building grounded theory. Nevertheless, this quantification of interviews is in itself a matter of contention.

The matter of ‘how many interviews is enough’ in qualitative research is a well debated issue. Baker and Edwards (2012) have gathered the opinions of over 14 expert voices and 5 early career voices on the subject. Opinions range from: using the purpose of the research, enough to answer the research question, accessibility to participants and resources available as a guiding factor (Brannen, Charmaz, Flick, 2012). Others, such as Mason and Doucet (2012), simply say ‘it depends’. Becker and Bryman (2012) on the other hand point to saturation of evidence enough to satisfy the theoretical category or point being made – which could even be just one interview. In line with the GT methodology, the number of interviews conducted is dependent upon the breadth and depth of knowledge sought in order to reach theoretical saturation from the data. The term saturation is itself misinterpreted by many conducting studies under the GT aegis, who work under the misconception that when the same themes, patterns and events are recurring i.e., no new themes are emerging, data collection can cease. In reality, the term refers to the saturation of categories where further data gathering generates no ‘new theoretical insights or reveals new properties’ (Charmaz, 2006, p113) of these core theoretical categories.

I decided to take a broad approach to the LTCs included in the study and consider all conditions, rather than sample on the grounds of homogeneity and
specifically study a few conditions. As Patton (1990) posits, there are strengths to be found in maximum variation sampling where interest lies in uncovering the common themes, patterns and shared experiences that emerge from ‘diverse groups’ (p233). This decision has been made as organisations are often exposed to a plethora of differing illnesses. Findings from the literature reviewed trended towards similarities in enablers and barriers to work for those with LTCs across all types of illnesses. This suggests that although specific conditions tend to be heterogeneous, there are generic barriers applicable to all.

4.6.3 Recruitment

A combination of cold call phone calls, emails, and letters, totalling 250 were made/sent to prospective businesses inviting employers/owners and managers to attend an individual interview. Organisations were approached by letter (Appendix 3) accompanied by an Information Sheet (Appendix 4) inviting them to participate. In the case of small to medium companies, a letter was sent to the company owner/managing director. For larger organisations, Human Resources departments were approached. I then followed up the correspondence by telephoning the companies 4 days later to ascertain whether they had received the letter and information sheet, and to establish whether they were willing to take part in the study. During both the purposeful and snowballing sampling process, if employers and/or managers confirmed their willingness to participate, then prospective participants were invited to attend an individual interview and an appointment arranged at a suitable time and location convenient for them.

Recruitment for this study was problematic, with purposive sampling yielding only 10 participants. People initially expressed their willingness to participate but this did not translate into tangible interviews. Coole, Radford, Grant and Terry (2012) in a study of employers’ perspectives of employees returning to work after stroke, encountered the same difficulties. They go on to suggest that a possible barrier to recruitment could be the sensitive nature of the research where prospective participants were wary of ethical and confidentiality issues and further fearing that their job may be under scrutiny. Snowballing and personal introduction therefore proved the most productive route to recruitment.
4.6.4 **Theoretical Sampling**

A key element of conducting a study using elements of GT is the concept of theoretical sampling as highlighted in Section 4.5 above. Theoretical sampling goes hand in hand with iterative data analysis in that during the coding phases, categories which need further elaboration so as to strengthen and develop your emerging substantive theory about the phenomenon, can be actively sampled for (Charmaz, 2006, Bryman, 2012). Similarly, refining categories can lead to identifying aspects of the study which had not been previously accounted for and can therefore dictate the direction that the study will go in. In this respect, theoretical sampling ensures that data collection does not become one dimensional and allows fluidity to collect data in order to explore emerging theories. Hence the number of interviews required, as discussed in the section above, is also directed by the theoretical sampling process which leads to saturation of categories and their properties.

Initial thematic coding for this study indicated that some views being captured were not necessarily from the ideal participant population, not being representative of those who deal with LTCs at the ‘coal face’ as it were, i.e. those with direct management responsibility of employees. It became apparent that there was an aspect of ‘distance’ from the shop floor. By this it is meant that some senior managers or company owners were imparting vicarious experiences of chronic conditions, those that their first-line managers generally deal with. However despite purposefully asking for contacts for front-line managers little was forth coming.

Theoretical sampling to substantiate an initial theory about the supportive nature of the dyadic relationship between the manager and the employee with the LTC was actively pursued. Other themes were also followed in attempting to conceptualise and integrate the emerging core categories and the relationships between them for this study, for example, when one manager mentioned that he was concerned about the effects of employees’ personal lives on their ability to manage their condition in work. To ascertain whether this concern was shared by other participants and hence of theoretical importance, this question was added to the interview guide and the responses then entered the analysis cycle. In total the interview question guide was revised 5 times (Appendix 5) so as to
probe for respondent experiences which would lead to saturation and refining of categories and their properties to substantiate the emergent key themes.

### 4.6.5 Participant Characteristics

An anonymised, tabulated list of participant characteristics is provided below (see Table 4). Forty participants were interviewed in total: 15 from public sector organisations, 21 from private sector organisations and 4 from 3rd (not for profit) sector organisations. Two participants were interviewed from the same organisation at their request. Twenty-five males were interviewed and 15 female.

Due to the sensitive nature of this research, steps were taken to ensure that the participant’s signature on the Consent Form could not be linked to an organisation, being mindful that participants were ensured of complete anonymity in freely speaking about their experiences. Participant names and organisations have been recorded separately and stored securely by myself for audit purposes only. Commensurately, organisations have been labelled with a general industry type in Column 3, Table 4. It was decided not to use the official UK Standard Industrial Classification of Economic Activities classification labels (ONS, 2009) as this may have provided a possible identifier to the organisation (given the localised geographical area of the sampling frame). Participants from the public sector have been classified as per the size of the department or area they manage, rather than under the larger public sector organisation to which they belong.

Please see over for Table 4, participant characteristics.
<table>
<thead>
<tr>
<th>Participant ID</th>
<th>Type</th>
<th>Industry</th>
<th>Size</th>
<th>Age</th>
<th>Sex</th>
<th>Level in Org</th>
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<td>40's</td>
<td>M</td>
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</table>

**Table 4: Participant Characteristics**

**Key:**
- **Non- Manual** = Managerial/administrative/clerical roles
- **Manual** = Physical labour, non-office based
- **Mixed** = Manages a combination of both manual and non-manual roles
- **Company Size** =
  - Small > 50 employees
  - Medium >250 employees
  - Large <250 employees

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The following charts present a breakdown of the participant demographics as captured on the Consent Form:

**Chart 1:** All Sectors breakdown by age and level in organisation

**Chart 2:** All sectors breakdown by gender and level in organisation
There were fewer females interviewed in the private sector being n=7 compared to n=14 male managers. None of the women interviewed classified themselves as middle managers. Of the 7 women interviewed, 5 of them were company owners or directors of their own company. As the participants were recruited via a mix of sampling methods, one possible explanation for this could be attributed to the nature of the avenues used for recruitment which favoured the small business sector such as online networks or breakfast meetings. Another explanation could be that the self-employed participants are inherently inclined to making new contacts as an integral aspect of running their business, and are therefore naturally more acclimatised to putting themselves forward in situations such as this.

Of the other females in the sample from the private sector - one woman was a director in a large private consultancy company and one was a senior manager in a large retail organisation. Female managers were actively sought out during the recruitment phase however, none from the middle level agreed to interview. This seems to some extent unsurprising given what is known from existing statistical data on the make-up of the UK working population that there are far fewer women in professional and managerial roles in the private sector than in the public sector (ONS, 2012). Official UK labour market statistics report that only 19% of women in the private sector are employed in high skill jobs, compared with 28% in the public sector. This trend is echoed in this data where female participants represented only 33% of the total private sector respondents compared with 47% females represented from the public sector respondents. It is also note worthy that the ONS (2012) reports that 66% of employees in the public sector are female, compared with around 41% in the private sector.

4.6.6 Data Collection – Interviewing

4.6.6.1 Ethical Considerations - Consent, Confidentiality and Anonymity

Ethical codes of practice dictate guidelines to ensure the safety of participants and their wellbeing during any research process. Murphy et al (1998) urge researchers to consider those aspects specific to qualitative research which may be considered harmful and note that this type of research could also jeopardise participants’ ‘psychological or emotional wellbeing’ (p10). Ethical guidelines
were instituted for this study and in particular the key principles of informed consent and confidentiality (Green and Thorogood, 2009).

Prior to commencement of data collection, ethical permission to conduct the study was sought from the University of Manchester. Permission was granted on 8th February 2011 by Research Ethics Committee 4 at the University of Manchester (Ref. 10347), with no amendments to the research protocol requested by the board.

Before commencing each interview, the study was described to the participant with reference to the Information Sheet (Appendix 4). The participant was given the opportunity to ask questions and was advised they could withdraw from the research process and interview at any time. Written informed consent was obtained (Appendix 6) if the participant was willing to continue. Informed consent is an ethical requirement of research to ensure that the participant is voluntarily entering into the study.

Due to the sensitive nature of this research, the subject of confidentiality and anonymity was important to discuss with participants prior to gaining consent. Talking about others’ illness and being honest about personal opinions of employees and employing organisations could be considered contentious. Here participants were concerned about possible ramifications to their job but also that their experiences and perspectives were personally sensitive about their employees. For example those opinions which are not generally discussed in public and which could be considered discriminatory (not employing the disabled) or socially undesirable (questioning the legitimacy of a condition) and speaking negatively about their employing organisations.

Before obtaining consent, participants were assured of the confidentiality and anonymity of their responses. Pope and Mays (2006) remind us that confidentiality and anonymity are different things, and are often conflated. Confidentiality was assured to participants in this study by explaining that the interview contents would be kept private and not divulged to employers, colleagues or others outside of my supervisory team. Participants were advised that the audio recording would be deleted once the research had been completed and that consent forms would be kept in a locked cabinet in my office at the
University. Participants were advised that some of their comments may be used in the final thesis but that there would be no way to identify who had said what due to anonymisation. Anonymity was assured by ensuring that any names inadvertently mentioned during interviews were not transcribed or were removed from the transcript. Participants were advised that no identifiers would be discernable from the transcripts of either themselves, their organisation or their employees.

4.6.6.2 Semi-Structured Interviews

Participant interviews followed a loosely structured format associated with the technique of semi-structured interviews commonly used in qualitative research (Britten, 2006). This format was chosen because of its adaptability and flexibility in allowing for the researcher to reflexively respond to, and question, themes salient to the participant (Bryman, 2012), rather than adhering to a prescriptive question and answer format as with structured interviews more commonly associated with the positivist paradigm (Bryman, 2012).

For this study, the aim of the research is to contribute to understandings of the influence of the management role in enabling employees with LTCs to be recruited into and retained in the workplace, but as accords with GT principles no a priori expectations were formulated about what themes would emerge from the interviews in respect of this. Therefore, a semi-structured approach was considered a particularly suitable way of gaining insight into the situated experience of participants without restricting their responses to an ordered sequence or beyond pre-identified broad open-ended questions. This also allowed me to explore themes and topics in-depth as they arose to ‘go beneath the surface of ordinary conversation’ (Charmaz, 2006, p26) which is advantageous when attempting to understand the complexities involved in supporting those with LTCs and the meanings participants attach to them.

The more informal, conversational style of semi-structured interviews (Burgess, 1982) allows for the interviewer to respond to unexpected themes emerging from the discussion and allows for them to be pursued and developed by the researcher (and the interviewee) without restriction. However, semi-structured interview ‘conversations’ are not completely free flowing and allowed to
develop as would be the case in the naturalistic settings of say ethnographic or observational research suggestive of an unstructured interview technique (Patton, 2002). They therefore sit between the formality of the structured interview with its emphasis on standardisation of questions to minimize variability and bias of response to increase comparability (Miles and Huberman, 1994), and the informality of the unstructured with its emphasis on having no predetermined questions and ‘going with the flow’ (Patton, 2002, p52). Semi-structured interviews are therefore a ‘directed conversation’ (Lofland and Lofland, 1995, p71) appropriate for those studies where the topic of investigation is known in advance (Green and Thorogood, 2009) with some predetermined broad questions but which remains open to the responses of the participant as in this study.

Broad questions were documented on an interview guide (Appendix 5) which was used as a starting point for discussion (Mason, 2002) and as an aide memoir. Again, aligned with the GT approach taken for the study, this was revised as salient themes became evident arising from iterative analysis of the data, and topics were added accordingly. Questions included on the guide were not used as a numbered script or tightly sequenced (Mason, 2002) but were naturally woven into the interview. As I became more confident with interviewing it became easier to allow the participant to direct the discussion and for me to fluidly interject questions from the interview guide. These were centred around the broad dimensions of social support, type of condition (symptom presentation), legitimacy, co-workers and employee characteristics. Participants were encouraged to share their views of social relations within the workplace commensurate with the focus of the study being the social context of work.

Interviews varied in length between 20 minutes through to 74 minutes and were audio-recorded with consent for ease of data analysis. Participants were not given a verbal definition of the term LTC prior to starting the interview nor reminded of examples of conditions such as those included on the Participant Information Sheet (Appendix 4). This was so as to allow participants to self-define their interpretation of what constitutes a LTC in order to ascertain their personal conception of LTCS and perceptions about supporting them. Those participants who asked me to define a LTC, were given a generic definition as
outlined in Chapter 1, section 1.0.1. These participants were referred to the longevity of the condition as being a salient feature compared to those employees with episodes of limited duration illness such as colds and gastrointestinal infections.

To open the conversation, participants were initially asked if they had had any experience of managing employees with LTCs and if so what this was, i.e., tell me anything. This question allowed the participants to start where they wanted and the interview flowed from there. Questions about the newly introduced GP Fit Note system were also included (see Chapter 2, section 2.2.5). It was felt that these interviews were an opportune moment to ask employers and managers thoughts on the new system and whether they contributed to the management and support of LTCs in the workplace.

However, whilst semi-structured interviews are a particularly useful technique with which to access those tacit things that cannot be achieved through observation or structured questionnaires such as people’s perceptions, experiences and understandings of events (Byrne, 2012), it is by no means without its limitations. Many in the qualitative research field remind us that the interview is a social interaction (Flick, 2002; Mason, 2002; Patton, 2002; Britten, 2006; Green and Thorogood, 2009, Bryman, 2012 for example) and as such attention should be paid to the language and the way it is used in the interview but also that the interaction itself creates meaning. This is important when considering the centrality of language for both the method of interviewing and the data collected (Green and Thorogood, 2009). As Green and Thorogood (2009) assert it is important to consider the implications on the resulting data of what was said and how, local and cultural linguistic knowledge and more importantly how this is interpreted by both interviewer and interviewee in representing subjective accounts of their world.

Patton (2002) suggests attending to question construction and to clarity of language appropriate to the participant. Moreover, Patton (2002) suggests that the interview guide can itself be problematic in semi-structured interviews. Firstly, important and salient themes may be inadvertently missed by overreliance on only capturing responses as per the questions on the schedule. Secondly, comparability across the data will be compromised because the
questions will be differently posed and sequenced at each interview, which will result in significantly different responses from participants (Patton, 2002). Rapley (2004) on the other hand views the interview guide as bringing a framework to the interview hence making it more systematic and reliable, which brings us back to the arguments of the applicability of the tenets of the positivist paradigm on qualitative research as discussed in Section 4.5 above. I turn to Mason (2002) here who reminds us that it is most important to ensure that we have data sufficient enough to make comparisons.

Holstein and Gubrium (2004) and Mason (2002) similarly bring our attention to the notion of the interview as a specific kind of social interaction, where meaning is co-constructed by both actors. As such, we should take into account that the participant cannot convey an accurate or real sense of self in this one specific interaction. Mason (2004) proffers that this bias cannot be eradicated unless the social context in which the interview occurs is included in analysis arguing that the social interaction should not be separated from the social context in which it occurs. Furthermore, Mason (2004) suggests that the reliance on talk and text generated through this specific interaction should be expanded to include the respondent’s wider social world in the interview for example, the spatial, visual and observational.

A further observation from the interviews for this study is the participants’ agency in their decision as to which experiences they choose to recount to me. This is a particular form of response bias which Reissman (1993) calls ‘representational decisions’ (p8) and it is for me to record and interpret this representation of their experience. In this study, as will be further discussed in Chapter 7, some participants came to the interview with pre-defined representational choices they specifically wanted to discuss. Some wanted to discuss particularly challenging and/or distressing experiences of managing those with LTCs, two others wanted to convey a message to Government with particular concerns.

Finally, response bias is a limitation in interviews which aim to explore sensitive topics considered private and difficult to talk about, or for which there is a fear of disapproval or repercussions from revealing personal thoughts (Elam and Fenton, 2003) as is the case in this study. The concept of social desirability bias
where participants monitor their behaviour and responses to questions so as to be socially acceptable is therefore discussed in Chapter 7.

4.6.6.3 Off the Recorder Discussions

Discussing the sensitive topic of disability and other people’s illness led quite a few participants to be more at ease once the audio recorder had been switched off. In this regard, many participants were more forthcoming about their experiences ‘off the recorder’, where they felt they could relax their front-stage act of impression management (Goffman, 1959) and policing of socially acceptable responses. This is a well-known phenomenon (Warren, 2002; Goodwin, 2006, p56) and will be discussed further in Chapter 7 in respect of its implications for findings, including the problems that this presents for the researcher.

4.6.6.4 Interview Setting

Interviews were conducted at a variety of locations and settings across the Greater Manchester/East Cheshire area, at the convenience of the participant. Locations included the participant’s place of work, their home address, my home or at the University. One participant showed me around his factory, which was very informative and helpful in putting his comments into context with regard to supporting those with LTCs in a manual manufacturing environment. Onsite interviews were beneficial in seeing the participants in their own environment, again giving context to the data by allowing a window onto the organisation at work (as per Mason, 2002 above). Most interviews were conducted during the day with two being conducted in the evening, again for the convenience of the participant.

A few participants were nervous about conducting the interview on company premises for fear of recrimination from their employer. For this reason, I remained completely flexible with regard to location. The lone worker policy (Appendix 7) as set out by the University of Manchester was adhered to when conducting field work. This involved ensuring my personal safety whilst out in the field by designating a contact person whom was advised of the location of the interview, times and anticipated length of the interview.
Interviews conducted onsite were often held ‘covertly’ and managers were very wary of confidentiality, ensuring that we could not be overheard. It felt very much a case of being ushered into offices for fear of being challenged as to why I was there and in one instance I was told to justify my presence by saying I was doing ‘general research into management’. Four interviews were conducted in public spaces at the participant’s place of work, which made the interview particularly difficult when participants were constantly checking who was about and using hushed voices when people came near.

One participant was particularly anxious about conducting the interview in a meeting room at their place of employment. Consequently, the participant was initially quite distracted. In this instance, I offered to re-arrange the interview for a more suitable venue and date. However, the participant decided to continue with the interview after asking me to ensure total anonymity but felt that Human Resources should have been informed beforehand. A few other participants were also keen to let me know that they had not obtained ‘permission’ from their organisation to speak to me and felt that they should have notified HR.

A further note of reflection here is that I dressed smartly to each interview as if I were working in an office, wishing to convey professionalism in my dealings with the participants. I felt that had I dressed less business like, I would have been viewed as less professional myself in the business environment and perhaps therefore not have engendered the conversations that were forthcoming from the participants. I also felt that presenting my self in this way portrayed my sincerity in enquiring about their experiences and that this contributed to the level of rapport built with the majority of the participants.

4.6.6.5 Interview Transcription

Interviews were transcribed using intelligent verbatim meaning that all words except for affirmative agreement gestures were captured. Fifteen interviews were transcribed by myself using transcription software loaded onto an encrypted University computer. The computer was only used by myself and was password protected thereby ensuring that no-one else had access to the
recordings or resulting transcripts. This was in accordance with the ethics agreement and confidentiality assured to participants.

Twenty-five interviews were outsourced to a transcription company regularly used and pre-vetted by the Department of Primary Care as the preferred supplier. Transcripts are sent and received via encrypted software. The time saved by outsourcing transcription is a clear benefit. The experience of transcribing the interviews took me back to the moment and in essence re-created the situation in the mind (Patton, 2002). This was quite a powerful experience as the act of transcribing evoked memories of the environment, the interviewee themselves; their character and mannerisms, and the sounds and activities of the environment around them.

4.7 **Data Analysis Process**

This section of the Chapter will chart a journey through the GT coding (data analysis) process to illustrate how the findings of the study were generated and conceptualised at each stage. By working recursively through the GT coding process as proposed by Charmaz (2006), I will explicate and describe how an interpretative analysis of the results was derived, leading to the generation of the central overarching theme for this study.

In presenting a theory that is an ‘accurate reflection of the data’ Birks and Mills (2011, p118), analysis concentrated on theory first, making it precedent, so that it is indeed grounded in the participants’ narratives and not subject to a preconceived framework other than that of the social context of work as detailed in Chapter 2 of this Thesis. As Dey (1993) proffers, the aim of a grounded theory study is to build theory from the data collected so that it is ‘fully grounded in the data’ (p103). The emergent theory is therefore an inductive interpretation of the data. This and the subsequent chapters provide a description and explanation of how particular interpretations of the data for this study were generated.

The GT process as it applies to this study is illustrated in the following flowchart (Figure 4). This indicates how a theoretical framework about the phenomenon of interest was constructed from commencement of data collection through to relational analysis and interpretation of the emergent substantive core categories.
Grounded Theory:
Socio-emotional consequence of supporting those with LTCs.
Extending Bolton’s (2005) Typology of Emotion Management in workplace to account for ambivalence = ‘Paradoxical’ tension

Further theoretical sampling if needed

Integrating memos diagramming concepts

Conflicts in ‘feeling rules’ between and within roles where supporting a LTC is non-normative to role (Sociological Ambivalence)

Sorting memo’s

Adopting certain categories as theoretical concepts:

External Pressures Public Role

Internal Pressures Private Role

Theoretical sampling and seek specific new data

Advanced memos refining conceptual categories

Focused coding = 47 categories Data collection

Initial memo’s raising codes to tentative categories

Initial coding = 1450 codes Data collection

Re-examination of earlier data

Research problem and opening research questions

Figure 4: The Constructivist Grounded Theory Process as applied to this study
Adapted from Charmaz K. (2006, p11) Constructing Grounded Theory
4.7.1 **Stage 1 - Initial Coding**

Analysis commenced as soon as Interview 1 was completed and proceeded concurrently with data collection and generation as per GT principles. Field notes detailing the context of the interview such as the location, any notable aspects of the interview, thoughts around participants’ behaviour and reflecting on my own, were written up and included in the analysis. The interview was transcribed verbatim. Thoughts occurring during the transcription process were captured as a memo and on an index card (see Appendix 8), and often sought to elucidate the ‘stand-out’ theme or essence noted from the data. For example, Interview 1 carried a prominent theme of empathy whereby the participant came across as a caring and thoughtful individual, considerate of his employee’s needs.

Manual notes were written on colour coded 5” x 3” index cards as follows:

- Pink for 3rd sector organisations
- Blue for Public sector organisations
- Green for Private sector organisations

The participant number, sector, size and type of industry were recorded on the card, as too was the participants’ level in the organisation, age and gender. Notes were then made on the card as to the salient themes arising from the interview, any in-vivo codes that were of significance and any other remarks arising from reading the transcript.

After completion, the cards were stuck onto an office wall as a visual reminder of each interview. The rationale for completing the cards was that they served to aide the comparative analysis method of the coding being instantly ‘visible’ thereby allowing for relationships between and within interviews to be observed without being constrained by the qualitative software package used. Recording notes in this way also allowed for the cards to be moved around as a ‘moveable feast’ so as to group them according to sector or industry type or category, thereby aiding further conceptualisation of the relations between and within the notes (codes) both on and off line.

Data analysis was aided by the use of Atlas.ti computer aided qualitative data analysis software (CAQDAS). Each transcript was uploaded to Atlas.ti for
storage and ease of coding. Prior to initial coding on Atlas.ti each interview transcript was read through thoroughly. The process continued for each interview and resultant transcripts, which were read on-line quickly and codes assigned intuitively, as advocates of the method suggest. There is a wealth of literature which debates the merits or not of using of computers for analysis in qualitative research (Chapple and Rogers, 1998), but most are of the opinion that software packages are useful for data management and for conducting initial coding exercises, where the coded data and attached quotations are easy to retrieve (Urquhart, 2013). From this perspective, using Atlas.ti was tremendously helpful during the initial stages to do what Dey (1999) terms ‘code and retrieve’ (p129), however it was of little use beyond this during the later conceptual and relational analysis stages. Thus, I agree with Chapple and Rogers statement (1998) that computers are not ‘essential for analysis of qualitative data’ (p559).

Codes were created as per the guidelines advocated by Charmaz (2006) and Strauss and Corbin (2008) where codes represent a dynamic interpretation of what is going on, what process is occurring and how it can be defined. What is the participant suggesting, and what are the meanings behind it? Strauss and Corbin (2008) further describe codes ‘as the names given to the concepts derived through coding’ (p66) and assert that codes are not just paraphrases of the sentence or paragraph, but an interaction with the data, digging deeper to uncover the ‘hidden treasures’ contained within.

As per the examples in Appendix 9, lines and paragraphs were either labelled with a newly generated code, with an existing previously created code or were labelled in-vivo. In-vivo coding involved coding using the words of the participants themselves as being indicative of a particular phrasing or vernacular expression that was of pertinence to the participant. For example, P6 (F, Non-manual, private org.) talking about co-workers’ support of those with illness being based on the strength of relationship, ‘whenever you can stick the knife, I mean it's human nature isn't it [laughter]’ and P4 (M, Pub, Mixed) ‘we’re still quite a macho culture’. In-vivo codes were chosen when I thought they were particularly indicative of the feelings of the participant, had particular meaning or stood out from the discourse as being pertinent and worthy of their own code. These codes can therefore represent a particular image, which conveys more
than could otherwise be labelled by the researcher. Strauss (1987) suggests that in-vivo terms have particular ‘grab’ for participants (p34) being inclusive of much local interpretative meaning and often colourful in their expressions.

Codes were simultaneously compared with all others as each transcript was coded, constantly looking for similarities in meaning between the codes as advocated by Myakut and Morehouse (1994). Memos were also generated detailing thoughts when comparing codes between and within interviews, and served to capture thinking about tentative categories and queries for theoretical sampling. Categorising the data through iterative coding served to expand and explain the interactive social processes inherent in the research situation as espoused by Birks and Mills (2011).

Initial coding continued in this way for each interview where each transcript was read and re-read, compared with previous interviews, memos, index cards and fieldnotes. As line-by-line coding progressed, similarities in participants’ narratives and the connections between them began to emerge within and across the data i.e.; after the first few interviews, recurrent codes began to emerge pertaining to similar themes with similar meanings. These were coded in Atlas.ti using labels generated from previously coded interview transcripts as noted above. For example, the code ‘Condition’ was created at Interview 1 when the participant mentioned a condition such as ‘diabetes’. This was then re-used in analysis of each subsequent interview transcript whenever a named condition was discussed. So too was the code ‘Barrier’, denoting aspects that the participant felt was a particular barrier to the employee’s success at work. And again the code ‘Enabler’, denoting aspects participants felt were particularly useful or helpful in enabling the employee to (re)enter the workplace. A bank of codes was therefore built commencing from Interview Transcript 1. These could either be assigned again or a new code generated throughout the coding process for all transcripts, and so on throughout until no new theoretical insights were emerging. Completion of initial line-by-line ‘open’ coding of all the transcripts generated 1450 codes.

4.7.1.1 Memos and Field Notes

Memos on general thoughts pertaining to the theory generation and interview content were kept from Day 1 of data collection (Appendix 10). These were
analysed comparatively - between and within interviews - along with the interview transcripts commensurate with the GT constant comparison approach. Memos contained thoughts regarding the comparative process and also thoughts on possible extant theory applicable to emerging concepts from the data or categorical observations. For example drawing on previously read literature or recording links between interviews when apparent. Memos were dated so as to be able to see a clear chronological audit trail of thoughts – both online, notebooks and diagrams – and to be able to see the maturing process of category generation through initial tentative theoretical concepts through to final theoretical integration.

Fieldnotes (Appendix 10) documenting the thoughts around each interview were also included in the data and analysed in the same way. Fieldnotes were captured as soon as I could record them on paper or straight into Atlas.ti. Fieldnotes included details of the setting and time of the interview, any reflections and observations that were considered important. I carried a notebook with me to capture thoughts as they appeared and transferred them to Atlas ti at the earliest opportunity.

However, whilst the majority of memos were captured on Atlas.ti many were handwritten or diagrammatic. Selected diagrams, illustrative of the thought process, were converted to electronic format for the purpose of transparency in illustrating how GT construction and integration was achieved for this study, an example of which can be seen in Appendix 11.

4.7.1.2 Memos – Tentative Categories

Conceptual analysis of the codes and their relations began from the commencement of data collection. Memos and diagrams capture thoughts with regard to emerging conceptual patterns and similarities in meaning of the code properties between participants. For example, Participant 1 mentioned themes whose dimensions covered feelings of empathy, balancing many voices, problems with supporting conditions such as stress. Participants 2 and 3 also mentioned these concerns alongside the fear of not complying with the law and the inhibitive nature of discrimination legislation, the personality of the employee (liked or disliked) and perceived legitimacy of conditions – and so on throughout the initial coding process.
After 5 interviews, tentative thoughts around provisional categories (and their relations) which were deemed to have important meaning for participants were diagrammed as per Appendix 11. Recurring themes began to emerge such as:

- Legitimacy – participants expressed scepticism regarding certain conditions such as stress and mental ill health. These were linked to thoughts around reciprocity and trust, compliance with legislation, disclosure and stigma and empathy etc.
- The employee’s personality - where personal support is influenced by how well liked the employee is.
- The notion of the unsaid was also observed – whereby participants were using non-verbal gestures to indicate the meaning behind their words – or saying ‘you know what I mean’ to express their private thoughts.

What was interesting was the strength with which participants’ feelings came across through the interviews, which was often not capturable on the audio-recorder. This was consistent across and between interviews, which served to corroborate participants’ individual narratives in constructing a broader picture of their role in supporting those with a LTC.

### 4.7.2 Stage 2 - Focused Coding

Although an ongoing thought process from Interview 1, the second phase of the GT analysis cycle involved the process of moving from tentative categories through to more substantive categories by grouping and integrating the 1450 initial codes into more selective categories (Saldana, 2011). The aim of focused coding is to consider which of the initial codes make the most analytical sense to explain the phenomena emerging from the data. Charmaz (2006) suggests looking at the most frequent and/or significant codes arising in beginning to define more conceptual and directive codes (or categories) to explain the data. This required me to make decisions as to what was important to be included in the coding based on themes emerging when comparing across and within the data.
4.7.2.1 Categorising

As analysis of the data progressed, the recurrence of codes with similar meaning began to emerge. It was apparent that these could form categories under which codes with similar meaning or that ‘look-feel alike’ (Lincoln and Guba, 1985, p347) could be grouped. In conducting this process, rules for inclusion of codes into categories were devised by describing each category’s properties (Lincoln and Guba, 1985). The majority of the 1450 codes were assigned to a substantive code family in Atlas.ti whilst some fell by the wayside as not being considered important such as ‘External Agencies – Support’. This occurred when there was only one or infrequent use of the code and was therefore interpreted as lacking significance (see Section 4.7.2, this Chapter). Codes were compared to categories and either grouped if they satisfied the inclusion rule, categorised elsewhere, or formed a new category and so on until all those codes deemed salient by myself were assigned. Using Atlas.ti made it easy to assign a category and then rename, re-assign or remove if deemed necessary.

For example, there were 55 codes which pertained to the participant’s expression of having to balance a multitude of elements in response to supporting an employee with a LTC. In examining and conceptualising all the code properties and their dimensions, it was deemed appropriate to categorise these codes as one core categorical concept. Therefore the process occurred as follows:

1. The code category was labelled ‘Balancing Differing Needs’ (coined so as to be indicative of the sub-codes contained within it).
2. The Property of this category is described as (codes must satisfy this rule to be included):
   - Participant has mentioned that supporting the employee with a LTC requires them to ‘balance’ many needs and pressures in some capacity.
3. Dimensions of the property are:
   - Participant has mentioned balancing the law, the employee, the business, their own needs and other employees.

In this way the 55 ‘balancing’ codes (or subcodes) were integrated into one conceptual category – that of ‘Balancing Differing Needs’ and assigned as a code ‘family’ in Atlas.ti. An indication of how a conceptual category was
generated can be seen in the following decision tree for ‘Balancing Differing Needs’ (Figure 5):

When conceptualising the properties of these codes and their connections to one another, it was apparent that many could belong to one (or more) core category or concept with similar content (Dey, 1999). These tended to be constitutive of or co-constitutive of the others. For example, an initial code of ‘Symptoms’, was grouped into the category Condition along with Defining a LTC and Medication. Similarly a code labelled ‘Stress as the new back pain’ was assigned to the general Stress category and also fitted into the category of Questioning Legitimacy of Illness (where participants were sceptical about the condition being non-genuinely used as a means to ‘play the system’).
This process was conducted iteratively for all the initial codes and a core conceptual category was created as a family in Atlas.ti, when it became obvious that the codes and their properties were related in some way and that the connections could be traced. This process resulted in 47 core code families (categories).

4.7.2.2 Conceptual Analysis

As conceptualisation of the core categories and their relationships was conducted attention was paid to ensuring that the data was not ‘forced’ (Kelle, 2007, p114) i.e., by applying my own existing theoretical and experiential conceptualisations onto the data. In observing the process of theoretical sensitivity I stayed close to the data and by using what Corbin and Strauss (2008) term analytical tools, to ensure that theory was ‘grounded’ in the data.

Conceptual analysis necessitated a return to the literature to investigate ideas for possible theoretical directions, which by implication were integrated into the constant comparison process and theoretical sampling. Initial theoretical thoughts regarding relations between the emergent core conceptual categories centred on the dimension of ‘balancing’ that all bar one participant mentioned in some form or another, as further elaborated in Chapter 5. Thoughts turned to relationships in the workplace, as participants appeared to be telling me that balancing was about their relationship with the organisation, external factors such as legislation, the employee and themselves.

Conceptualising the core categories with regard to these relationships showed that there was a distinct split between those dimensions and elements that were ‘personal’ to the participants and their relationship with the employee and those that are ‘external’ to the relationship. External factors are mainly structural elements outside of the participant’s control but which are influential to the way they deal with employees’ with a condition. This painted a picture of the employee-manager relationship being influenced and shaped in many ways - not least by micro-level personal thoughts and feelings of the manager and meso-level organisational structure - but also macro-societal structures in the form of Governmental legislation, law, the health care system and the social-cultural world to which employees belong.
It also became apparent that the *unsaid* during interviews was often more pertinent and telling than what was said (coded in Atlas.ti as ‘the unsaid’). By this it is meant non-verbal communication such as eye movements, hand gestures and silences, to indicate judgement values or which alluded to the participant’s real thoughts and feelings about the situation in question. These occurrences were captured in the interview field notes and discussed in memos, however it became clear that by only focusing on coding written data, I was not taking into account these aspects of the study. I was overlooking those elements of the interview which cannot be captured in words alone. These extra ‘things’ encompass non-discursive elements such as the environment, situation and body language. In this instance, the non-verbal communication and off the recorder discussions proved to contain more insight into the participants real thoughts and perceptions than was captured formally. This is discussed in relation to findings in Chapter 6, Section 6.6.

For this reason it was decided to explore analytical tools which might allow me to make the unsaid visible in my analysis, which led me to Situational Analysis as proposed by Clarke (2005).

4.7.2.3 *Situational Analysis*

In brief, Situational Analysis (SA) supplements, expands and extends GT by being a complementary tool for analysis which takes into account ‘non-human’ (Clarke, 2005, p60) elements of the interview not usually explicitly accounted for in the GT analysis cycle. This accords with Mason’s (2002) view of contextualizing interviews as discussed in Section 4.6.4.2 earlier and includes material elements or objects which have meaning for the situation. Ideologically SA challenges the notion that only humans matter or matter most. Clarke (2005) uses the example of the French wine growing industry to illustrate this point where ‘in France, grapes are very serious non-humans’ (p61). According to Clarke (2005) nonhuman objects/actants and discourses have a life of their own, and suggests that these therefore need to be accounted for in shaping our theories and should accordingly be made visible in our analysis. For Clarke the focus of interest in GT analysis is on the situation of inquiry and in particular, understanding the elements of the situation and their relations. Clarke argues that elements of a situation need to be specified in analysis of the situation itself.
as they are constitutive of it – they are it. Everything in the situation both constitutes and affects everything in the situation. SA therefore complements traditional GT analysis coding by forcing the researcher to consider all aspects of the situation (or the phenomenon of interest) which serves to influence the emerging story, rather than focusing primarily on participant’s verbal narration of action and basic social process.

Clarke (2005) has devised a diagrammatic mapping process to aid researchers in elucidating and articulating the elements of a situation and advocates completing any one or all the three ‘maps’ outlined below, to supplement the GT analytic process:

1. **Situational Maps** – Write down (articulate) all the elements in a situation and the relations between them. Researcher should consider all the human/nonhuman, material/symbolic and discursive elements as framed by the participants and themselves. Those things that structurally condition interactions through their specific agencies, properties and requirements, for example legislation, and the demands they place on humans, should also be included. In this study, the situation is taken to be supporting a LTC in the workplace and includes everything pertaining to the participant, the employee, the condition and the workplace which is involved in this situation.

2. **Social Worlds/arenas maps** – Researcher to consider and note what are the social worlds operating here? For example; the medical world (i.e., GPs, hospital clinicians), the world of employment (i.e., Human Resources, co-workers) and the world of Government legislation (i.e., DDA) are encountered by participants in this study. Researcher to consider which worlds come together in a particular arena and why? Why do some actors participate in particular worlds and not others? What are the relations between them?

3. **Positional Maps** – Researcher to consider and lay out the major discursive positions taken and not taken by participants, articulated and not articulated around the situation of inquiry. Plots differences in positions, controversy and concern about issues, absences of positions and discursive silences. ‘Positional maps represent the heterogeneity of
positions’ (p126). Enables the researcher to see what is unexpected or not understood – in my case to hear the “unsaid”.

Using the technique of SA mapping allows researchers to consider things that are significant in shaping participants’ social worlds but which are normally trivialised or disregarded such as material elements (workplace environment, equipment) or cultural elements (institutionalised organisational cultures, normative expectations of managerial/social roles). In this sense it enables the researcher to interrogate the data in fresh ways and to get information out onto the table, such as any assumptions and preconceptions brought to the research – which are also included in the maps. For this study’s analysis I attempted all of the above maps, however SA was chosen mainly in an effort to articulate ‘sites of silence’ in the data, therefore the Positional Map (Appendix 12) was of most importance.

Completing this map provoked analytic thought as to what seems present but silent or unarticulated in the data i.e., what is the elephant in the room that participants did not want to talk about yet intimated through non-verbal gestures and body language - and why did they chose not to talk about it. Contrasting what was being said with not being said, and plotting issues of concern and controversy to participants such as around legitimacy of conditions and social desirability, allowed me to theorise on participant’s feelings of discomfort and its consequences. This was pivotal in analysing the relations between the key themes emergent from the data, as will be presented in the following results Chapters (5 and 6) and discussed in Chapter 7.

Despite this, whilst Clarke’s theory is applauded for provoking researchers to analyse their data more deeply and to reflect on those complexities that constitute the ‘messiness’ or ‘doingness’ of life (Mathar,2008, p1; Wulff, 2008), it has yet to be widely used. Mathar (2008) in a review of the technique suggests that clarification of the terms ‘situation’ and ‘relational analysis’ would be beneficial, arguing that Clarke does not define what a situation means in terms of how it is temporally or spatially bounded. Similarly that the term ‘relational analysis’ does not ask how the elements of the relations are produced nor how they ‘condense themselves into elements.’ However, these limitations
were not troublesome for the purposes of this study where the technique was purely used as a tool to aid and complement data analysis

4.7.2.4 Theoretical Focus

As outlined in Section 4.7.2.2 above, initial theoretical thoughts centred on the impact of illness to the structure of the employee/manager dyadic relationship and hence on the nature and type of support afforded to employees with LTCs. The influence of relational demands, conflicts and reciprocity in understanding the nature of the relationship when illness is present were also considered as potential theoretical concepts.

These conceptual thought processes were eventually discarded as not reflecting participants’ perceptions of their experience grounded in the data. Nevertheless, moving backwards and forwards through the data and returning to the extant literature as the analysis process progressed was beneficial in helping me to achieve theoretical focus. Useful insights were gained throughout this process which enabled me to interpret those meanings and social processes perceived as of primary concern to participants. Here it became apparent that it was not their relationship with the employee at the centre of their concerns per se, but their difficulties with balancing the many conflicting elements associated with supporting them (for example balancing the employee’s needs with the economic needs of the organisation). This conceptualisation of the data therefore emerged as a ‘theoretically salient insight’ (Donovan and Sanders, 2005, p525) or a phenomena of significant meaning to the participants.

4.7.3 Stage 3 - Advanced Coding: Theorising

Glaser (1978, p72) describes this part of the analytical process as ‘how substantive codes relate to each other as hypotheses to be integrated into a theory’. This involves synthesising and linking the substantive categories which begins to weave the fractured data back together (Strauss and Corbin, 2008). The aim of advanced coding is to explain a process or a scheme associated with a phenomenon (Charmaz, 2006). Therefore, in further analysing the 47 selective categories (see Appendix 13) it was apparent that these were connected to six individual components (or demands) which constituted participants’ perceptions of balancing. These components were assigned codes reflecting the nature of
the perceived demand into which the 47 selective categories were synthesised (see Appendix 13). Further examination of the remaining six categories revealed that they fell into two distinct domains related to the locus from which the components (demands) stem, being:-

- External - public pressures arising from the demands, responsibilities and obligations of the participant’s professional managerial role and
- Internal - private pressures arising from private feelings, thoughts and evaluations associated with their individual social role in supporting those with illness.

Participants expressed their difficulties in ‘balancing’ these often conflicting multiple demands and pressures, where balancing both external and internal role demands in needing to support those with LTCs caused the majority to express ambivalence and emotional disquiet. However, to tease out my theoretical thoughts on this and to further explore participants’ expressions of difficulty, I utilised the method of diagramming called ‘conflict clouds’ (Dettmer, 1999) (Appendix 14). This was effective in attempting to conceptualise why participants perceive of their supportive role as a challenging balancing act. Relating core categories using the conflict clouds also provided insight to the emotional consequence of conflict where, as can be seen from the diagram in Appendix 14, tension arises from the incompatibilities between the wishes/obligations of the manager and the demands of other stakeholders.

Theoretical insights from this process led to a return to the sociological literature to identify suitable theory by which to interpret participants’ perception of ambivalence between and within both their roles and feelings. This led to the identification of the theoretical framework outlined in Chapter 3 of this thesis which is utilised to interpret the findings from the analysis process and which are discussed in Chapter 7.

4.8 **Using Elements of the Grounded Theory Process – A Reflection**

Coding line-by-line and to such succinct codes means that the ‘essence’ of what the participant is saying and the account as a whole is fractured (Reismann, 2008). I felt that this process of splitting the data loses some of the essence of the narrative, a well debated phenomenon in qualitative research (Atkinson,
Coffey and Delamont, 2003). The codes then merely become words without the meaning, context or intention. For this reason as analysis progressed, I decided to keep a note of the essence of each interview on its individual index card, capturing the overall feeling of what I interpreted as being implied by the participant and/or the message that the interviewee was getting across. I also found getting my thought process onto paper to illustrate the transparency of the coding process particularly challenging, especially as much of my relational analysis was conducted diagrammatically.

In a brief early memo generated at the start of the data collection I reflected that; ‘Coding is very subjective and depends on the mood you are in on that particular day.’ Initial line-by-line coding is meant to mitigate this problem by immersing the researcher in the data and focusing them on micro aspects of the process a step at a time (Charmaz, 2006), therefore concentrating them on the text. Whilst writing my thesis I also realised that I had fallen into the pitfall identified by O’Reilly et al (2012) in that I had attended more to themes than theory on occasion despite asserting to the contrary. This blinded me to what was grounded in the data.

By reading others’ accounts of their experiences of conducting a study using GT principles, where many discuss the identification of a central category only to realize later that this was a theoretical meandering, I realised my own journey has emulated these. Rejecting approaches and categories that did not capture participants’ perceptions caused anguish and was time consuming, and involved returning again and again to the data attempting to induct and interpret their experiences. This involved copious memo writing and new coding from the data. I therefore reflect on my experience of using GT principles and elements as one involving a lot of ‘mental gymnastics’ as described by Goldsmith (2007, p121) in Birks and Mills (2011).

4.9 Chapter Summary

In this Chapter I have presented the qualitative methodology underpinning the study and the methods by which data was collected and analysed, which were informed by the principles and practices of constructivist Grounded Theory as espoused by Charmaz (2006). In the following Chapters I go on to present the
findings from this process where data analysis has indicated that participants’ experiences of managing LTCs in this study are many and varied, as is the range of conditions encountered and their approaches to supporting them. In Chapters 5 and 6 I therefore present the findings from the analysis process as detailed above, specifically focusing on exploring the properties and dimensions of the key themes as inductively interpreted from the data. Chapter 5 will elaborate on the core category that managers are perceived as Tightrope Walkers, balancing many demands, interests and responsibilities both integral to their role as a manager and those of their personal social role. Chapter 6 will elaborate the second core category of Getting Personal, exploring personal, private feelings, thoughts and evaluations around these tensions – which were often unsaid.
5.0 Introduction

As introduced in Chapter 4, I will now go on to explicate and explore the first substantive category emergent from the data. Using examples from participant narratives, I will focus on those external pressures expressed by employers and managers which constitute their view that supporting those with LTCs is one of a difficult ‘balancing’ act. Hence participants are conceptualised as Tightrope Walkers, derived from their perception that they are treading a fine line between responding to the demands, obligations and interests associated with their ‘public’ social role such as those of the employee and the condition, those of the organisation, the law and other (co)workers, as well as their own personal interests and values of their ‘private’ individual social role pertaining to illness/conditions, the individual employee and maintaining professional integrity. In this Chapter I concentrate on the former, explicating the external economic, bureaucratic and political pressures identified by participants which manifest when managing other people’s illness in the workplace. The aim of this Chapter is therefore to illustrate the properties of the core category of ‘balancing differing needs’ (see Section 4.7.2.1) pertinent to participant’s professional social role as a manager.

5.1 The Category of ‘Tightrope Walker’

Participants were asked to share their experiences and perceptions (both positive and negative) of and for, supporting and retaining an employee with a LTC in the workplace. More specifically, participants were asked how they see their role in supporting those with LTCs and helping them to manage their condition.
at work. Participant 20 (F, public org.\textsuperscript{10}) in the quotation at the start of this chapter encapsulates the unanimous response conveyed by all but one of the participants in this study, when she says that she is walking a fine line between the multiple pressures associated with managing and supporting an employee with a LTC. Similarly others mentioned that:

‘[it’s a] difficult path you tread in between trying to deliver business performance and trying to manage the welfare of somebody who works for you.’ (P12, M, private org.)

‘You’re in the middle, you’re trying to manage the situation so that the workers and being helped and she is being helped (alcoholic employee) and trying to do it within the law’ (P14, F, private org.)

‘I act as the cushion really between the powers that be saying we need more money I’m pushing back saying, it’s not as easy as that. And I try and keep that pressure off the guys on the ground so I’m... I absorb quite a bit.’ (P8, M, 3\textsuperscript{rd} sector org.)

Thus, the notion of participants as Tightrope Walkers was borne from a combined interpretation of participants’ phraseology and noting participants’ physical reactions and non-verbal expressions of emotional disquiet during interviews. Participants were keen to convey how difficult they found it to manage an employee with a LTC and these emotions were tangibly evident in the interviews although not always explicitly articulated verbally, and hence were not always capturable on the audio-recorder (see Chapter, section 4.6.4.3). For example, participants 10 (M, private org.) and 16 (M, private org.) used the word ‘minefield’ alongside facial expressions and body language to indicate their tensions and personal conflicts when managing staff with a LTC. Using expressive gestures, or non-verbal leakage as Ekman and Frieson (1969) define it, is thought to betray those thoughts usually consciously withheld from open disclosure. This will be explored and evidenced further in Chapter 6 of this thesis.

A key finding from the study is that the perception of tightrope walking is consistent across all industry types, sectors and sizes, and is not specific to participants or sector type - counter to traditional assumptions regarding the commercial nature of private organisations. This will be elucidated later in this

\textsuperscript{10} Bracketed participant characteristics attached to quotations are abbreviated as follows: Participant number = P*, participant gender = M/F (Male or Female), participant employed in = Public, Private or 3\textsuperscript{rd} sector organisation (org.).
Chapter. It is apparent from the data that the many demands and interests which are (or become) involved when an employee has a LTC, ‘add’ to the already busy role of the manager. Participants imply that these pressures present additional burden and conflicts for them, especially for those inexperienced in managing employees with sickness. Pressures they perceive come from competing demands, interests and obligations as visualised in the following diagram:

![Figure 6: Being Tightrope Walkers: Participants Balancing Act – Professional ‘Public’ Social Role](image)

As per Figure 6 (highlighted) participants discussed four main external demands which they feel exert a pull on their professional managerial role when managing and supporting those with LTCs. These aspects constitute four components of the core category of ‘balancing differing needs’ which will now be explored.

5.2 **Balancing Differing Needs – The Employee**

As previously outlined in Chapter 4, the majority of participants had had experience of employees with LTCs within their organisation and had either managed them directly or could talk about others in their hierarchy who had. Participants tended to frame their responses around mainly negative experiences
they had had of LTCs or disability in the workplace, but often went on to balance this with examples of positive experiences with successful outcomes. Here, one of the overriding concerns for participants is balancing the employee’s ‘needs’ – physical material workplace accommodations and non-material social (emotional) support as well as accommodating their condition (type, symptoms etc.) - with all other responsibilities concomitant with the professional management role. In order to facilitate a successful working experience, employers and managers expressed a conflict in having to respond to these needs whilst also ensuring value to the organisation, remain within the law and manage other staff.

Participant 6 encapsulates this dilemma along with a sense of ambivalence and discomfort alluded to by most participants in the study, by suggesting that accommodating employees’ needs, in this case providing alternative work and specialist equipment so as not to aggravate the condition, has wide ranging effects.

‘You have to change the work schedule of the entire building and others to accommodate the needs of the individuals depending on what their illnesses and ailments are. So it does have quite an effect on, not just the person and not just the employer but also the work colleagues that are with them.’ (P6, F, public org.)

Participant 31, talking about line managers in his organisation, aptly summed up the sample’s tensions in responding to the needs of the employee when he said:

‘So they struggle sometimes in establishing exactly what they should be doing and how far they go, and how you strike a balance between what the organisation needs and the business needs, and support measures for the individual concerned, and that is problematic.’ (P31, M, public org.)

5.2.1 Employee Needs – Material Support

Participants predominantly described employees’ needs in terms of tangible, material, physical aspects that they can facilitate and provide in order to enable them to conduct their job both in maintaining and/or returning to work. Material/physical needs in this respect ranged from implementing adaptations to the workplace such as creating disabled toilet facilities (P10) and thinking about how those with limited mobility use the workspace. As P8 said this could be:

‘simple things like making sure that the cups in the kitchen are not put on a high shelf, they’re put on a low shelf.’ (M, 3rd sector org.)
to providing specialist equipment (computers, software, uniforms, phones, desks etc.) and using other workers in a supportive capacity, especially for those with conditions where safety might be compromised:

‘s so the people who were visually impaired, there was a system set up that worked of buddying up, so if there an evacuation somebody would know, it was their job to be with them and to make sure that they got them evacuated safely’ (P21, M, private org.)

Those material needs which appear to contribute most to participants’ perception of balancing are those which require alterations to employees’ contracted working arrangements, and which therefore impinge on the managers’ obligation/responsibility to provide value to the organisation through the employee (see Section 5.2). These are accommodating employees’ requirements for reduced hours, allowing time off for medical appointments, flexible/altered working patterns, reassigning work to co-workers, altering the job duties where possible such as P5:

‘It’s just mainly that obviously if someone’s had a bad back you make sure that they’re not doing any heavy lifting or they’re not repeatedly going up and down stairs’ (F, public org.)

And reassigning the employee to an alternative role if possible as in the case of P26 (M, private org.) moving a manual worker to an administrative/receptionist position:

‘...think what you have to do is if they’ve been on long term sick for whatever reason just to look at their role within the[org]... and whatever you can do to make it easier without taking away their whole job if that makes sense’ (M, private org.)

Of these, the majority of participants were in agreement that a flexible approach to return to work using a phased return or negotiating reduced hours is a tangible, successful way of supporting those with LTCs (where the structure and policies of their organisation allow). However, most participants placed a caveat on the nature of these measures, stressing that they are viewed as temporary with an expectation that the employee resumes normal contracted working after a certain period of time (usually dictated by organisational sickness absence policy). For example Participant 32 (M, public org.) describing how he supports an employee with HIV associated depression:
P32: ‘because he's back to work a lot quicker and he's a lot happier straight away because he is busier and involved in the teamwork etcetera.’

DLB: So that's a like a phased return and then...

P32: ‘Yeah any long term absence we have a phased return up to 12 weeks, so you’d still come in on full pay but reduced hours and we’d stretch that across that 12 week period...you know, a couple of weeks of reduced hours, phase it back into full time’

This was indicative of the phased return approach described by many participants which is intended to acclimatise employees back into the working environment, building up recovery and preventing relapses by ‘easing them in gently’ (P4, M, private org.) As would be expected, those participants from large, non-manual (administrative) organisations with increased financial and staffing resources find it is easier to accommodate material needs in the form of reduced hours, time off, role re-assignment, specialist equipment etc. This is compared to those working in manual (manufacturing) organisations where there is limited scope for redeployment to other roles or areas for example, between the shop floor and office based duties, especially if the organisation is small to medium sized. For example one participant said:

‘...they've got something that means they can't physically do the job, there probably isn't anything really that they can...Because it's not like if they took any training we would give them another post. Because we wouldn't bend over and create a new post specifically for someone.’ (P16, M, private org.)

A pattern which is consistent across and within interviews is the contradictory nature of participants’ narratives, which belies their feelings of ambivalence. On the one hand they speak of positively accommodating employees’ needs but on the other, are tempered by the economic demands of the business and the politics of the law, etc. The following participants both exemplified the ‘sympathy BUT’ dimension of balancing differing needs when they ventured:

‘...and having a plan when people come back to work, that they're not expected to just pick up and get straight into it. Being realistic really and just pacing people. But, again, that's difficult to juggle because we expect a certain level of performance. But, again, with reasonable adjustments and stuff I think it is about having that conversation isn’t it about what’s reasonable, what’s not, what’s acceptable to the organisation, what’s not, what’s in your best interests, what’s in our best interests and trying to reach some common ground really, somewhere to find a way forward.’ (P22, F, public org.)
‘So, if you want me to do something, if you want me to make an adjustment, I will make a reasonable adjustment, but I will also always have my eye on the business...I have to still be able to do my business while supporting you.’ (P20, F, public org.)

5.2.2 Employee Needs - Social Support

Aside from material support, participants often talked about supporting employees in non-material ways. This was described under the umbrella term of ‘support’ and encompassed a broad range of socio-emotional needs ancillary to employees coping with work and integrating back into the workplace after periods of absence. This is predicated on having open and honest communication in the relationship where keeping channels open when the employee is at home (through phone calls and home visits) being welcoming and fostering an inclusive, open environment upon return is considered important.

‘...basically I think from a line manager perspective, it’s just to do with talking to that individual, making sure that... on a regular basis. Making sure that they’re happy, that they’re able to cope, monitoring what they’re doing.’ (P27, M, private org.)

‘Making sure you’re aware that they’re gonna be coming in at nine o’clock and having a plan to sit down with them....and they already feel nervous about coming back. So they’re not big things, but little things to them are massive.’ (P33, M, private org.)

Many agreed that maintaining social contact or ‘staying connected’ as Participant 19 (F, private org.) defined it, is key in getting employees back into the workplace where early intervention is proven to increase employee confidence and the likelihood of return to work. Proactively managing individuals back to work is generally advocated throughout this cohort, socially supporting recovery and ensuring that employees return to work when the time is right and in the ‘right frame of mind’, (P33, M, private org.). When back at work, there was consensus that support is approached on an individualised, case by case basis where getting to know the staff member, ‘making certain you talk to them’ (P39, M, public org.) and listening to them is, although obvious, considered fundamental by all as this quotation illustrates:

‘I think you’re like being... it can be somebody that they can talk to, basically, so you can listen to them. And also that bit about... that you also have a role as a sort of coach, if you like, a little bit, so you’re
listening to what they’re saying and asking them questions, and actually that can be quite helpful to people I think.’ (P27, M, private org.)

‘Well, I would hope that anybody reporting to me would be happy to disclose that information to me in the first instance so that I was able to support them, if they were struggling they could come and say, “I’m struggling today”, or, “This is the time of the year when I do dip a bit low, and can we look at how I can manage that?” (P23, F, public org.)

As the preceding quotation suggests, awareness of the employee’s ability to cope with the condition on (re)entering work and their responsibility in managing this was important to most managers in the sample. Participant 38’s response was indicative of this when he said that his thoughts centre on ‘how do we make this work’, conscious of both the potential detriment to the employee and the organisation of getting it wrong. Participant 25 (F, public org.) suggested that lack of thought towards employees’ capacity to cope on return to work could be a barrier to a success if managers assumed capability at pre-absence levels without adjusting for loss of confidence or reduced ability:

‘I suppose there can be a mismatch, because the organisation has just been carrying on as normal, and not stood still, whereas the individual, if they’ve been at home on their own they’ve just been out of it, and that it’s like them stepping on a moving escalator when they’ve just been stood still; and whether or not that actually makes it harder for them...I don’t know whether as a manager I’ve ever given enough thought to where their capability might have been and where it is now, and where their confidence might have been and where it is now, and making sure you’re matching up the support; because I think the evidence is that if you get that much right they’ll improve much quicker; if you’re trying to match them at the level they were before they went off and they’re lower than that then they’re going to struggle. So, I think it’s quite a tricky one.’ (P25)

Non-material support was also portrayed by participants’ as emotional support. Employers and managers described the requirement for them to be a listening ear to employees, allowing them to share their difficulties in having a LTC and coming to terms with it, as in the case of an employee with Crohn’s Disease (P29) or more generally (P34):

‘But from his perspective I think that helped him, the supporting mechanisms around, that the team were all willing to listen and have a shoulder to cry on because he had never really had that either.’ (P29, M, public org.)
‘...so I think there’s been sometimes it’s a shoulder to cry on or just to talk and talk about their condition and just to have that open and honest communication.’ (P34, F, private org.)

However, many participants found the emotional aspects of supporting those with LTCs personally difficult to cope with (detailed in Chapter 6) worsened by having to balance employees’ emotional needs with the prescribed demands and requirements of the organisation, as the following quotation highlights:

‘It’s very emotional. I mean everybody...I mean any of these people are very emotional about it. And to some extent, it’s their own realisation of their condition, followed by the fact that your work are then talking to you about it.’ (P15, M, private org.)

As described in Chapter 3 section 3.3, Bolton (2005) alerts us to the notion that feelings are also prescribed by the organisation but as the following instances highlight, personal philanthropic feelings around other people’s illness are also invoked. Specifically, participants found supporting the emotional needs of those with certain conditions particularly challenging. Here Participant 30 typified the majority when discussing the emotional impact of supporting an employee with cancer:

‘so you are balancing the emotion and her illness and what's she's going through, we are trying to keep everything, all the business working at the same time.’ (P30, M, private org.)

or as in this maternity related case:

‘...so that was quite difficult...it was almost a bit like a, you know, the trial and error to get to the right outcome for her really, but that was quite difficult because it was a really emotional period for her. So I had to balance giving her the support whilst also making sure that the business was, you know, like was considered as much as possible in that situation, but yeah that was a difficult period.’ (P32, M, private org.)

Finally, it is clear that employees’ material (physical) and non-material (socio-emotional) needs in working with a LTC are complex and broad ranging. However, participants also identified that there was a third element of employees’ needs to attend to, that of the condition.

5.2.3 Employee Needs - The Condition

In total 56 conditions were mentioned during the interviews including various types of cancer (neoplasms), multiple sclerosis, diabetes (type 1 & 2), Chronic Fatigue Syndrome, Spina Bifida, musculoskeletal disorders, HIV, alcoholism
and substance abuse, mental health issues, bowel disorders, heart conditions etc. Conditions were classified as per the International Classification of Diseases published by the World Health Organisation (IB ICD-10, WHO, 1994). Findings from this study mirror those of the national trend in the UK, where mental health and stress related conditions were the most frequently mentioned, and which are currently the number one causes of sickness absence and applications for Employment and Support Allowance benefit claims (see Chapter 2) as follows:

<table>
<thead>
<tr>
<th>Reasons for Employment and Support Allowance Benefit Claims</th>
<th>Rank in order of ESA caseload no’s (Feb 2013)</th>
<th>Rank in this study</th>
<th>No. times mentioned this study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental and Behavioural Disorders</td>
<td>1</td>
<td>1</td>
<td>51</td>
</tr>
<tr>
<td>Other (including cancer, diabetes, injuries, digestive, blood and genetic disorders)</td>
<td>2</td>
<td>2</td>
<td>46</td>
</tr>
<tr>
<td>Diseases of the Musculoskeletal system and Connective Tissue</td>
<td>3</td>
<td>3</td>
<td>19</td>
</tr>
<tr>
<td>Diseases of the Circulatory or Respiratory System</td>
<td>4</td>
<td>4</td>
<td>16</td>
</tr>
<tr>
<td>Injury, Poisoning and certain other consequences of external causes</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Diseases of the Nervous System</td>
<td>6</td>
<td>5</td>
<td>8</td>
</tr>
</tbody>
</table>

**Table 5: Conditions reported in this Study compared to UK National reasons for ESA claims**

Whilst the majority of participants described their experiences of supporting a range of conditions, five interviewees chose to discuss only one or two specific cases with which they had particular difficulty. These were cases of an employee with Chronic Fatigue Syndrome (CFS) (P12), one with alcohol dependency (P14) and one with ulcerative colitis (P27). Two others contrasted their experiences of managing employees with leukemia and one with connective tissue disorder (P22), and one with cancer with a musculoskeletal disorder (P30). Participants discussed their difficulties with managing these particular cases, in essence using the interview as a safe space in which to express their concerns and tensions over their handling of the situation. For example, in the case of the employee with CFS:
‘I’d like to think I managed it well as far as I can as I have not managed anybody like that before. Sure I made some mistakes I’m sure I did, would’ve done things differently in certain situations but there we are, it was a difficult thing to manage’ (P12, M, private org.)

The other participants mirrored this view in questioning their individual supportive behaviour. P14 (F, private org.) summed up her frustration with supporting an alcoholic employee by exclaiming ‘it’s a nightmare on legs!’

Support for varying conditions was often described in terms of those that were visually symptomatic denoting for many participants seriousness and genuineness of illness by presentation of tangible ‘physical’ symptoms. Many elaborated on their experiences and difficulties of managing those with conditions that are visually asymptomatic or with medically unexplained symptoms such as viral conditions, bowel disorders and mental ill health and CFS as here:

‘Yes I think if, you know, someone comes along with a broken leg for example you’ve got an obvious physical manifestation of something and, you know, people work round it in a sense of, sort of, you know, travel is clearly out so you manage that situation.’ (P12, M, private org.)

‘Unless it’s something like they’ve broken their leg or it’s an operation which is quite tangible and quite different. But I think when you’re dealing with mental health there’s quite a different response and it’s very little understood.’ (P19, F, private org.)

This finding will be further explored in Chapter 6 of this thesis. Suffice to say here, that of the many conditions discussed, stress and mental health conditions were perceived as being the most difficult for participants to support and manage.

5.2.3.1 Mental Health Conditions and Stress: A Particular Challenge

The finding that two thirds of participants reported experiences involving stress and mental health conditions is consistent with current figures in the UK which suggest that the prevalence of stress is increasing in the workplace and that mental ill health affects 1 in 4 of the population (MIND, 2013). Participants find these conditions particularly challenging to support and the majority expressed that they feel that they are operating in often uncharted territory. P11 (F, 3rd sector org.) and P31 (M, public org.) express the difficulties of the cohort by saying of supporting those with MH conditions and stress:
‘I think mental health is the biggest barrier. That’s my opinion. It’s like you’re on a treadmill. You sometimes feel you’re getting somewhere and somebody is really progressing, and then all of a sudden it can just change and you’re back to square 1. That’s what it feels like a lot.’ (P11)

‘I think mental health in itself is very problematic because the range of approaches and the ranges of... The ability of the manager to work with the individual in an open and... we need a direction of travel to get to where we need to go, and I need you to work with me to get there; the levels of agreement to doing that vary wildly.’ (P31)

The majority of participants, with only a couple of exceptions such as Participant 8 (M, 3rd sector org.) when discussing stress said ‘but it’s funny I don’t consider that... well I didn’t consider that as a long term condition’, recognised that mental health conditions could potentially be long-term. There was a lot of non-verbal communication in interviews where mental health and stress conditions were discussed and people would intimate their thoughts by rolling their eyes or gesticulating with their hands so that it was not recorded on the audio recorder (for reasons that will be discussed in Chapter 7). For example when describing the difficulty in discerning when someone was genuinely ill as evidenced in Chapter 6.

Six participants described an awareness of the increasing prevalence of MH conditions and stress problems at work. Respondents discussed various reasons for this which are illustrated in Chapter 6 but one participant was explicit in venturing to verbalise sceptical thoughts about the genuineness of stress as a condition shared by many in the cohort:

‘I think it’s [stress] the... it’s kind of the in-word isn’t it, ‘I’m stressed,’ and yeah, I think over the time that I’ve been in management and working in this industry I’ve seen it definitely being a very common excuse that people are... have got down on the sick note, yes definitely.’ (P9, F, public org.)

Contrary to expectations, there was little description of employees’ use of medication either inside or outside of the workplace. Of the eight managers who mentioned this, the particular concerns were about employees not-adhering to medication regimens and specifically with mental health conditions, where two participants saw noticeable changes to employees’ behavior in these instances. P31 (M, public org.) said:
‘To be honest with you, one of the biggest and most common issues that we have is people choosing to take themselves off their medication. So where people are taking their medication then we can manage mental health issues that are medicated quite successfully. But it’s when they take themselves off their medication and the response of the organisation when the manager’s sat there thinking I’ve seen this before and I think they’ve either changed their medication or they’ve come off their medication and it’s beginning to exhibit itself in the workplace, it’s very difficult to go over to someone and say excuse me, [chuckles] can you tell me whether or not you’ve taken yourself off your medication please? It’s a very difficult area to deal with.’ (P31)

Around a quarter of the participants mentioned particularly successful strategies in getting those employees with mental health conditions back into work. Participants confirmed the notion that it is harder to get people back into work the longer they have been off and that this is especially difficult with mental health conditions, which is commensurate with existing research (see Chapter 2, Section 2.2.6). They recognised that the main hurdle is just in getting employees back through the door, brought on by the fear of returning to work through perceived stigma of mental health conditions which are perceived as less ‘socially acceptable’ than physical conditions (P18, M, public org.). This is consistent with policy literature on barriers to returning to work for those with MH conditions as detailed in Chapter 2 Section 2.4.2.

‘I find by encouraging people to come back into the work place and have meeting here helps them, in terms of you know, get over the threshold because you often find with depression and anxiety although the workplace may not have any part in the person being absent, it can become a barrier in terms of a person feeling comfortable coming in because they may not want people to say hello how are you.’ (P34, F, private org.)

Participants expressed awareness of condition specific needs of which they may not necessarily have had previous experience, including symptom management and medication taking. In some instances participants voiced the concern about their lack of experience in this area, not being medically trained and were therefore reliant on Occupational Health, HR or the GP for advice. Therefore expressing a lack of confidence in supporting those with LTCs, especially where they appeared to feel out of their depth in meeting their managerial responsibilities to the employee. This was largely manifest in participants’ descriptions of having what they termed ‘difficult conversations’ (See Chapter 6) with employees as follows:
‘So things like mental health conditions are very challenging, dependent on how...and quite often it comes down to how prepared the manager is to have quite difficult conversations. Because that's always part of the challenge, is that whatever we do has got to be in effect with consent and support from the employee concerned. And there are certain conditions where that might not be forthcoming, and that I suppose does become a challenge.’ P31 (M, public org.)

In managing an employee with a LTC participants were aware of the need to balance the physical limitations of the condition and the employee’s welfare with the requirements of the job as Participant 12 (M, private org.) and Participant 27 (M, private org.) explain:

‘The, you know, the priority was the condition, that’s, you know, it would have been unfair and unreasonable to try and push somebody in a position where they have this illness.’ (P12)

‘If they’re well enough to do some degree of what their job is then that’s what they should perhaps be doing, so it’s just... the main barriers are around trying to match up what needs to be done with what that person is capable of doing at any one time’. (P27)

Many of the managers in the sample also want employees to be realistic about their condition and their capabilities but often find that employees can be over ambitious or in denial, in order that there is no detriment to their job and hence income. A level of realism is required, leaving the manager to attend to these needs. This was problematic for some managers who expressed their awareness of the extent to which the condition structured the working relationship as P12 (M, private org.) suggested, ‘the condition had an impact on how I approached her about management.’

‘it was basically trying to strike the balance... the right balance between making sure that I wasn’t going to increase the level of stress on her, but also making sure that the business got some value out of her being employed.’ (P26, M, private org.)

With regard to the instrumental nature of the relationship, managers talked about what they want from the employee in order to be able to support them in managing their condition in the workplace and enable them to do their job. This includes honesty, openness, communication, pro-activeness, early discussions – not letting things go on too long, taking responsibility for self-management of their condition and managing the life/work balance so that they can cope with work.
‘I think they’ve got a responsibility to manage their own conditions as best they can with support, ... and it’s striking that balance isn’t it of prioritising your own condition and your own problems, but when that gets to a stage where it’s actually impacting on service users that’s the time not to be at work really.’ (P23, F, public org.)

‘And it’s that personal responsibility thing again isn’t it, to manage to yourself, and what you’re doing outside of work is your own business but if it’s impacting on your job then it is our business, and that is difficult really.’ (P22, F, public org.)

‘Well I think they’ve got a considerable responsibility, [sigh] and, I mean you just get, some people will just innately get that, and [pause] and be doing all they possibly could in order to sort of be keeping on top of whatever their illness is....’ (P39, M, public org.)

Across this particular cohort there is a commonly shared perception that employees have responsibilities too – both to the organisation and to themselves in facilitating a successful working experience. Most mentioned that if they can see that employees are willing to help themselves then they are more willing to support them. The tension this creates for participants when employees fail to self-manage their condition is evident in the quotations below:

‘...potentially it would go the formal route of like a disciplinary, that has happened if people aren't managing themselves or... yeah it's a difficult one isn't it really. If somebody is not looking after themselves then they would fall in line with standard group procedures, policies. If they are managing themselves, you know, we would be equally supportive.’ (P31, M, public org.)

‘I’d give him all the support that I could, but again, the organisation would seem to go the extra mile for somebody who, it would appear, didn’t... or would use their illness to maybe take advantage of our sickness policy in terms of the time off that they could take. And will take advantage maybe of management and the support that they will give. So sometimes I suppose there’s an imbalance.’ (P29, M, public org.)

Many expressed that management of LTCs is a ‘two-way street’. There is very much a feeling of the need for give and take on both sides, as P9 (F, public org.) illustrated, ‘so, tell us what it is and we’ll work with you’. Participants discussed this in terms of finding a common ground in providing mutually beneficial support (both material and non-material) to enable the job to be done:

‘So I’m a firm believer and I think an employer to be successful in staff management has to have that balance of give and take. You can’t take all the time and give nothing. You know, so we have...we have that trade off so you get the odd one who’ll push the boundaries, you get the odd
one every now and again who'll go a bit too far so you just have to reel
them in. So flexibility cuts both ways. (P10, M, private org.)

A small portion of participants were unsure what defines a LTC and expressed their ambiguity over the terminology by referring the question back to myself and asking for clarification. This in itself opened up a further area of discussion in terms of what constituted a ‘serious’ or legitimate/genuine illness with tangible symptoms, which will be discussed in Chapter 6. For example P9 (F, public org.):

‘I suppose, I’m not sure what you would class it as, if someone say had an accident and hurt their back? Are you classing that as an illness as well as like cancer?’ (P9)

Most of the participant’s mirror P31’s issue that medication is a difficult area to deal with and P22 (F, public org.) also felt support was compromised by not understanding the medication, suggesting that:

‘If I, maybe, had more information about the medication she was on..... in that, she’ll say something and then, almost, sort of, say, well, I didn’t say that, you know, I wonder what effect the medication is having’. (P22)

An additional concern for many respondents is the problems associated with the longevity of the condition. This impacts the employee and employer from a financial perspective in respect of covering (and paying for) extra staff to cover the workload and with performance (career) management. Here as P11 described, it is difficult to manage employees’ career expectations within the limitations of their condition, in this case a MH condition:

‘that expectation and as a manager you’re taught to manage expectation, but again the conflict is, if I actually were to tell you, really straight, my opinion which is that that’s not ever going to happen, I could make you ill. So it’s that kind of judgment all the time, how far can I say? How far can I get my point across without emotionally wrecking you? So it can be difficult.’ (P11, F, 3rd sector org.)

Managers mentioned that it is hard to manage the unpredictability and episodic nature and fluctuations in health that certain conditions present, again for balancing cost and productivity reasons, and feel that this can be problematic, especially when combined with the longevity of the condition and knowing that there may not be any improvement. For example in a case of an employee with stress (P1) and CFS (P12):
‘I think that must be (the most) difficult one to handle, because, you just don’t know when they’re going to return and how things are going to be when they return.’ (P1, M, public org.)

‘So it was very hard to know what she was going to deliver and when and, you know, deadlines were missed and people were let down and, you know, so when she was having a bad episode you really couldn’t tell what you were going to get out.’ (P12, M, private org.)

For many, supporting the employee and their condition also involves arranging and organising additional support from Occupational Health with the facility for onward referral to physiotherapy or specialist agency support. As would be expected, public sector and large private organisations in the study have good access to specialist support and Occupational Health facilities. In contrast, the six participants from small organisations did not mention referral to Occupational Health (outsourced or otherwise) at all:

‘...but long-term we tend to see them every 6 to 8 weeks, so at that stage we advise them opportunities we can give them physiotherapy, you know, referral for a specialist if need be if we have the capability of that you know, if it’s a knee injury then fine we can see what (they’re capable of?) and so, we’ve got physiotherapy and we refer them for our occupational health anyway so they can be assessed by our own medical staff which can suggest something for them.’ (P35, M, public org.)

5.2.4 The Demands of the Medical World

The majority of participants had or have some form of experience with the medical world where it intersects with the world of work in the form of primary and secondary care (hospital) appointments treatment regimens, medication, clinician advice about the employee’s condition, symptom management and receiving a GP Fit Note etc. Again, participants described their tensions with balancing the demands of the medical world upon the employee and their capacity to perform their job, as in this participant’s concern over an employee with responsibilities for others:

‘An employee became pregnant and at the time she was on antidepressants and she came off those antidepressants while pregnant because she didn’t want the stuff in her system. I’m not 100% sure if antidepressants can affect the baby whilst being pregnant I’m not too sure. But she felt that they did, she didn’t even get doctor’s advice for it at the time and said right you know I’m on them, I’m now pregnant I’m coming off them. And that caused quite a big personality change so to say.’ (P26, M, private org.)
Nearly half of the sample talked about employees taking time out for medical appointments and the subsequent consequences for productivity or inconvenience of having to arrange cover for them. For example P10 (M, private org.) said it was more difficult to accommodate time out for non-manual staff in his organisation compared to manual workers who were encouraged to attend appointments out of working hours:

‘It's more of an issue with office based staff and you just have to really manage it and you just have to manage it, and you just have to be fair by the people and manage it. And often if somebody's taken a couple of hours off to go to the doctors they often work later at night.’ (P10)

This notion was practically enforced by some participants who suggested that their organisations encourage appointments to be taken out of working time if at all possible. For example P4 (M, private org.) said that this was stated in their HR sickness absence policy where it was suggested that employees:

‘do it out of office hours, but if not, if you can try and do it at the start of the day or the end of the day and try and manage your work commitments’. (P4)

This was echoed by others such as P9 (F, public org.) said of staff taking time off for medical appointments that,

‘it’s fair enough I think like the first time, but when it starts getting a regular physio appointment, we will... we need to say, ‘You need to start taking it in your own time, or making the time up really.’ And yeah, HR support that as well. We’re not saying we’re not going to allow you to go but we’re saying, ‘Can you work with us on this’’ (P9)

5.2.4.1 The GP Fit Note

As outlined in the Chapter 2, the introduction of the GP Fit Note to replace the Med3 Sick Note in April 2010 occurred during the PhD research period and it was therefore deemed an ideal opportunity to ask participants about their perception and experience of using it. Especially as the use of the Fit Note is directly relevant for this research in that the ethos behind the Fit Note is to encourage employees back to work sooner.

In this sample, 20 participants had seen the new Fit Note, 16 had not, and 4 were either unsure or I had omitted to ask. Of those who had seen the Fit Note their reaction was in the main negative. Comments centred on the suggestion that
GPs were not completing them correctly and that they were being used in basically the same way as the old Med3 sick note.

‘At the top it says, ‘This person is not fit for work’, so there was a tick. But then further down it says, ‘This person should remain off from’, so it was a date in May until the date this Monday, so it’s almost like contradicting information. That really shouldn’t have been ticked because you’re signing that person back to work, the following day’. (P9, F, public org.)

Overall participants felt that the sentiment behind the fit note was a positive step in the right direction towards getting employers and GPs working together to get people back into work. As P24 (F, public org.) suggests, ‘I think just the term ‘fit note’ rather than sick note does sound a more positive.’ A few expressed cynicism towards the way they were being implemented and used for example P25 (F, public org.) encapsulated many others views when she said:

‘there is still a tendency for some GPs just to sign people off when that’s what they ask for, because it’s just easier.’

The majority felt they had yet to prove beneficial (although this situation may be different 3 years post introduction) as this participant suggests:

P31: ‘I don't think there's any added value from them at all to be perfectly honest with you. In fact, some of them are downright unhelpful.’

DLB: That's interesting.

P31: ‘So what we'll have is circumstances where to my mind, so someone's got a broken arm, to my mind well, we'll be able to find something else for you to be doing in the meantime, and the doctor will still say off for eight weeks. And the employee will wave that under your nose and say well, actually I'm off for eight weeks don't you know, because that's what the doctor's said. And that becomes very challenging at that stage, because I still work in the premise of you speak to the employee about whether or not there is something that they can be doing, and if there is, they can go back and speak to the GP.’ (P31, M, public org.)

5.2.5 Support for Managers

A surprising finding, given that participants experience difficulties, is that only a few explicitly mentioned that they feel un-supported by their organisations when needing to manage employees with LTCs. Many defer to Occupational Health and HR as a crutch – as will be elucidated below – and rely on them for tangible
support, with mixed results. For those who reported this, this is a source of tension and frustration when not having any medical knowledge and little or no experience of managing those with LTCs. This was mentioned by a couple of employers in terms of their knowledge of LTC’s for example:

‘...but, I do think, I probably need to know more about the condition, so that I can deal with it with a knowledge base, rather than a feelings base.’ (P22, F, public org.)

This quotation belies the tenets of Hochschild’s (1983) concept of emotional labour (see Chapter 3, Section 3.2.3.4) where it is desirable to transmute private feelings in accordance with the professional expectations of the managerial role (Chapter 3, Section 3.1.5) in managing employees. Another participant during our post interview conversation (who I do not identify for confidentiality reasons) alluded to the lack of support from senior management. He felt that money spent on training courses for sales would be better spent in training managers to deal with sick employees and felt there was more financial gain to be made here, as when people are off sick they are not able to bring sales in.

Finally, only five participants disclosed that they had at some point, or were currently, suffering from a LTC themselves and that this had had some bearing on the way they supported others.

5.2.6 Enablers and Barriers - Participant Perspective

A finding of note concerns participants’ perceptions of barriers or enablers to employees working with a LTC. Responses have been incorporated into the above sections as often they were part of a broader discussion on what/how participants perceive as their supportive role and what they view as particularly successful, or not, in helping those with conditions to manage at work. Participants reported enablers and barriers in the same way as employees (see Chapter 2, section 2.4) where enablers and barriers are expressed as material and non-material needs (defined in Section 5.2 of this chapter) in enabling employees to return or remain in the workplace. What is interesting for this Chapter is that some of those aspects which employees report as being enablers to work are those which employers and managers consider a barrier, such as phased returns, finding an alternative role for the employee, reduced hours and flexibility.
These are demands which participants describe as exerting the most external pressure by impacting upon their commercial responsibilities to the organisation in managing productivity and profitability for the business.

More significantly, participants also perceive that they provide and/or agree that having open and honest communication and good working relationships are key to successful employment for those with LTCs as the following illustrates:

‘I think that the relationship between the individual and their line manager is crucial ..... there’s got to be a good relationship there to be able to be open and honest with each other about what’s working and what’s not.’ (P25, F, public org.)

What is interesting is that this is not reflected in research from the employee’s perspective which cites the lack of social support and unsupportive relations as the main barrier to work with a LTC. This highlights a differing in perspectives of the phenomenon of interest for this study, where participants perceive they implement or agree on the importance of the social aspect of work which contrasts with the employee’s perception that this is neglected. However, this observation is based on the wider literature capturing the employee perspective as detailed in Chapter 2, and not on the perspective of the employees employed by the participants in this study who may offer a different experience.

5.3 **Balancing Differing Needs: The Organisation**

The perceived requirement to balance the needs of the employee, as outlined above, with the prescribed needs of the business is the most frequently cited external pressure. It is clear that their sense of obligation to the organisation and the economic and bureaucratic demands of it exert a strong pull on their role as a supporter of those with LTCs. Employers and managers expressed their sense of conflict and emotional discomfort over ensuring that the business need was being met, therefore fulfilling their obligation to the organisation, whilst at the same time supporting the employee and meeting their needs. P12 (M, private org.) eloquently expressed the conflict on behalf of the cohort when he said:

‘Well I think you’ve got two roles really I think the role of as the manager. So you have a duty of care for the individual but also a duty to the company and so, you know, my role as really trying to facilitate an appropriate workload and environment that allowed a balance between a need to recover and what she was able to do during this period with what the business sought to achieve. So yes that was, sort of, my role
was to ensure that that happened and I think the other aspect is that you have a, you know, a sympathy for an individual who has a medical condition, you know, which affects how they as an individual live life.’ (P12)

In essence, participants expressed what are normative role expectations of their managerial position in that they are required to act ‘as agents of the employer who are accountable for the performance of the workers they manage’ (Bellaby, 1990, p48) and retain authoritative control over employees in order to achieve organisational goals and objectives - whether commercially for profit (private orgs.) or bureaucratically (public orgs.) driven. Managers in the study report that they are therefore tasked with facilitating productive output from the employee by ensuring that they are capable of doing their job and that they have the correct material and non-material means to do so. The majority of participants expressed the difficulties and frustrations that these demands present in balancing commercial economic and bureaucratic pressures on the one hand and altruistic concerns about the welfare of employees on the other, as the following quotations illustrate:

‘So the conversations are sensitive anyway and you have to balance it right between they're off work and your role is to support them while they're off work and support them as much as you can, but you've also got in the back of your mind that you are trying to sort of manage the businesses expectation of bringing them back in.’ (P32, M, private org.)

‘So I had to balance giving her the support whilst also making sure that the business was, you know, like was considered as much as possible in that situation, but yeah that was a difficult period.’ (P31, M, private org.)

‘So there was... it was basically trying to strike the balance... the right balance between making sure that I wasn’t going to increase the level of stress on her, but also making sure that the business got some value out of her being employed.’ (P27, M, private org.)

‘But the impact on a small business of having somebody like that as an employee is tantamount to you may as well chuck your business away.’ (P14, F, private org.)
5.3.1 Business Needs: Managing Conflicting Demands

‘...but, in their coming back, they are coming back to do the job that they are employed to do. So, it’s quite a...it’s, sort of, a double edged one really, that they, you know, yes, I’ll put in support, but, there is that they are...that is the job that they are doing. And, so, you know, that sounds really hard but, I think, you know, what they are employed to do is [job duty] and, therefore, yes, with support but they’re still, at the end of the day, that’s the job they’re doing.’ (P22, F, public org.)

The above quotation belies the main pressure felt by participants, which stems from the perceived intrinsic responsibilities of their managerial role. Nearly all of the managers’ expressed their difficulties with the conflict experienced through having to do the organisationally prescribed requirements of their role/job – which is to provide value to the organisation and meet business needs through managing productive employees - whilst simultaneously being (un)sympathetic and understanding of the employee’s needs, carrying out a duty of care to them and allowing them to be less productive as per the restrictions of their condition. This pressure can be expressed in accordance with Merton and Barber’s (1963) concept that conflict (ambivalence) arises between and within the normative expectations of differing social roles, in this case professional and private roles (Chapter 3, section 3.4). Major conflicts for participants in this respect, being the need to ensure that the employee is productively contributing value to the organisation (by doing the job they are contracted to do). As the following quotations illustrate:

‘There’s no real way of getting round light duties, because they’re not doing really 100% of their job and though we can make adaptations, for a certain percentage of it, but we can’t allow someone just not to do anything all day and pay them.’ (P9, F, public org)

‘Yeah. But on the other hand we have got to keep a focus on what we’re here for and what we’re here to deliver and we have got to do that.’ (P6, F, public org.)

‘But from the organisation’s perspective it's about support and management, and actually getting a sustained and appropriate level of output from an individual, because that's what ultimately an employment relationship is about. So it can be challenging.’ (P31, M, public org.)

‘People are employed to do a job and that is what is expected. Problems arise when this cannot be facilitated. Employment relationship and whatever sympathy we have at the end of the day, that’s what we’re looking at.’ (P20, F, public org.)
Participant 27 (M, private org.) articulates this conflict well when he said:

‘So it’s like that balance I think that I was talking about in the first instance: making sure that they’re doing something that’s useful but actually they are... that it’s better for them to be there than being paid and not doing... so that’s purely from a company perspective, but I think also you’ve got a responsibility to, on a personal level if you like, in terms of the relationship that you have with an individual to make sure that you sort of look after them basically, because you’ve got a responsibility for their well-being. It’s a duty of care if you like from a line management perspective, so I think that’s the other... so it’s a balance. So essentially what you’ve got is a trade-off I think with the duty of care for an individual, and actually making sure that the company gets value out of employing somebody. The two are not incompatible I don’t think.’ (P27)

What is interesting about this quotation is that further in the interview the participant went onto describe how incompatible the two are, a pattern which was repeated in many of the interviews. Participants expressed their private personal feelings of discomfort at the position this places them in between the employee and the organisation, where meeting their responsibilities to the organisation are incompatible with the personal feelings and/or responsibilities towards those of another human being with a condition (which is explored in Chapter 6). This is suggestive of participant’s emotion management work as per Bolton’s (2005) Typology (Chapter 3, Section 3.3), as P12 expresses:

‘... I mean, on the one hand you’ve got a lot of sympathy for the individual on the other hand you’ve got a responsibility, the opposite, the company and, you know’ (P12, M, private org.)

Some participants rationalised their perceptions about balancing the employee and the business need by focussing on the business need as a priority:

‘...it just comes back down to a practical level and it’s just...I don’t know if it’s because my mind is so clinical and I just, kind of, see, task A to B and if somebody’s not around, obviously, we don’t want them to be unwell and you feel for them, but when it comes to the actual work, which is what we’re here for, we just need to find a way around it.’ (P3, M, private org.)

‘...we’ve got major contracts, you know, if you have got a weakness in the system then, you know, the firm has to come first, not the individual’s predisposition to come back to work.’ (P29, M, private org.)

‘Very much from a commercial point of view the various members of staff are there to do a job and my role as a manager was to enable them to do it to the best of their abilities and to look for any abilities as one would always do with the results’. (P23, F, public org.)
‘So I'm afraid we're very objective and fairly hard line and I'm sure....But actually you're not fit for work. I can't, I'm afraid I can't just give you something light to do because it's unfair on everybody else.’
(P16, M, private org.)

Whereas other participants such as P30 (M, public org.) below, further articulated their conflict by expressing that it is difficult to know where the priority lies:

‘Is there always that clear cut balance? No, there’s not. Sometimes the balance is in favour of the individual. Sometimes it balances in favour of the organisation depending on your view.’ (P30)

Coupled with the need to provide value, many participants described the financial implications of managing the associated cost of the employee’s reduced working capacity, phased returns, material accommodations and covering the workload during periods of absence. Having to replace staff temporarily, especially in some instances not knowing when they will return or whether the absence will reoccur, is a huge burden for many especially those from SMEs. P7 speaks for the majority when she said:

‘...but for us it meant that we had to pay her, her manageress salary - we are only a small business and pay somebody else to do her duty sort of at least took over [name], so we were paying twice of course and it was, it was crippling - it was very, very difficult as I say for a very long time.’
(P7, F, private org.)

‘We haven’t…oh it depends on the funds you see. So if we have funding then we do. But that’s not always available of course and then we are paying two salaries so it’s a problem really, it’s a real issue because we have to cover [name] work and we don’t always have the funds.’
(P18, M, public org.)

‘just cos’ as a percentage of the workforce these people that need the extra adjustments kind of, its going to be more noticeable and it’s going to have a bigger impact on the business, I would guess. I mean were not huge but we do, if when people are off, I mean we’ve got 13 staff on payroll now and then there’s 80 volunteers but, yeh even we notice if somebody’s off sick it does have an impact.’ (P37, M, 3rd sector org.)

Although it is seen as a particular problem for SMEs, participants from larger organisations also expressed their frustrations at the cost of finding ways to cover the work:

‘but I see it being a real strain if you had somebody, between five people and somebody's has an illness which affects their work and you have to
try and accommodate that. Because there is a cost associated with it, I can see how smaller companies, that'd be quite difficult for them.’ (P13, M, private org.)

Participants also cited their difficulties with needing to get the right balance of spending time, effort and money on supporting those with illness, with the impact to the business. In supporting an employee with ME, including home visits, phone calls and re-assigning projects that were not delivered on, P19 (F, private org.) said:

‘The management time to actually manage her was greater than what the business was getting back.’ (P19)

And in this instance it was easier and cheaper to retire the employee on ill health (capability) grounds than to keep pursuing a return to work at any cost, which was also reported by seven other participants.

The problem of time was mentioned by a few other participants. Resolving team issues related to the employee with the condition, managing the employee’s performance, adhering to, and implementing sickness absence policies were all regarded as negatively taking up their time. P35 (M, public org.) discussed a combination of these issues both on and off the record, where off the record, he felt the problem was the time/cost he incurs in managing those with LTCs whilst trying to manage the whole workforce. On record P35 said:

‘it’s very time consuming, we have procedures in place but I get, personally I get frustrated with them cos’ if this was my business if it was my, I own this company me and my dad, some of these people would have gone (a) long time ago.’

5.3.1.1 Public versus Private Sector Attitudes Towards Commercial Value

What is interesting from the preceding section is that some of the quotations come from participants employed in the public sector where traditionally there has been little concern with commercial aspects of the organisation (being government funded). However, a key finding from the interviews is that this notion is no longer applicable to the public sector employees in this study. All participants expressed similar concerns and difficulties when managing individuals with a LTC, across sectors. Similarly, all participants were conscious of the ‘bottom line’, or the impact to the financial health of the
organisation, to a greater or lesser degree dependent on their position in the organisation.

However, what do differ are participants’ perceptions of how illness is managed in the opposing sector. For example, some of the private sector managers in the sample perceive that public sector managers have a less difficult role because they do not have the commercial aspect of the job to consider. For example:

‘We are running a business, yeah I mean we are running a business, you know, I've got to bring in revenues, I've got to make the client’s delighted, you know, nobody is going to get, you know, the local council is not going to fall into bits if it doesn't perform. It's not, it's not going to happen and so the incentive is not there.’ (P30, private org.)

In the age of austerity (post 2010), this is no longer borne out as P6 (F, public org.) stated:

‘because like everybody else, we’re a business and at the end of the day the budgets are getting lower and the staffing levels are decreasing and the work’s getting more demanding’ (P6)

Similarly, some of the public sector managers in the sample perceive that private sector managers take a hard line with regard to illness management precisely because they are profit driven. Participant 25 (F, public org.) did however question this, ‘I mean whether or not there’s less tolerance in the private sector I don’t know, I don’t know whether that’s just an assumption we make.’ Private sector managers see the public sector as being ‘less fair’ (P13, M, private org.), perceiving that public sector sickness absence management policies encourage high absence levels in comparison to the private sector – again this cohort suggests this is no longer a reality as will be discussed in later in this chapter. The perception of the 3rd sector is that it is a ‘pink, fluffy, soft place to work’ (P8, M, 3rd sector org.) – although again, in current austerity times, this is not the reality and charities are now more commercially driven and becoming a ‘hardnosed business’ as stressed by P8:

‘...we’re all target driven so everybody’s got their income target and much like any sales environment so they need to achieve their income targets to make sure that they get the pay increase going forward.’

5.3.2 Organisational Culture

As can be seen from the above section, participants’ perceptions of public and private sector attitudes towards the management of illness and providing value
are not dissimilar. Furthermore, it was also found that public and private organisations shared common perceptions towards fostering positive organisational culture with regard to supporting those with LTCs. Here, consensus was found across interviews as to the influence of organisational culture on how illness is talked about and perceived in the working environment, in that responsibility for fostering a positive organisational culture towards supporting illness should be directed by those at the top of the hierarchy, i.e. from the top management down. This can be seen when comparing public and private sector descriptions of organisational culture around providing both material and non-material support to those with LTCs:

‘Culturally it's not a case of well, that just sounds like it's going to be a pain to organise. The attitude has got to be well, my first response is yes, we'll look at doing that for you. But I need to explore the practicalities of that, and if we're going to have difficulties then we'll come back to you. But the other thing is a culture where managers don't simply just say no. You go back with something that if you can't do it in the exact way that the employee's requesting, then what can you do? And that should be the response that we get from managers, rather than well, I can't do what you're asking, so no. Our emphasis has got to be well, if we can't do it as an organisation, what is it that we can do, so we try to find some middle ground with the employee. So that's the culture that we try to instil in the managers that are supporting people.’ (P31, M, public org.)

‘...we don't operate a them and us business we operate a...we can see everybody as a team and I very much promote the culture everybody here has a job to do, everybody has a part to play and it doesn't matter whether you're brushing up, running a machine or selling or whatever, if one person wasn't doing their job we couldn't achieve the greater good.’ (P10, M, private org.)

5.3.3 Bureaucratic Demands

Participants were also asked how they manage absence for those with LTCs. The response to this from all respondents was through HR led organisational Sickness and Absence management policies and procedures, in place for both acute and chronic conditions, although the degree to which they are formalised is dependent on the size of the organisation. Descriptions of their sickness absence policies suggest they tend to follow a similar format across all sectors and industries types, although often containing organisation specific elements. One organisation voluntarily gave me a copy of their sickness absence management procedures and guidelines. Copies were not collected from the
others for confidentiality reasons because of the company identifiers they contain. The majority of participants, especially from the larger organisations, both public and private, indicated that a system of trigger points was in operation where a number of absences occurring in a set period would prompt a review meeting with onward referral to HR/Occupational Health if necessary. Participant 6 (F, public org.) explains:

‘We have what we call trigger points, so there’ll be trigger points like three absences in three months, six absences in six months, 15 days or more in 12 months, and when people hit those triggers we’ll get them in for a review, talk about it, see what the problems are. If that then persists we’ll get them in again and then we’ll say we’ll have a review in three months but we need to see an improvement. You would find that we do have people with ongoing issues but believe it or not they are treated the same.’

Most of the participants felt that having a defined absence management procedure, which is easy to follow and involves clear steps towards supporting the employee is the fairest way of dealing with employees. Many respondents seemed to view sickness absence management procedures as a means of diffusing emotional conflict, providing a crutch utilised to avoid personalisation of what could be termed a difficult situation, especially if the employee or co-workers challenge the system. This can be seen in various lights, including that of removing responsibility from the participant in that they do not have to make their own decisions with regard to managing the employee. Reliance on absence management procedures was a common theme throughout the interviews, as the following quotations illustrate:

‘We have had a situation where somebody wasn’t keeping their part of the bargain and they weren’t keeping in regular contact with us and turning up to occupational health, and to the meetings, to the point we even went round to her house - because we can do that as well - and she wouldn’t answer the door. So it’s actually frustration of contract that we dismissed her on...but the policies are good enough to back you up and use them, and HR is fantastic in supporting you. It’s just that with our department, the size of it, I would say probably a lot of my time is taken up with dealing with the Sickness Absence side of it.’ (P9, F, public org.)

‘But I also think, and it sounds very kind of black and white, but the right processes that allow you to be fair, consistent and reasonable with everybody. And I think if you get all that in place, because I think the key word is there, is being fair and reasonable with everybody. We make a lot of decisions we don’t necessarily want to, I don’t want to get somebody walking out the door.’ (P15, M, private org.)
As per the quotation above, the majority of participants stressed that it was important to have policies and apply them consistently. Participants felt that it is necessary to be consistent in their handling of absence management so as to appear fair to all members of the workforce. Managers need to be seen to be doing something for the sake of co-workers and teams otherwise they are open to criticism of unfair treatment and letting the team down.

‘But because of the nature of our business and the numbers we have we’ve got to follow that process. And, again, we’ve got to be fair to all our department and treat them all the same, so as a department that’s what we do, we follow the procedure.’ (P6, F, public org.)

‘And that applies to everybody. The thing is it, you’ve got to treat everybody the same, to be fair you’ve got to apply the policy to everyone. So one of my managers has a fortnight off sick, they get an improvement notice same as the person who’s been off for 3 months with something that we thought, that his perhaps playing it, cos’ we treat everybody the same.’ (P35, M, public org.)

Interestingly, participants in the 30s age group appeared more process and policy driven. Respondents were more likely to refer to Human Resources and Occupational Health for advice, or let them handle the situation for example Participants 4 (M, private org.) and 25 (M, private org.) respectively:

‘I think we had one chap, one of the juniors came to me, this is about three months ago, he’d banged his head in a pub the day before and he was feeling unwell, he says, is it okay if I take the rest of the day off? So I get things like that but not necessarily long term illness and I think, like I said, it’s, usually, the directors or HR which will deal with that more closely.’ (P4)

‘I think my role is to generally cope... first of all manage the situation properly through the company guidelines and through the whole HR policy and legalities of it all.’ (P25)

However, there were some participants who suggested that their approach to absence management procedures was flexible and led by the needs of the individual. For example Participant 25 (F, public org.) who suggests that it is ‘down to the managers to be creative’ and ‘that everybody’s different so what works for one is not going to work for another, and you just have to figure it out really’. And Participant 32 (M, private org.) as follows:
'It is tough but I guess the main thing is that like if you can sort of like, when I took over managing the difficult case where I had been really accommodating and you can see that actually their absence has gone down to, you know, so there is a significant difference, you can kind of justify the actions you have taken, but yeah it's, it is a difficult one in this environment to actually get it right. There is probably no right or wrong answers, you know, I get the right balance I guess.' (P32)

For small companies such as in the case of Participant 14 (F, private org.) supporting an alcoholic employee, co-workers became frustrated that the absence process leading to dismissal had to be adhered to for legal reasons. This caused resentment in the workplace although they were placated by knowing that there would be a resolution to the situation at some point in the future. In small to medium sized organisations, participants explained that often a staff member was given responsibility for sickness absence management and for HR.

Interestingly, a few participants remarked that those with LTCs rarely need to be managed through the procedures, or disciplined for performance or absence reasons:

‘You’ll find in my experience that the people who have either terminal or long term issues that are making the effort to come into work are not the people that hit the triggers and go through that process. They keep you fully informed, they’re doing everything they can possibly to keep themselves fit and well and able, they’re doing everything the doctor’s asked them and you’ll find that their goal is to be in work. Which is ironic, but the situation.’ (P6, F, public org.)

5.3.3.1 Occupational Health and Human Resources

As previously mentioned, onward referral for specialist advice and help is, for the majority of participants, accessed via in-house or outsourced Occupational Health advisors, and most have Human Resources departments they could defer to for advice on legal matters and managing employees. However, for many in this cohort, using Occupational Health and HR added to their frustrations in supporting and balancing those with LTCs because they feel they cannot rely on the information to enable them to successfully manage the situation, for example Participant 20 (F, public org.):

‘so you decide based on the advice and information that you’re given, so if they’ve giving you rubbish advice and information, or very vague advice and information, you can’t make a good decision, and at the end of the day, if you make a bad decision, you’re the person the member of staff will go for. You’re the person the grievance will be taken against.
You’re the person who’ll end up stood in front of an industrial tribunal.’
(P20)

Other comments regarding the usefulness and helpfulness of Occupational Health and HR were similarly negative. P39 (M, public org.) conveys the frustrations of many when he said:

‘I’m sorry to say that my experience of occupational health is largely negative. I don’t think that they are a particularly, professional, I, the people that we seem to work with, they see themselves as professional and medical professionals. My experience is that they very often, either will go for the, basically just allow the employee to tell them what they want them to hear and then write that down and tell us what we already know, and make decisions which seem to be based very much on subjective, and emotional sort of responses rather than medical hard, sort of objective knowledge and understanding, which I find extremely unhelpful’

However, others saw the positive in perceiving Occupational Health and HR as a potential support avenue with medical and legal expertise, albeit with mixed results:

‘as well, now, that, actually, somebody who can help you and somebody who can, you know, give support if needed, a bit hit and miss but, you know, it is another network that they can pull on.’ (P22, F, public org.)

‘Yeah, we’ve got... yeah there’s... we’ve got a whole HR team, sometimes good sometimes not so good but they’re there to support you. But their attitude it very much you ought to be dealing with any situation by getting advice from them rather than handing it lock, stock and barrel saying oh that’s an HR issue you get on with it, it’s very much you have to deal with it with their support’. (P8, M, 3rd sector org.)

‘As I say to me, the more you know about a condition the better, because if you’ve got somebody sitting down with ya telling ya I can do this and I can’t do that, and you’ve you’re just believing everything you’re hearing then you’re really at their beck and call. That’s what occupational health’s role is for, they there to tell us what they can and can’t do, we don’t need to know about their condition just tell us what they can and can’t do and that’s why their our medical expertise.’ (P36, M, public org.)

There was general consensus however, that Occupational Health/HR advice and guidelines are required in order for managers to support employees and remain on the right side of the law.
5.4 **Balancing Differing Needs: Legal Requirements**

In addition to following organisational policies and procedures with regard to managing long-term sickness, participants expressed their need to adhere to employment law in all aspects of their dealings with those with a disability or LTC. Most participants acknowledged that working within the framework of the law is a good thing and as Participant 18 (M, public org.) says *has been very, very helpful, because it sort of sets the parameters* in getting people to recognise their responsibilities. However, concerns about contravening discrimination and equality legislation (the DDA 1995 and Equality Act 2010) as set by the UK Government and associated regulatory bodies (i.e. Health & Safety Executive), was omnipresent across all interviews and is reflected in how support for LTCs is shaped in the workplace as highlighted in the following quotations:

> ‘Yeah, you have to be very, very mindful and very, very careful of legislation, because of course, if anybody does have a sickness or disability, quite rightly, people are very, very protected and shouldn’t be discriminated against.’ (P28, F, private org.)

> ‘Yes, because it is, particularly where managers are dealing with a case that now falls under the Equality Act, so we’re talking about a disability, yes. Managers are quite concerned about how they manage those circumstances, there’s elements in terms of the legislation which whilst they’re aware of it is unclear and untested.’ (P31, M, public org.)

Participant 14 (F, private org.) characterised the experiences of others when she likened trying to support the employee and other staff within the law as *‘treading on egg shells’*, being mindful of her words and actions. Here, all of the participants spoke about their anxieties and fears in keeping within the remit of the law when supporting those with LTCs, highlighting that this is another pressure to balance in being tightrope walkers.

> ‘And I think unfortunately one of the worst elements, or the most difficult elements of this, is the managers, it creates a sense of fear of getting it wrong. And I think that's quite often the motivator for ringing me, is that they're frightened that they're going to do something wrong... and there's certain conditions which are more problematic, clearly.’ (P31, M, public org.)

> ‘You’re in the middle, you’re trying to manage the situation so that the workers are being helped and she is being helped (alcoholic employee) and trying to do it within the law,’ (P14, F, private org.)
Participants fear being taken to tribunal as a consequence of contravening legislation, a costly and potentially reputation damaging exercise with obvious repercussions for their own job. Participant 10 (M, private org.) sums this up:

‘The law is stacked against you....if you do have to get rid of people, make people redundant they can say well I’m disabled, you’ve got rid of me for...you know, it’s all...and sometimes as a company, as an employer you’re actually defending yourself and even though you’ve done nothing wrong, somebody makes an allegation against you and they get no win no fee you’re on the back foot, you’re having to defend yourself and it can go on and before you know it you can end up at a tribunal running into big money.’ (P10)

Many participants such as P16 (M, private org.) and P6 (F, public org.) verbalised their concerns about supporting those with LTCs in what they see as today’s litigious ‘claim culture’. Others such as P3 (M, private org.) termed it the ‘sue-sue culture’. By this, participants express their perception that there is an increasingly pervasive culture in the UK where individuals look to financially gain from certain situations (accidents, inequality), where they consider it not to be their fault. Participant 10 (M, private org.) refers to this in the quotation above when he talked about the popular concept of individuals engaging solicitors to take on their case ‘when they can get no win no fee’. Participant 3 was particularly concerned with the claim culture:

‘...and everyone jumps on the band wagon, once they’ve seen one person do it they think you know everyone that’s left, they do it then everyone can do it. It’s a human right now to sue people.’ (P3, M, private org.)

Participants described their experiences in the illness context where employees potentially use the tenets of the law to either financially gain from the situation or to use it for their own agenda in gaining (or not), the working situations they want:

‘...we had a load of diabetics who said we can’t work at weekends it’ll play havoc with my diabetes. And it was all a game to get, nobody wanted to do these weekend shifts. As long as it’s planned in advance and you’re able to make, change your medication your times, you know they can live a normal life as anybody else would without us having to just, take on board what they said. But a lot of people are not, they hear the DDA and it’s don’t wanna touch ya. People think the DDA is a get out of jail, it’s not [laugh].’ (P36, M, public org.)

‘And it sounds very callous, but sometimes you have a feeling that an accident isn’t right. You can’t re-enact it, you can’t recreate it, you just can’t figure out how it happened. And then you look at the history of this
person, who’s kind of claimed every year, and you think okay, there’s something…you’re very accident prone. But to show that to the team manager and say well, you’re going to let them do this because you’re leaving the gap. And I don’t think that’s callous and I don’t think it’s harsh, I think it’s countering the way that culture is going, which is even if there’s no blame there’s still a claim. So [knocking] you know.’ (P15, M, private org.)

As in many of the interviews where participants talked about disabilities/LTCs, questioning legitimacy and legislation, there was a lot of non-verbal communication. This is evident in the last line of the above quotation, where the participant knocked on the table to intimate his personal thoughts about the situation. Again, this is expanded in the next Chapter.

Because of the fear of the law, many stressed the need to make sure they did everything to the letter and by the book, taking advice from lawyers and HR as in the cases below, so that they could provide evidence of their actions should an employee try to claim discrimination or mistreatment.

‘As to how we treat them is we try and make sure we do everything by the book and even handed. From a legal point of view we have employment law specialist who tells us what we need to do if we want to make any actions to get round pitfalls of having disability discrimination or something.’ (P16, M, private org.)

‘So we use, I use them in a very sort, of what's the word, I let them give me the advice and I follow it pretty well much to the letter.’ (P30, M, private org.)

‘…still have the audacity that they say right we’ll take you to court cos’ it’s unfair and you’re like well I’ve followed the system as it is, and then you pray you got to court and you’ve followed everything right because not even ACAS can give you the right information about what to do on things like this. You’re just left there in the dark hoping it’s all going to be alright.’ (P2, F, private org.)

A number of participants also expressed the fact that the law appears to be very much on the employee’s side and therefore made them feel the guilty party when having to discipline those with LTCs:

‘…she disagreed with us and then basically turned it on its head and accused us of harassing her and discriminating against her and she lost a tribunal claim against us for discrimination and in the end the (name) just agreed to pay her off. So we felt again that we’d done everything correctly, she’d actually committed a fraud and we acted properly in disciplining her because of it and yet in the end we had to pay out £12,000 because the (name) didn’t want to fight it and whatever else.’
The risk that certain conditions present in the workplace was also a concern to many participants where ensuring compliance with Health and Safety regulations is paramount. And for some participants such as P10 (M, private org.) was a consideration in employing those with disabilities:

‘s if you brought somebody in who’s disabled you’ve got to do a lot more risk assessments on the role, on the job role, which you probably won’t have to do so much on a normal person’. (P10)

Managing risk was mentioned predominantly in manual organisations where conditions such as alcoholism, substance abuse, diabetes, musculoskeletal disorders and epilepsy for example, are a considered a possible safety threat to the employee themselves or those around them. This is especially true when the employee is responsible for handling machinery or is responsible for the safety of others within the organisation. Participant 38 (M, 3rd sector org.) depicts others’ concerns aptly:

‘I think managers by and large are, I mean I can only talk about here, my communities here, are supportive of that but they’re nervous I think also in terms of health and safety that, if something were to go wrong kind of that, so I think it’s a bit of a fine balance. They’re very supportive, they want to make it work on the other hand there is a fear that if they were to have an accident or something to happen that you know, have they filled out all the necessary paperwork, and have they gone through all the procedures necessary, so. Yeh it’s a bit of a balance.’ (P38)

5.4.1 SMEs and Legislation

Participants from small to medium sized organisations (SMEs) expressed particular concerns with legislative regulations and the constraints of the law, which they find cumbersome and restrictive, where the ‘one size fits all’ (P14, F, private org.) approach irritates them. There is a perception from these employers and managers that the amount of legislation is prohibitive for smaller organisations and that the law favours larger companies as exemplified by Participant 14:

‘If you have to just do the SSP and you can get that back that’s not an issue, but if I’ve got to pay somebody for three years and then get
somebody in to do that work that will cripple me. We’re too small. And this is the problem with legislation, a lot of the time it’s a one piece of legislation fits all and it’s alright for the big boys, for the big, 1,000 people working for them. If two of them are alcoholics or two of them are depressives or two of them have got a chronic illness like heart disease and continually having to have time off or whatever it happens to be it’s a small proportion, and the other 998 can cover because they’re only having to do a tiny bit. When you’ve got nine and one goes the percentage is too high to deal with. You’re in a real mess.’ (P14)

Owners and managers of small organisations in the sample are very conscious of the financial cost to employing someone with a LTC, not only in terms of adjustments and covering employee absences, but also with regard to legislation and the threat of being ‘sued’ as described in the section above. Participant 7 (F, private org.) voiced what others only implied:

‘Well if you are going to take somebody on and let’s be honest there is a lot of competition for jobs these days and there always was - and if you have a choice you are not going to choose somebody who has a condition that you know are going to be off work for long periods, you won’t, nobody will.’ (P7)

A few respondents expressed their anxiety about employing people with a disability or LTC, as they feel they can not easily terminate their employment contract if things are not working out as Participants 10 (M, private org.) and 21 (M, private org.) said:

‘So the difficulties of employing disabled people in this business or any other business like this are basically a) if you ever needed to get rid of them it’s very, very, very difficult’ (P10)

‘but you’ve hired her and you can’t get rid of her so it’s sort of like you’re stuck in the middle here!’ (P21)

‘Well everyone that’s had illness on a long term thing has had to end up doing, resigning because there’s no way physically I would ever dare to fire them, the people I even fought gross misconduct I’ve ended up in court about sort though that’ (P3, M, private org.)

Two SME company owners perceived me to be a conduit to government in getting the message across that legislation is too restrictive for smaller organisations. In these cases, one participant was very keen to direct the conversation towards the issues around legislation and the interview agenda was directed by this. Another was keen to talk about the lack of Government support, both financially and socially, in employing those with a disability/LTC
again suggesting that he has to be ‘very, very mindful’ of the law, which ‘...a) it’s an irritant and b) sometimes it just isn’t fair, but that’s...you know, that’s the law of the land so to speak.’ However, P10’s interview illustrated the contradictions outlined earlier in Section 5.2.1 this Chapter, found across many interviews, in that whilst personally happy to employ an individual with a disability/LTC, he expressed his difficulties in meeting his responsibilities to the organisation (through productivity and value) with personal feelings and/or responsibilities towards those of another human being.

5.5 Balancing Differing Needs: Co-workers and other staff

Finally, balancing all of the above needs with those of other employees in the workplace appears to be another significant area of tension for participants. Here, they recalled many negative experiences with managing other team members and co-workers required to support their colleague(s) with a LTC. When asked, negative co-worker responses to support were described over twice as frequently as positive co-worker support, indicative of the difficulties participants encounter in this particular aspect of their managerial role. As Participant 16 (M, private org.) and Participant 20 (F, public org.) epitomized when balancing employees with recurrent absence due to their condition:

‘So I think managing sickness is a very tricky thing because it's trying to be caring, but in a manual environment it's trying to be caring to those other people who are working and not just the sick people.’ (P16)

‘Actually, I’ve got to think about other people who come to work every day’ (P20)

Participant 7 (F, private org.) suggested that some co-workers, railing against the perception that the employee is ‘letting the team’ down, are particularly negative, which is indicative of many other participants’ experiences:

‘and if the turnover is really quick and, you know, you don't actually get to know people very well you just, you don't care, you know, whenever you can stick the knife, I mean it's human nature isn't it [laughter]’ (P7)

A few participants therefore discussed the need to manage negative perceptions towards an employee with a LTC because of the consequences for team morale and productivity, such as Participant 14 (F, private org.):
Co-workers were in the main presented as either resentful of employees with conditions and/or dubious about the legitimacy of their conditions and reasons for time off work. Most managers pointed to rigorous adherence to absence management procedures as outlined in Chapter 2 (section 2.2.6) in this instance, to indicate to other employees that they were managing the situation in a fair and consistent way. According to participants, co-worker resentment arises when having to take on their colleague’s work and cover for them, which is particularly difficult for employers and managers to address as the following quotations highlight:

‘And there were one or two people in particular, you know, they felt quite strongly that as a team we were being, you know, we could be much stronger without her and therefore some resentment started to grow towards the end as well. So that was, again, something I had to try and manage.’ (P12, M, public org.)

‘Oh yeah, I mean what people don’t like is where they think they’re being taken advantage of and that doesn’t matter what medical condition or anything like that is going on within the office, or the relevant relationship, if people feel they’re being taken advantage of that’s when they tend to become...that’s where the friction tends to come from’. (P21, M, private org.)

Feelings of resentment are further generated when participants are unable to disclose to other staff why the employee is absent (as a result of privacy laws protecting the employee). For example in describing co-workers’ response to an employee with undisclosed depression, Participant 26 (M, private org.) explained:

‘So I didn’t want to give any particularly preferential treatment to her coming back as [job], because all the other [job] would be like well we had a hard time at work, we know she’s been ill and we know she’s pregnant but she can still... she’s still capable of doing the job so why are you mollycoddling her so much? And I couldn’t go into specific details because she didn’t want anyone to know in the first place that a) she was on antidepressants and b) that she’d come off them. So it was quite a challenge in order to protect that privacy of hers whilst making everyone else aware that she’s off sick,’ (P26)
A few participants suggested that disclosure is a double-edged sword. Managers struggle with managing co-workers when the employee also chooses not to disclose. Although managers acknowledge that this is understandable for many reasons and that managers’ and employers’ have to legally maintain employee confidentiality, it poses a significant difficulty to their supportive role and is therefore more desirable if they do disclose. For example in managing an employee with a MH condition P37 (M, 3rd sector org.) speaks for others when he expressed:

‘... but if you’re going to make adjustments for them, for example freeing up time so they can go to counselling or assessments or whatever, then justifying that to the rest of the team is very difficult.’ (P37)

Again managers feel caught in the middle in this instance between co-workers and the employee with the LTC around legitimising the illness, which brought in elements of distrust and honesty from all parties.

‘Funnily enough, it’s a bigger problem is where somebody has got restrictions and other members of staff can be, ‘why am I always having to lift this heavy stuff, why can’t they do it?’ And you can’t explain to them, you can’t freedom of information or protecting their thing, you can’t tell ‘em what’s gone on, so it sometimes causes a bit of bitterness.’ (P36, M, public org.)

‘So we wouldn’t disclose it but it you normally find it that people who’ve got to that level is because they don’t really care in any case so they’ll go and say it. I think if they know there are processes in place and they’ve got confidence that people are having their the welcome back and attendance reviews and things like that, maybe that minimises it because they actually think, they’re getting dealt with. And it’s all fair... so it’s very robust I suppose, that they maybe have faith that they can leave it with us to deal with it if it needs dealing with. But I know especially on the smaller departments where people are working in closer contact and on nights because....I know my [name] said a comment was made and [clicking fingers] he immediately was there - woa, come up with me, not having that.’ (P34, F, private org.)

Many participants described their difficulties in ensuring that the workload was distributed fairly amongst others to mitigate resentment:

‘But, again, as a manager you’ve got to assess that you are being fair with everybody, whether there’s an illness around or not so therefore you have to make sure that you do rotate things, that you don’t give all the heavy work or all the manual to one individual.’ (P6, F, public org.)

Co-workers were also discussed in the light of their relationship with the employee with the LTC, which will be explored in Chapter 6. Suffice to say in
this Chapter, that many participants suggested that co-worker support is
dependent on the employee’s personality and whether they are liked or not. This
is more applicable to positive support which Participant 24 (F, public org.)
conveys as follows:-

DLB:  How do you find colleagues and co-workers? Are they very
supportive as well?
P24: ‘Well again I think a lot of it is down to personality. Because
they've been extremely supportive yes.’
DLB: That's interesting. Do you think if…
P24: ‘I think if the person had been a moaner and a groaner
constantly, chip on the shoulder type person, it could have been
different. But the experience that we've had has been extremely
positive. All the staff have been keen to help if there were bad
days to take over and to do a little bit extra themselves, that kind
of thing. But I do think partly that's down to the individual
personalities.’

However, participants perceive co-worker support to be finite and there was
much discussion about the length of time unconditional support was provided by
colleagues – again this was influenced by personality, perceived legitimacy of
condition and length of service which is covered in Chapter 6:

‘Well they were supportive to a degree then got absolutely fed up of it
and basically said she needs sacking. I said I can’t just say sorry, you're
sacked. I have to actually go through…so I did everything by the book as
advised by the human resources people, and said this is what I need to
do, show me how to do it. This is what I have to do because otherwise my
business and my other staff are going to be gone.’ (P14, F, private org.)

‘I think where it starts to become extremely difficult is when other
people’s workloads are impacted on. So I think everybody has - or
hopefully everybody has - a certain amount of tolerance and empathy,
but when they see in their eyes somebody being treated more favourably
perhaps than they are, or taking the Mickey out, you know, and it’s kind
of…then it gets really difficult, because then the empathy goes, and it’s
impacting on them and the service; and that’s when I suppose as a
manager you really have to look at what is reasonable and what isn’t
because you’ve got the rest of the staff welfare to worry about as well
and you can’t overburden others too much whilst you’re trying to
support someone. So that’s quite difficult.’ (P25, F, public org.)

5.6 **Conflicting Case**

There was only one negative case in the data which could not be attributed to the
category of balancing differing needs. Participant 34 was the only participant
not to mention any feelings of balancing, either explicitly or implicitly. This seemed to be because in her capacity as a Personnel Manager she had only one staff member reporting to her, and therefore had no responsibility for managing staff that were directly important to the financial health of the organisation. In this instance, there was no commercial/economic pressure to balance. Her interview was therefore biased towards talking about policy and procedures for managing illness within her organisation, placing an emphasis on ‘support plans’ for getting those with LTCs back into the workplace. When asked how the line managers in her organisation support those with LTCs, the participant did not mention any words that would imply they experienced the feelings associated with ‘balancing’ – even though they were directly responsible for ensuring employee value to the organisation. The participant came across as very maternalistic in her management of illness, suggesting that if managers felt out of their depth they would:

‘...come to me, or my compliance manager cos’ ...... she’s got access to Occupational Health as well as I’ve got, so if that manager came to us we would talk them through what they need to do.’ (P34, F, private org.)

The participant implied that she would closely guide line managers through the process, almost in a hand holding fashion, to bolster their confidence in dealing with the situation. The data from this interview did however, share many other commonalities with the others such as providing material and non-material support (as described above), wanting honesty in communication, questioning legitimacy and having difficult conversations for example.

5.7 Chapter Summary

This Chapter has focused on the first substantive category derived from the data, that in supporting those with LTCs participants perceive they engage in a balancing act of many external pressures through the demands, interests and obligations associated with their professional ‘public’ role as a manager. Participants described how these pressures include balancing the needs of the employee with the normative role expectations of the manager, which traditionally focus on managing employee productivity in contributing to organisationally prescribed economic commercial (for profit) and/or bureaucratic objectives. Additional to this, participants reported that when supporting an employee with a LTC, they encounter other demands, potentially
outside of their normative everyday duties, which they find difficult to balance. These include condition specific needs such as dealing with the medical world, adherence to disability/equality legislation and managing other (co)workers responses to illness.

Evidenced in the data is the feeling of ambivalence arising from between and within these competing demands and external pressures. In essence participants report they experience conflict in their role as a manager between their expected (prescribed) responsibilities to all concerned. As a result, all bar one of the participants expressed their role supporting those with LTCs as a difficult balancing act. In the next Chapter I move on to elaborating the second substantive category which is that participants also balance the pull of perceived internal pressures arising from private feelings, thoughts and evaluations associated with their personal social role when supporting those with LTCs.
CHAPTER 6: Getting Personal

6.0 Introduction

Following on from Chapter 5, I will now go on to explore the second substantive theme emergent from the data which is that participants also balance the pressure of private feelings and emotions when managing those with LTCs. Private pressures were those interpreted as inner personal feelings, thoughts and evaluations commensurate with participants’ individual social role arising in response to other people’s chronic illness. The aim of this Chapter is therefore to explicate the properties which constitute this theme, categorised as ‘Getting Personal’ and which both comprise and result from, participants’ perceived balancing-act as illustrated in Figure 5, Chapter 4, p122.

These are illuminated and presented sequentially in this Chapter commencing with participants’ expressed personal frustrations and conflicts with supporting employees within the organisational framework. This is followed by an exploration of the finding that participants’ personal perceptions about the employee’s personality are an influential factor in the provision of support. Next I present participants’ reported difficulties and tensions with discerning the legitimacy and genuineness of certain conditions. This was a substantive theme in the narratives, along with concerns about conversing with employees about sensitive matters related to their condition. Finally, this Chapter concludes with an examination of the finding that participants perceive that they try to maintain a boundary between the private feelings and thoughts of their personal social role and the responsibilities of their managerial role in order to retain their professional integrity.
6.1 Defining the Category of ‘Getting Personal’

In the quotation highlighted at the start of this chapter, Participant 27 (M, private org.) expresses his personal, private feelings about managing an employee with a chronic bowel condition. He reported that getting the balance right between his own feelings towards doing the right thing for the employee and the demands of his obligations to the business caused him ‘mental torture’. In this instance, as with others in the cohort, the manager was struggling with ambivalence arising from how he would personally wish to manage and support the employee, with also meeting his managerial obligations to the commercial, bureaucratic, political demands and interests of the organisation, the employee, legislation and other staff as defined in Chapter 5.

It should be said that P27 came across as a particularly empathetic individual, with a high level of concern for the wellbeing of all his employees. However, his statement underlines the category of ‘getting personal’ where several recurring themes throughout the data suggest that, regardless of industry type, sector or size, participants express they experience personal emotions arising as a consequence of having to support an employee with a LTC. Or to use Hochschild’s (1983) terminology (Section 3.2.3.4 - Chapter 3) personal ‘private’ feeling acts are evoked in this situation in addition to those ‘public’ feeling acts, intrinsic to the participant’s managerial role, which are prescribed by external interests as noted above.

This became apparent when participants were expressing their perceived difficulties in having to balance many needs and interests, and more specifically, when these demands and requirements are incongruent with their own personal ‘private’ feeling acts. Conflicts and emotions experienced in response to internal pressures relating to less tangible ‘private’ feeling acts and personal thoughts were often implicitly embedded within participants’ descriptions. As described at the beginning of Chapter 5, these tensions and feelings, which are thought to be shaped by the participants structural position, cultural beliefs, socialisation process and moral and emotional norms (Sloan, 2007), were often conveyed via non-verbal gestures or tacitly within interview responses. Whilst there was some direct expression of their perceptions, many participants
indicated their thoughts non-verbally when what they were trying to communicate was of a sensitive nature, had potentially socially undesirable or politically incorrect connotations or that the situation was uncomfortable for them. This is suggestive of the emotive nature of the subject matter (illness) which provokes personally sensitive views central to the category of ‘getting personal’. The notion of ‘getting personal’ therefore encapsulates the ‘personal’ dimensions of participants’ perceived balancing act (see Fig. 7 below) when supporting an employee with a LTC which I will now go on to explicate.

![Diagram of Manager/Employer Tightrope Walkers]

**Figure 7:** Being Tightrope Walkers: Participants Balancing Act – Individual ‘Private’ Personal Social Role

6.2 **Internal Pressures - The Employee**

As can be seen from Figure 7, five themes emerged from analysis of participants’ narratives which they describe in relation to private inner feelings, thoughts and pressures associated with their personal social role. Commencing with the employee, these will be presented with reference to participants’ perceived reasons as to why private feeling acts are evoked and, where discussed, the subsequent impact on their professional managerial role.
6.2.1 Doing the Right Thing versus the Business Need

As explicated in Chapter 5 participants expressed difficulties in balancing their perceived conflicts between the needs of the business, legislation and other staff with those of the employee. Participants cited a primary conflict as stemming from their need to meet the responsibilities of their management role in ensuring that the business need is met, whilst also being cognisant of the employee’s welfare and their reduced capacity to provide value consistent with the personal social role. As Participant 24 depicts when making time for an employee with a viral condition working in a role with shifts:

‘...and I did quite regularly just in a very, very general way, just say 'are you feeling okay? Are you still alright?' So around lunchtime I'd sort of try to remember. It's difficult isn't it as a manager?' (P24, F, public org.)

In some cases participants’ descriptions were accompanied with non-verbal expressions of discomfort. These were taken as implying that their own personal values and responsibilities in how they perceive another person should be supported/managed when ill (as would be the case in a peer to peer, intimate, proximal relationships) are incompatible with how organisational structures and procedures require them to support/manage another person when ill (in a manager to subordinate, formal, distal relationship). Some participants described this experience in terms of doing the right thing for the employee or by practising good duty of care as the following quotations exemplify. For example, Participant 12 (M, private org.) when managing an employee with CFS whose condition was unimproved over a long period of time, Participant 5 (M, public org.) managing an employee with prostate cancer and Participant 11 (F, 3rd sector org.) supporting an employee with a mental health condition:

‘...we put her through a number of training courses and, you know, really in way to, kind of, set her up for the future really which was not something that I probably should have done but it seemed the right human thing to do, if you like. Well the company gets no benefit from it but, you know, it was relatively modest expenditure and I think given all that happened it was, sort of, the right and fair thing to do.’ (P12)

P5: ‘I’ve supported him by being in regular contact with him, going out to visit him at home and things like that, so that’s how I, mind you, it’s not clinical in any way, it’s just, I perceive as good, you know, duty of care.’

DLB: Mmmm, good practice.
P5: ‘Yeah, good practice. And it’s instinctive rather than following any, you know, prescribed policy or procedure.’

‘And so you almost give in because you think you can’t cope with the change but you’re giving in... you know what I mean? It’s not the business, not the right business decision to do, but it’s the right for that person at that point....so you do sometimes feel like your decisions aren’t purely made on being the best for the organisation. They are sometimes best for the individual which...do you know what I mean?’ (P11)

The notion that participants find balancing their responsibilities to the employee with the needs of the business personally uncomfortable is further interpreted from the data by the contradictions within interview narratives. For example P27 (M, private org.) initially said that he thought the ‘two are not incompatible I don’t think’ but then went on to describe that balancing the two caused him to experience ‘mental torture’ (as above), the expression of his private feelings act denoting that he personally thinks they are incompatible, for example:

‘I think part of your role is perhaps to make sure that people aren’t over-burdening themselves but they will be wanting to contribute and wanting to do things, so I think that’s the way you hit the balance. But it’s not an easy thing to do but I think that’s what you’ve got to try and do.’ (P27)

Participant 15 (M, private org.) provided a similar example when initially suggesting that in balancing responsibilities to the employee and the business, the manager (as intrinsic to the role) should retain some emotional distance:

DLB: So it’s a good balance for a manager to have that, but to be able to have that little bit of distance and look at the business case as well as the...[employee]?

P15: ‘Absolutely. You have to do that. And that’s where I said about the sympathy. Sympathy and empathy. Because I’ve seen people go into work and they almost go into emotional meltdown themselves because something’s happened to somebody else, and it’s just like well, you’re not helping the situation, you actually need to take that...you need to put that disconnect in there.’

But he then went on further in the interview to describe a case of managing an employee with cancer which he had found particularly personally upsetting which was also evidenced by the participant’s non-verbal behaviour:

‘We went to go and see him before Christmas just to see how he was - he was a great guy - he just said...at the end of the session he was completely uplifted because he said, “I’ve heard you’d given my job to someone else.” I said, no I haven’t, I’ve put a temp in the job and waiting for you to come back. But his whole hope in his life was he was
This contradiction between the demands of the public managerial role and the caring behaviours normative to their personal social role, was repeated across and within many interviews and is consistent with Merton and Barber’s (1963) theory of sociological role ambivalence as outlined in Section 3.4. However, this theory does not explain participants’ perceived ambivalence experienced between the obligations of the managerial role and personal feelings experienced when supporting a person who is ill, which is discussed in Chapter 7.

Participant 35 (M, public org.) was another participant who he suggested that in his managerial role he maintains distance and adherence to organisational absence management policies in his support of employees but described certain cases of employees with cancer and diabetes, in which he belied his personal compassion and sympathy;

‘s o although I distance myself, I’m not a robot but, I can be unemotional, I do feel for the family, so, but I’m there almost to offer some support if I can.’

But it was noted in the fieldnotes for this interview:

I felt that P was probably very compassionate underneath the exterior, by some of the things he said, especially when it was about people he liked or who were good workers, or the circumstances surrounding their illness.

(Fieldnote Excerpt Interview 35)

Participant 5 (M, public org.) rationalised his decision making between the needs of the organisation and those of an employee with cancer by using his own moral script, which was echoed by others such as P6 (F, public org.) and P25 (F, public org.):
‘...so there are reasonings behind that, and as long as you can stand up and say well actually yes, under normal circumstances I would have done this but due to the circumstances...and I think anybody anywhere with any ounce of compassion would agree... ’ (P6)

‘It’s very difficult and you want to sleep well at night so you want to think ‘I have done everything I could’ ..but as long as you’ve tried everything within reason – and sometimes even a bit more than that – just to think that there really was nothing else I could have done about that then that’s all you can do.’ (P25)

Conversely, another observable contradiction across narratives were participants’ reports of their frustrations with the restrictions of organisational sickness absence processes - necessary to keep within the remit of the law - in being able to terminate a problematic situation or ‘get rid of’ the employee as six participants\textsuperscript{11} termed it. Participants express ambivalence arising from not wishing to retain employees in the workplace but being organisationally and legally bound to. This particularly occurred in those cases where there appeared to be less sympathy for the employee, exemplified by Participant 14 (F, private org.):

‘You have to actually go through a procedure, so it takes about six months - and it sounds awful to say - to get rid of her, but I couldn’t do this for another 12 months or another 6 months or forever because ultimately everybody else in the office was suffering.’ (P14)

As will be explored later in this Chapter, participants reported unsympathetic views of supporting employees with a LTC for a multitude of reasons but predominantly influenced by the level of their affinity to the employee and ambiguity over the genuineness of the employee’s condition. Many, including Participant 26 (M, private org.) below describing an experience of an employee who was disliked by co-workers, described their tensions in having to go through a protracted process that was time consuming and uncomfortable for both themselves and others as the following highlights:

P26: ‘...So it was just a really, really long drawn out process, that because she couldn’t come in and work because she was off sick made it worse for me and worse for the [name] in the end.’

DLB: So if she could have come in... is that a health and safety and risk?

\textsuperscript{11} Not identified for confidentiality reasons.
P26: Yeah, it’s for a variety of reasons really. If anything happens to her in the [name] whilst she’s on that sick related leave then I think as far as the [name] are concerned I’d be in a whole heap of trouble. And also with it affecting her mental health and affecting her whole stress levels and her blood pressure, we had to wait until those... it sounds strange really because we don’t... I didn’t want to tackle the issue whilst her blood pressure was up there because it would have gone off the scale. However, I had to wait for it to come down a few levels as it were in order to then have to deal with it and while we were dealing with it, it would go back up a few levels if that makes sense because obviously it was a very stressful time trying to resolve it.’ (P26)

In contrast, there were more participants who felt constrained by organisational structure and processes for the opposing reason, where they want to do more to support the employee in a system which is predicated towards ensuring value through capable, healthy, productive employees. Some also indicated that they sometimes felt compelled to act in a certain way for the greater good of the organisation and their managerial responsibilities, but conforming to these pressures could depict them to be overly harsh. Participants used emotive language both on and off the audio-recorder when discussing experiences where they followed strict organisational procedures which they knew would impact negatively on employees:

‘But when someone does go off sick and they go off long term, your heart sinks a bit. Particularly the guys on the shop floor, if someone goes off because you’re thinking they’re going to come back and they’ll come some - you know, we get sob stories off people. One of these guys who has his back issue saying ‘I need to work, I need the money’. We’re saying ‘well you can’t’... can’t I just come back and work on the [job duty] and sit behind a computer? It’s like no because it’s not fair to everybody else. I think sometimes therefore, we feel like we’re a bit heartless’. (P16, M, private org.)

‘Eventually though, because of his condition and the number of times that he was off sick, it came to the point where we were unable, if you like, to continue with his contract; and that was probably one of the most difficult days that I ever got because I had to go round to his house, and he was really sickly, poorly at the time. I walk into his living room and he’s got… his bed is in the living room, and his elderly parents are caring for him....But organisationally, even in those circumstances, you get to a point where it’s like, ‘Well there’s got to be a cut off with the contract. We can’t just keep paying and paying and paying when he’s not in work.’...but again, I don’t think he was going round and saying, ‘Thanks a lot but you’re fired’, because essentially that’s what we did. ‘You’re dismissed.’ That’s that. You’re terminating the contract, no matter what pretty sentence you use you’re still saying, ‘You’re sacked’, 

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and it’s because you might die. And that felt awful. It did. It’s sort of like as a manager, it sticks in your throat.’ (P29, M, public org.)

Taking into consideration the examples above which evidence participants personal judgements and evaluations in ‘doing the right thing’ for employees, it was interesting to note that out of the 40 participants in the sample, only one explicitly talked about their personal morals in this context as quoted:

‘...you can deal with your own morals and you keep on going and the way you think is best. You constantly doubt yourself because not even the people you ask the information for can give it you [ACAS]. So you just hope for the best in what you do.’ (P3, M, private org.)

However, what is apparent from many of the illustrations in this section and throughout the participant narratives, is the finding that the employee’s personality bears an influence on participant’s feelings and is commensurately reflected in reports of their supportive behaviour, as will be explored next.

6.2.2 Employee Personality

Although not initially part of the interview schedule, it became apparent after the first five interviews that participants’ perception of the employee’s personality is an important aspect in their supportive role and hence influences the nature and type of support they (and co-workers) provide. Participant 25 (F, public org.) described her experience of an employee with a mental health condition who was well supported materially and emotionally because he was liked. As P25 said ‘he was a person first, I think that’s the thing’ and then went onto define the following, which is indicative of many others’ responses in the sample:

‘Personality always helps; I think if a person is difficult, for whatever reasons, then I don’t know whether it would be human nature that you’re less likely to go out of your way for someone who you don’t really get on with; you might do the bare minimum but you might not do any more than that. Whereas if you get on with someone and they have got a long service and have always committed, well, then you’re going to think, ‘Well, we’ll get through this blip and then get them back to where they were.’ Yeah, I think you’d tolerate more with somebody who you’ve got a good interpersonal relationship with more.’ (P25)

Captured across the data, many participants related positive experiences of supporting employees with LTCs when the employee was liked and with whom they had personal affinity. Likewise, negative experiences were related to those with whom they had less affinity or disliked. For example Participant 19 (F,
private org.) described a positive experience of supporting an employee with MS and retaining him in work because he ‘was just a lovely, lovely man, everybody loved him’ contrasted with an upsetting ‘hugely frustrating’ negative experience in managing an employee with a mental health condition. Participant 13 (M, private org.) similarly described ‘some tension with’ and the ‘constant’ challenges of managing a negative experience of supporting an employee in a team who ‘wasn’t everybody’s cup of tea...who’s a problematic character’. Participant 22 exemplified this when contrasting two particular cases of employees with LTCs in the same team:

‘...and, I think, the hard bit is, with [name], having that diagnosis, actually, then, I saw a different person and he’s become this on board, great, he’s been fab. [name], I’ve never known anything different, so the whole time I’ve been here, I have seen that person, in that light, now, some of that might be her! It might be nothing to do with the condition, it may be that that’s what she’s like, so that’s quite hard, really,’ (P22, F, public org.)

Participant 30 (M, private org.) expressed this in more succinct terms when comparing an employee with a musculoskeletal condition and one with cancer:

‘We miss him terribly and he is good and that’s the difference. So if a guy is a good, great attitude, great man, then you want him back, we miss him, I love him to bits. This lady she has been with us three months, we don't love her to bits - she is okay, she is one of, you know, so there is no real emotional attachment there.’ And went on to say ‘...you know, we miss [name] because he is funny - we don't miss [name] because she wasn't particularly funny...we actually physically love him you know, emotionally love him.’ (P30)

Participant 22’s quotation also exemplifies the point that a few participants mentioned that they had only ever known the person as having a LTC rather than knowing them prior to acquiring the condition. In these cases the participants questioned whether this would have made a difference to the employee’s performance and behaviour in the workplace, and hence their level of support, or whether this was down to the employee’s individual character. Others described the employee’s personal approach to coping with their condition and managing it and whether they take a positive or negative view of their situation, also has an impact on how they are supported by managers and co-workers alike, as illustrated by Participant 24 (F, public org.)

‘Well again I think a lot of it is down to personality...I think if the person had been a moaner and a groaner constantly, chip on the shoulder type
person, it could have been different. But the experience that we've had has been extremely positive. All the staff have been keen to help if there were bad days to take over and to do a little bit extra themselves, that kind of thing. But I do think partly that's down to the individual personalities.’ (P24)

Whilst the influence of the employee’s personality is perhaps an unsurprising finding (Chay, 1993), what is interesting from some of the narratives, such as Participant 30 above, is the contradictions occurring where participants attempted to convey their egalitarian approach to supporting employees as per Participant 29:

‘... I don’t think it’s whether it’s the personality is more well liked than others. I’ve never seen that. I just think that everybody is... I’d see everybody being treated as equal.’ (P29, M, public org.)

He then went onto talk about particular cases with warmth, compassion and an intangible sense of goodwill compared to others where the individual was seen not to be helping themselves or there were questions regarding legitimacy. In this instance describing an experience of supporting an individual with Crohn’s disease where the whole team monitored his wellbeing and diet for example;

‘We all became his mother, for want of a better phrase. So in essence his condition did improve. There were, on the odd occasion, where he did have prolonged periods of sickness, but they were... they were down to sort of like picking up a bug. Now, was it that he picked it up with us? Was it that he picked it up outside?’ (P29, M, public org.)

Contrasted with a diabetic individual who:

‘doesn’t care about his diabetes, doesn’t care about his weight issues and all the rest of it. I’m kind of sounding bitter and twisted about that. I’m not.’ (P29)

The feeling of goodwill was evident across many interviews where participants were effusive about those employees they liked. Correspondingly, some suggested they were keen to support the employee and ‘bend over backwards’ (P4, private org.) to help them manage their condition and retain them in the workplace, as the following examples depict:

‘So actually I have to say the line manager of that person [employee with epilepsy] has really bent over backwards I think to, to make it possible for work to continue and at the same time be safe for that person and for the organisation actually you know cos’ the risk to the organisation of things going wrong so. But I think it depends on the managers having that, putting the effort in actually to, to allow that to happen and you
know I guess with the right people then you know you make the effort.’ (P38, M, 3rd sector org.)

‘also you can protect people a little bit because you can also turn a blind eye to somebody having an extra few minutes for their lunch break, or whatever, if you know that things are horrid.’ (P20, F, public org.)

‘And I’m only, I only bend the rules marginally and it’s not really bending the rules, it’s being, compassionate to a long-term sickness is when we’ve got somebody, a life threatening situation or somebody’s that’s had a fairly traumatic period of their life.’ (P35, M, public org.)

Likewise participants will exhaust many avenues in attempting to find the right support solution such as regular contact, amending work schedules, relieving duties and so on as in a case of a well liked employee with CFS where Participant 19 (F, private org.) suggested they tried everything because there; ‘was something about her...’. Participant 32 (M, private org.) managing an employee with a condition affecting the immune system, suggested that in this particular case, the management of absences and subsequent phased return to works were dealt with extremely flexibly:

‘more so than in any other case I've ever have managed and we would like, you know, we would literally anything that we, anything that he really wanted would be agreed.’ (P32)

The above quotation also illustrates the trusting relationship the participant said had been built between himself and the employee, which enhanced their support and the fact that the employee was not perceived as a malingerer or non-genuine as the following quotation highlights:

‘...and it wasn't a case of it being abused anyway, he is not that type, wasn't that type of person so, you know, we could accommodate.’ (P32)

The feeling of goodwill was understandably not continued where the participant perceived personal reasons to be less sympathetic towards the employee. In these cases participants expressed their frustrations and tensions, as demonstrated by Participant 9 (questioning legitimacy) and Participant 39 (a disliked employee) below:

‘And again, you probably are going to be more colder to someone that has just messed you around, not been in contact, they let you down and you’re thinking... you start questioning whether their reason’s been genuine because of all the different reasons that they’ve been off, rather than just one person that’s never been off for ten years all of a sudden
goes off because someone saw them slip at work and they broke their back or something.’ (P9, F, public org.)

‘I mean a member of staff more recently who is a challenge, and she’s about as good an example of taker as you could possibly come up with. Now she might have a whole set of reasons sort of history outside of work, for why she behaves like she does, but from an employer’s point of view, I’d see her gone tomorrow without blinking. Extraordinary drain on her managers, adds precious little but thinks she’s just victimised and I’m absolutely damn certain that she’s not. And some of her colleagues would see her you know as just, how does she get. ’ (P39, M, public org.)

Conversely, the expression of guilt and shame about negative thoughts towards the employee personally and/or about their condition was embedded tacitly in non-verbal gestures accompanying interviews or in off the recorder discussions. For example Participant 9 above when recounting her perceptions of ambiguity around the genuineness of cases, struggled to articulate her feelings when rationalising them, whereas Participant 12 (M, private org.) was more explicit:

‘And you get to know the ones that are kind of genuine as well. I think it’s... probably you get a bit sinister and you get a bit like aware of it I think. And then you can be quite... I think you can take... you’ve got to take individual cases without reasoning and putting your own feelings onto it too much as well. I think that’s just... that’s just what I think humans are like generally though aren’t they.’ (P9)

‘So when we were getting poor work performance because of an exacerbation of her condition, I have no idea if it’s because there was too [much] work I’d given her, so I feel guilty about that’ (P12)

Similarly, Participant 1 (M, public org.) lamented his feelings about an instance of not being ‘as warm as I should be’, towards an employee taking time out for a medical appointment.

When asked about their experiences of co-worker support, the responses were unequivocal. Again the majority described the connection between the employee’s personality, the closeness of interpersonal relationships and the co-workers’ willingness to, and type of support. Participant 21 (M, private org.) summed this up for the cohort by saying, ‘whether they’re well liked is vital as well, because that goes back to it’s a social interaction, so...and that will make a difference.’ Here, participants were much more communicative in talking about their perceptions of co-workers support presumably because it is less personally sensitive to them. When asked how they find colleague and co-worker support of those with LTCs, participants described more negative
experiences than positive, usually involving aspects of resentment. This included resentment deriving from perceived unfairness in covering an employee’s workload (as outlined in Chapter 5) but also in cases where the employee was disliked or considered a malingerer as per Participant 12 and Participant 26’s experiences below, who both found co-worker behaviour personally difficult to manage:

‘Well one individual in particular I think just he did get frustrated. So if she’d ask a question he’d go [sigh], you know, he’d tut and turn away and that’s all at the end. And, you know, that she noticed of course as you would and they ended up having a very frosty relationship as a result of that, you know, she got the view that he was just out to get her. He formed the view that she wasn’t worth anything and, you know, it…that was difficult’. (P12, M, private org.)

‘So there was people that liked [name] and got on with her which then they started to really dislike the people that caused her all the stress and all the problems and vice versa. Because the people that were causing her stress were like well, why are you supporting her she’s not very good at her job, she’s not nice, why are you her friend and vice versa. It was a really miserable time.’ (P26, M, private org.)

Of those commentaries that described positive co-worker support it was noted that many participants attributed this to the closeness of relationships within the team. Many of these had been built up over time, as the following quotations highlight:

‘Yeah and also, I think it has to do with the turnover of people, I mean if you get to know your colleagues really, really well I think it matters to you a lot more what happens to them and if the turnover is really quick and, you know, you don't actually get to know people very well you just, you don't care, you know.’ (P6, F, public org.)

‘But again it was somebody who has been here quite a long time and the staff had a lot of affection for. There was no problem on those lines, the staff were quite supportive and keen to help that person.’ (P24, F, public org.)

Similarly employers and managers also highlighted the type, strength and length of relationship with employees where closer, open and honest relationships was perceived as a key enabler to a successful working experience and return to work, as Participant 25 highlights:

‘I think that the relationship between the individual and their line manager is crucial because if that’s the only person they want to disclose to then there’s got to be a good relationship there to be able to be open
and honest with each other about what’s working and what’s not, or what the next plan is.’ (P25, F, public org.)

The need for good, clear, open and honest communication between all actors was consistently cited across the interviews as being important or even key in the employee/manager relationship, as highlighted above, when supporting those with LTCs. Contrary to this however, the majority of participants also made it clear that they find it particularly difficult to converse with employees about matters relating to their condition.

6.2.3 Having Difficult Conversations

The need to have what participants’ term as ‘difficult conversations’ with employees was a consistent theme across interviews. Participants described either their own or other managers’ reticence to engage in conversations or to avoid communicating with employees about their condition. Reasons for this included reluctance to talk about personally sensitive matters, being fearful of contravening discrimination legislation and/or shying away from confrontation. This stands in contradiction to participants expressed need for openness and honesty and the perceived importance of communication as a key enabler to a supportive relationship. As Participant 31 (M, public org) remarked, ‘and it's challenging things to talk about, so I think there's a barrier straight away.’ Aside from those conversations which are personally distressing such as when needing a compassionate response to other people’s illness (Section 6.2.1 this Chapter), participants described their experiences of needing to have more functional conversations about the job. They report finding this personally and emotionally uncomfortable and, as Participant 20 (F, public org) expressed, ‘a bit unpalatable for everybody.’

In the first instance participants suggest that this pressure stems from anxiety in talking with others about sensitive conditions. This could be indicative of the culture of reservedness in the UK towards discussing matters considered embarrassing or taboo (Fox, 2008) given that the majority of participants in the sample were taken to be of British ethnicity. Some participants reported that this results in reluctance to broach difficult conversations with employees as the following exemplify:
'They are difficult yes. Sensitive too, long term sicknesses don't ever tend to...well they're not colds or flu, it's always something that's i.e., depression, stress related, work related stress, or a more sort of serious ailment.' (P33, M, private org.)

‘A lot of people don't do return to works, or put them off because it's uncomfortable, and you're gonna have to engage in a conversation about why somebody was off ill, and maybe it's sensitive, or maybe it's about what medication, or you know.’ (P33, M, private org.)

‘I think what always stands in our way with this type of stuff is people are afraid to talk about it. And if you can improve their ability to have those conversations and reduce their fear of having them we're going to be in a far, far better place. Because if you have a straight forward conversation with somebody you're going to...and make them feel comfortable enough to tell you then you're going to be able to manage the situation far more constructively for both parties than if you're all making assumptions and you're not really saying it because it's always put in the difficult pile and someone's too afraid to say something. And often with illness I think that happens quite often.' (P20, F, private org.)

Discussions with employees about mental health conditions appear to be particularly challenging. Participant 5 (M, public org) likened it to walking around on ‘egg shells’ for fear of upsetting the individual while Participant 31 and Participant 19 relate that for managers:

‘...it’s a bit out of the norm and it takes managers out of their comfort zone to have that conversation, to negotiate with an employee what we’re going to do in response to behaviour (MH) which your colleagues think is just a bit odd’ (P31, M, public org.)

‘...because they to be honest really don’t want to have those conversations because they’re really hard. So they ask for every bit of help they can get or just don’t have the conversations, avoidance is probably the biggest thing that happens, them just avoiding it’ (P19, F, private org.)

Secondly, the anxiety of saying the wrong thing to the employee and/or fear of contravening discrimination legislation/employment law or just generally getting the conversation wrong was also a key reason cited for reluctance in having conversations with employees as P23 (F, public org.)

‘And I had difficult situations because other managers haven’t dealt with something at an earlier stage, and I think that’s very unfair sometimes that people will just avoid things because of the difficult nature or fear of recrimination or they’re going to have a grievance put in against them if they get it wrong or if they suggest anything, and it fester’s and the problem gets worse, and the further down the line you’re in a more
difficult situation. I mean I’m not saying it’s easy. I’m not saying I haven’t avoided things in the past myself. But I think as a general rule I would advocate honesty and tackling things at as early a stage as possible really.’ (P23)

Moreover, as the above quotation indicates, there is a concern for the consequences of avoiding difficult conversations with employees which is shared by others in the sample such as P32 (M, private org.):

‘Because you’re nervous and you’ve got that lack of confidence anyway sometimes you don’t ask the questions that you needed to ask because they’re uncomfortable or the nervousness of the situation takes over and you forget to ask. So you come away with not as much information as you should have and, therefore, the management of sickness isn’t as great for them because we’ve not offered them the right levels of support.’ (P32)

‘...and it was a problem, you know difficulty for her, by allowing people to sort of, I don’t know, by not being honest and upfront and having that kind of properly informed discussion with people that are sort of struggling and suffering in a variety of ways, I just think you end up doing them more harm than good as well, and I don’t think it’s very healthy for anybody.’ (P39, M, public org.)

For others, an additional burden was the need to have potentially confrontational conversations with individuals where ambiguity as to the genuineness of the condition was in question. Here, some participants suggested that these conversations are particularly challenging from a personal perspective, where there is a need to remain non-accusatory, viewing all illness as genuine to remain within the law, until proven otherwise. P28 (F, private org.) is indicative of other participants in describing her anxieties over these conversations, and remarked:

‘...obviously, having to be really, really respectful and careful. All the way along the line, you’re thinking about the genuineness of any sickness or inability, as opposed to not.’ (P28)

6.3 The Condition - Discerning Tangibility and Questioning Legitimacy

Discerning tangibility, genuineness and legitimacy of conditions was a significant theme across interviews. The majority of participants recounted their perceptions and confusions about what they perceive to be a ‘serious’ tangible condition, which also crossed over into their experiential descriptions of
legitimacy and genuineness. It was clear that many felt strongly about this particular aspect of supporting those with LTCs. Much tension and conflict arises from personal evaluations about the situation and the need to manage employees within the remit of organisational sickness absence policies and legislative guidelines.

Whilst concerns over legitimacy, tangibility and genuineness were consistent across all interviews there appeared to be more cynicism expressed from those in manual work environments. This finding is consistent with current literature in this area (Bellaby, 1990, Tarasuk and Eakin, 1995 for example) where sickness absence is particularly problematic in labour intensive occupations arising from a high prevalence of musculoskeletal conditions (CIPD, 2012) and subsequent claims to the validity of the condition. Also congruent with existing research (Dix, Forth and Sisson, 2008), those participants in manual organisations and the public sector (heavily unionised environments) were also more likely to report concerns over breaching employment and discrimination laws for fear of engendering industrial tribunals.

To illustrate the theme of tangibility, many participants expressed their perception of what constitutes a tangible, genuine condition. This was often framed in terms of what would be considered a ‘serious’, ‘real’ condition such as cancer as encapsulated by the following quotation from Participant 33 (M, private org.):

‘And also the nature of the condition too, so if somebody's off with a more serious condition long term, such as cancer related.....then straightaway the support mechanism is there and people start really, you know, no questions asked, and rightly so.....when somebody's off with IBS or something that's not as severe I don't think it's treated the same way.’
(P33)

As alluded to in the above quotation, positive support for conditions was more readily expressed for those conditions perceived as ‘genuine’ and tangible. As P5 (M, public org.) noted about co-workers, ‘and they do rally around people who are ill, genuinely ill, whatever illness it is’ and P36 (M, public org.) about managing LTCs through the sickness absence process, ‘[we] get em in and support them that are genuinely ill’. Some also mentioned post-interview that they would do anything for those they felt were genuinely ill. However, like the quotations from P19 (F, private org.), P24 and P25 below, many suggested that
perceived tangibility could also be evaluated on the visibility (presence) or absence of physical symptoms (or obvious impairment) which is also implicated in questioning legitimacy:

P19: ‘You have much more sympathy if you’ve got cancer or you’ve had an operation or you’ve got MS than if you’ve got anything... any mental illness.’

DLB: So it’s having the visible symptoms versus...?

P19: ‘I think people understand if it’s something you can put your finger on. Whereas I think if they don’t understand it they can either be sceptical or just scared actually not knowing what to do.’

‘Yes I think tangible symptoms are far easier to - I was going to say, own up to, I don’t mean that in that way, but you know what I mean? It’s far easier to say even that you’ve got terrible toothache or that you’ve got migraine or... well it’s usually obvious that you’re quite ill and it’s far easier to say that than to say, I just feel really tired, I feel so tired I want to go.’ (P24, F, public org.)

‘I think it’s just more acceptable as a physical condition because people can see what the problem is, can’t they, whereas they can’t see what’s going on in somebody’s head.’ (P25, F, public org.)

The ambiguity caused by those conditions perceived as less tangible i.e. those that are visually asymptomatic such as stress, mental health conditions and bowel disorders or those with medically unexplained symptoms such as Chronic Fatigue Syndrome, aroused further scepticism as to the legitimacy of the condition. A finding which is consistent with existing research detailed in Section 2.4.1-Chapter 2. A few participants were frank in their discussions about the difficulty in discerning the genuineness of illness as Participant 9 (F, public org.) exemplifies,

‘I’m not trained enough to do that but I think just general common sense. You can see the people that are anxious and you can just see the way that they’re conducting themselves, and then others I think that it’s just a statement, a throwaway statement, and I think it’s just hiding something else. And you get to know the ones that are kind of genuine as well.’ (P9)

Many participants implied their scepticism when considering the genuineness of conditions, which appeared to be underpinned by personal evaluations of the situation. For example Participant 12 (M, private org.) added a moral dimension to what he was saying by using body language to indicate that he was not entirely assured as to the genuineness of the condition:
‘...until recently [I] managed somebody who had Chronic Fatigue Syndrome or that was the diagnosis that she shared with me, with the company’ (P12)

When taken together with non-verbal gestures and in the context of the complete interview narrative, the quotation conveys the participant’s personal thoughts about the supportive situation. This was indicative of many others across the sample as will be discussed further in this Chapter.

6.3.1 Questioning Legitimacy

‘I would say the people who are long term sick fall into two categories really. Those ones who I would call trying it on, and those ones who are genuinely sick.’ (P16, M private org.)

Participant 16 aptly captures the essence of the perceptions of many in the sample where they described their tensions in supporting those people and conditions that they suspect to be non-legitimate. In recounting their experiences, five participants spontaneously used the phrase ‘swinging the lead’ and/or ‘playing the system’ (coded in-vivo) to indicate their thoughts about those employees considered to be acting speciously, as exemplified by quotations from P20 (F, public org.), P37 (M, 3rd sector org.) and P6 (F, public org.) below:

‘it upsets me is that there are people who will swing the lead, and there are people who are genuinely ill, and so what you have to do...and the people swinging the lead are usually the ones who are quite vague about what’s wrong with them,’ (P20)

‘Because I meant the thing is you can still be disabled and swinging the lead. Doesn’t make you an angel just because you have a disability [laugh].’ (P37)

‘You’ll know the people that are playing the system because they’re the ones the claim’s coming off. Basically you’ll get one of these where there’s blame there’s a claim coming through...’ (P6)

Personal thoughts around the employee’s motives for presenting with non-genuine illness were prevalent both verbally and non-verbally (as introduced in Chapter 5) through these accounts. A proportion of participants expressed their frustrations at having to support the employee within organisational and legal frameworks whilst suspecting that, counter to this, the employee has an alternative agenda.
‘The not so good experiences is when you know honestly and truthfully that people really don't want to come back into work and they're using every avenue they can to not come, for whatever reason, whether that's personal or whether it's they enjoy being at home...and they're actually making it a bit more difficult process than it needs to be... And they're the frustrating ones cos you...the home visits and the interviews and the sort of dialogue becomes a lot more tense and not as flowing when you’re not working to the same sort of common ground, and that's frustrating.’ (P33, M, private org.)

‘...there’s nothing you can do about it your hands are tied, you’ve just got to deal with it, put a smile on your face and do the best that you can for the people that are in the game, for the people you’re trying to do, you know what I mean?’ (P3, M, private org.)

In many instances, discussions about questioning legitimacy were again accompanied by non-verbal gestures and expressions not able to be captured on the audio recorder, which hinted at participants’ personal evaluation of the situation. For example, in the Reflective Memo captured following the interview with P15 (M, private org.), I noted that:

There were also some interesting comments about legitimacy of illness which is sometimes hard to ascertain. The interviewee denoted this by his body language and eye movements without explicitly mentioning this for the audio recorder.

Interview 15 Fieldnotes/Memo Excerpt

One example captured on tape was P28 (F, private org.) who recounted a case where she had found out that the employee she was supporting had repeated the sickness absence process at other organisations (for financial gain), and therefore tried to convey her moral evaluation of the situation by saying to me, ‘You see what I mean?’ (P28). P28 also put her head to one side and looked straight at me to convey meaning and understanding between us. Another where the manager was discussing a case where an individual with a neck injury was spotted (by the participant) playing a game machine:

'and he was looking up like this [strains neck to illustrate] to see where the next row is and you’re like that [sharp intake of breath]...there’s always somebody who’s happy to say, ‘there’s nothing wrong with him you know’. It’s a bit of a balancing act at times.' (P36, M, public org.)
Those who had had particularly negative experiences of managing employees who were non-genuine, related that it had left them cynical about supporting illness in the workplace going forward, as the following quotations highlight:

‘So it does make you sceptical and it does make... because I was... it quite upset me at the time because I felt like I’d been really duped and I feel quite... I feel I’d been very gullible because to see them then up and about and operating exactly as they had been before just was... oh it was just hugely frustrating.’ (P19, F, private org.)

‘There will always be people who will make the most of...I think the difficulty is that I think when managers can become quite cynical to that if they’ve had a number of cases, and I think that can colour their view on a particular issue. And I think that it's unfortunate because that has a bearing on other genuine cases ultimately’ (P31, M, public org.)

Whilst the majority of the experiences exemplified above cover a range of chronic conditions, participants cited the perceived ambiguity surrounding stress and mental health conditions as posing even greater personal difficulty.

6.3.1.1 Mental Health Conditions, Stress and Legitimacy

Mental health conditions and particularly stress consumed a large proportion of managers’ and employers’ concerns and frustrations about supporting people with LTCs, as mentioned in Chapter 5. Stress is the primary reason for long-term sickness absence for non-manual workers in the UK and second behind musculoskeletal conditions for manual workers, with mental health conditions being the third main reason for long-term sickness absence across industry types (CIPD, 2012). Interestingly, only four of those participants who did not mention any experiences of stress or mental health conditions were employed in manual industry types. Conversely, a few managers from manual organisations described particular difficulties with managing employees with stress.

One of the participants in this instance introduced a key finding with regard to stress, intimating the perception that the term is now used by employees for non-legitimate reasons when wanting paid time off time work but not wishing to use annual leave days. Here, the participant suggested that stress is the new ‘back-pain’, where there is a cultural hidden understanding in the UK that some employees use the ambiguity of back-pain (when non-genuine) to obtain a sick note from the GP to exempt them from work. Participant 6 (F, public org.) stated:
P6: ‘But it is…I’d say it’s the old back problem is now stress problem.’

DLB: Really?

P6: ‘Yeah. I’d say in our experience yeah.’

DLB: It’s been replaced, one for the…

P6: ‘Yeah. Because, yeah, I think mental health issues are the number one reasons. So some are work related and some are personal. Yeah, there are a few. I’d say there’s a lot more that aren’t…’

This was a conversation that was again littered with non-verbal gestures, such as open arms and eye movements, where the participant was trying to convey her personal perceptions to me without verbalising them for the recorder. Behind the snippet of interview transcript detailed above it was inferred from the non-verbal communication that the participant was implying to me ‘do you know what I mean?’ inviting me to understand her personal private thoughts.

Participant 6 suggested that the rise in stress related absence in her manual working environment could be due to the introduction of the new Fit Note (See Chapter 2 Section 2.2.5). An employee presenting with back-pain would have traditionally been certificated as unfit to work and therefore exempted. Whereas the criterion of the Fit Note now focus on fitness for work, where work retention is possible and beneficial in most circumstances, including for musculoskeletal conditions. Participants report therefore, that employees have looked to alternative conditions where there is ambiguity over the benefit of remaining in work – such as stress – to exempt them from work as the following quotation highlights:

‘I think possibly with the fit note in the fact that there are more options now than the old sick note, because in the old sick note you basically got a reason and that was it, whereas now there are well maybe they can come back to work, maybe they can’t, maybe they need to do reduced hours, so it’s not a full day so we can phase them in or maybe the amendments there are various options.’ (P6, F, public org.)

Perceived personal moral evaluations as to the spuriousness of the term ‘stress’ and its use by the employee and the GP on the Fit Note are also expressed by others in the sample. Participant 21 (M, private org.) for example expressed this phenomenon more explicitly:
'Yeah, and I think there’s more monitoring of what’s going, so they have
to find something to put on the note, and whether it’s a bad back or 24
hour flu which people have stopped believing in because it doesn’t exist,
I mean 24 hour flu is a bit like the tooth fairy really isn’t it, came along
and gave you a day off [both laugh]. And now people put stress down.'
(P21)

‘It’s a hard one as well to get back in because I think probably if people
do know that people have been off long-term with stress the colleagues
don’t accept it as much as if you’re off sick with like a broken back,
because people can’t see stress. It’s in your head and it’s not like you
can wear a plaster and people see it. It’s... the psychology behind it and
I think people just think because it is over-used that when you have got
genuine cases people think, ‘Oh, they just can’t be bothered to come into
work. They’re using it as an excuse and they’re lazy’. All that kind of
stuff that you get, so it’s yeah... a bit more work needs doing on that I
would say, but I think the GPs need to work with companies a lot more
because it’s far too easy for GPs giving out the sick notes.’ (P9, F, public
org.)

It was clear from the findings that many participants feel anxious and ill
equipped when supporting and managing those with mental ill health, which
accords with existing research in this area (see Chapter 2, Section 2.4.3) and
sector org.) typified this when she said:

‘With mental health it’s such a grey area, and everybody is so individual
that you... there isn’t a sort of set, ‘Right, we do this, this, this type
thing.’ (P11)

Participants expressed that their anxieties and tensions stem from a multitude of
reasons ranging from the ‘misunderstandings around mental health conditions’
(P19, F, private org.) and negative stigma associated with these disorders:

‘It’s very difficult to manage but, well, I think most employees, if they’re
suffering something physical, it’s obvious and they will approach and do
something about it but I think there’s still a bit of taboo around any
long-term mental health problems in the workplace.’ (P5, M, public org.)

‘I’m ideally I suppose, we’d be in a position where there wasn’t such a
stigma attached particularly with mental health. There wasn’t such a
stigma attached that people could speak about it freely and securely in
their jobs, but I do think there lots of people won’t say, I’m facing these
problems because they’re worried about the stigma, and how that, they’ll
be treated.’ (P37, M, 3rd sector org.)

Together with anxieties and concerns about the employee’s behaviour
manifesting in the workplace which P17 (M, private org.) and P37 (M, 3rd sector
org.), describing his experience of an employee with bi-polar disorder, both illustrate:

‘we’ve got a really nice [job] and she in the past has had problems, nothing physical, but depression, alcoholism and I don’t know, she responded wrong to something, which made us question, do we renew the contract? And I’m, no hang on a second, let’s...this was years ago, not that we class what happened years ago, but you kind of see something and a behavioural thing going on. And is that going to come back?’ (P17)

‘So that was quite tough, to manage just in from the respect of, the health condition wasn’t managed or diagnosed at any point so she was kind of finding her way through it with us there were fireworks at times, there was rows, there was tears, there was kind of the full range of emotions that she was kind of swinging through.’ (P37)

There were many participants however, who expressed their perceived anxieties and conflicts in being supportive as stemming from the asymptomatic nature of mental health conditions and associated ambiguities. Both of the participants below conveyed their personal emotional discomfort in these situations. Where P1’s contorted facial expression conveyed his concerns. P24 (F, public org.) continued to discuss the case off the recorder to retain confidentiality, as noted in the interview fieldnotes. Participants found the need to manage the scepticism of other (co)workers as well as their own feelings and the needs of the organisation very difficult in this case, as the following highlight:

‘I think the most difficult one to handle is probably if someone’s off long term with stress. I think that must be (the most) difficult one to handle, because, you just don’t know when they’re going to return and how things are going to be when they return....You know where as if, and it’s probably a lack of sympathy with that particular condition or situation where if someone’s got something definitive that you know cancer or something, I don’t know whether that’s me personally but, it’s slightly easier to be more compassionate in that situation, you know if when it’s stress I don’t know.’ (P1, M, public org.)

P24:  ‘Yes I have, perhaps I’ve been fortunate. I have had experience in a previous job of somebody with a mental health problem. That's some time ago now, but in a way that was harder to manage because it wasn't something that the rest of the team could be really made fully aware of. And again it wasn't a tangible obviously, so that was harder. I think I've been fortunate in not having had many instances of that kind. But I can see that that could cause a problem.’

DLB: Was that difficult to manage at that time?
P24:  ‘Yes it was actually yes, but that's going back a few years now’
Interestingly, in contrast to the majority of participants, Participant 39 (M, public org.) expressed an alternative personal perception of stress. This was an interesting contradiction within his own narrative which was effusive about social support for those with mental ill health, but unlike many of the other participants, explicitly tackled implied moral evaluations:

‘...because my personal view is, and again I mean it’s what I think not what I do with my staff, I don’t have a great deal of time for stress for example, it’s like no I think that’s called life personally and some people are more capable of dealing with it than others.’ (P39)

6.3.1.2 Surveillance and Legitimacy

An interesting finding was the report by two participants that in some cases they employed surveillance mechanisms to monitor employees who were certificated as unfit for work with a LTC but where the legitimacy of their illness was in question. These experiences of surveillance were found in the manual sector concerning employees claiming they could not work due to a musculoskeletal problem, such as a bad back, which prevented them from working. Despite this, participants suspected that they were ‘trying it on’ for either financial gain from the company or because they did not want to do a particular job. For example Participant 15 (M, private org.):

‘And this chap, who couldn’t lift, couldn’t move his shoulder above his...kind of went...moved everyone out the way and said, “Look, I’ll show you how it happened.” And did the job. And the health and safety manager just stood there and reported it and took photographs of it all. And then came to me and said, “You know the guy who can’t do anything with this shoulder, well there’s photographs of him doing the job apparently he can’t do.’ (P15)

Participant 16 (M, private org.) also talked about surveillance of a particular employee who was photographed lifting a sheep but claimed he could not come to work and lift a brick.

‘I mean there's two people, because we've had surveillance on them on the back of them putting in liability claims for accidents at work. One of whom was complaining on the back issues, of a repetitive strain nature. So there isn't a specific thing, but there's lots of things. We've had him, we've seen him playing physical football. We've had him - his parents own a farm, a picture of lifting sheep and stuff, but he can't actually come and lift a brick. That's what tells us that he's trying it on.’ (P16)
6.3.1.3 Social Media and Legitimacy

Aligned to surveillance of employees, an unexpected finding in the interviews was participants’ reference to employees’ use of Social Media (and in particular Facebook) whilst absent from work with a LTC. A few participants mentioned that they had seen, or had been told about their employees’ social activities which brought into question the legitimacy of their condition. For example, Participant 3 (M, private org.) talked about an employee with a blood disorder:

‘he was saying he was staying in all the weekends and you he was really sort of like ill but then he was out at gay pride and sort of having photo’s on things like Face book that was shown round all the staff room of him taking drugs and it was sort of like well [laugh, laugh] so you’ve just given yourself enough rope to hang yourself there.’ (P3)

Participant 28 (F, private org.) specifically brought up the use of Facebook as a particular problem with members of her workforce and along with other participants, described how hard it is to manage the feelings of co-workers as well as their own when:

‘They’re just seeing a colleague who’s not coming to work, and yet is able to do other things in their private, and domestic and social life. So those issues are quite hard as an employer. They really are quite hard.’ (P28)

Two other participants discussed the use of Facebook between their employees but had chosen not to engage with it as Participant 39 (M, public org.) suggested:

‘...and really very occasionally people will bring stuff saying this person’s said this about this person on Facebook what you going to do about it? But, and I mean we deal with those situations but they’re very very hard to prove, generally would have been removed from Facebook before you can get at ‘em...you know I mean they’ll be a whole range of kind of pressures and views being expressed by those members of staff that want to engage in that way which we will have not knowledge of. But I’m kind of quite happy to keep it that way for as long as we’re allowed to.’ (P39)

In these two cases, the participants were keen to retain the professional boundary between themselves and their employees commensurate with the status of the managerial role, as will be explored next.
6.4 Maintaining Professional Integrity whilst Being Tightrope Walkers

Many participants were conscious of maintaining professional boundaries between the need to be supportive and sympathetic towards employees whilst also having to fulfil the obligations of their role to the business. Here, some participants were aware that the blurring of the boundaries between professional and personal roles would compromise their integrity as a manager but nevertheless found this difficult to achieve in the circumstances. A few participants rationalised this aspect of their role by suggesting that they communicate clear boundaries to employees with LTCs so as to appear consistent and objective, as the following quotations explicate:

‘I suppose on a one to one, getting to know the member of staff who I’m managing and being clear about boundaries, being clear about personal and professional responsibilities, and leading by example and setting that culture and that standard really.’ (P23, F, public org.)

‘Very difficult; because you don’t want to upset people, you don’t want to make anybody feel worse than they already do - you’ve got to work, you know, you’ve got to be colleagues - so it is quite complicated.’ (P25, F, public org.)

‘And trying to be as objective as possible, which perhaps takes some of the soft woolly sides out. But as soon as you try and almost treat somebody as an individual on their own and you’re thinking, I hear your sob story, and I can understand it. You just open up all sorts of cans of worms’ (P16, M, private org.)

Participant 15, unlike the majority of participants, was more explicit in the use of specific emotion words when attempting to rationalise the influence of feelings in the workplace in pursuit of maintaining professional boundaries:

‘And it can be very emotional, but the point is that’s the separation between the empathy and the sympathy because what they don’t need is you getting emotional about their medical condition, if you know what I mean.’ (P15, M, private org.)

The fact that emotive language is little used by participants throughout their responses is indicative of the normative expectations of the management role as presented in Chapter 3 Section 3.1.5. This suggests that it is considered preferable for managers to present themselves as distant and rational, rather than weak and emotional to retain professional integrity further discussed in Chapter 7. Contradictions within a selection of participants’ narratives however, also
belie their difficulties with this rational/emotional boundary of protecting professional integrity, given that balancing the needs of those with LTCs is often an emotive experience. For example, of those narratives where this emerged (see also Section 6.2.1) a pattern was observed whereby the participant was initially positive about their experiences or a particular employee and then later in the interview contradicted this perception. For example, Participant 8 recounted:

‘But it’s about... it’s all been very positive actually, very positive indeed. I can’t think of anything negative at all, because they are individuals that are bringing very good skills to the organisation and we are utilising those skills.’ (P8, M, 3rd sector org.)

Whereas later he on went onto discuss his difficulties with a particular case that he felt unable to manage.

‘Apart from that long-term one which is... I just said I can’t handle this one any longer because it’s been going on for so long and it’s going up to another level and I think that has to be handled by an HR professional rather than the manager.’ (P8, M, 3rd sector org.)

Noted in the memo for this interview is that although the participant initially came across as very positive and professional in his assertions, I felt he was too polite to share his feelings about negative aspects. Likewise, Participant 21 mentioned his personal difficulties in managing an employee with a mental health condition but generally kept the interview focused on his positive professional managerial style in supporting those with a LTC as follows:

‘But no, I can honestly say I never really have found that there was anything more frustrating or difficult about it than with any other member of staff. That’s maybe an odd response, maybe not one you get from most people, I don’t know.’ (P21, M, private org.)

A few participants purposefully chose to discuss personally and morally sensitive matters off the recorder, as introduced in Chapter 4, Section 4.6.4.3. In this context, participants’ choice as to what was verbalised both on and off the audio-recorder and the display of non-verbal gestures to avoid being captured on the recorder, was taken to imply acts of impression management (Goffman, 1959, see Chapter 3, Section 3.3.5) in pursuit of maintaining personal and professional integrity. The most striking of these was Participant 24 who although very nervous about being recorded, was very positive about her organisation and her experiences of managing employees with LTCs. P24
thought about what she wanted to relate to me during the interview and considered her responses carefully. Yet when the audio recorder was turned off, she proceeded to talk to me frankly about a previous negative experience which she felt she could not put on record and did not want audio recorded. This conversation is not detailed here to protect P24’s confidentiality. Likewise, when the audio recorder was turned off P30 also suggested he would talk to me frankly (again not detailed for confidentiality reasons), suggesting that what was captured on the recorder was considered socially acceptable (see Chapter 7, section 7.2.2).

Impression management was also manifested in other ways; through expressions captured on the recorder in relation to rationalising comments about their supportive behaviour as discussed in Chapter 5, and non-verbal gestures. On the recorder there were a few participants who it was interpreted, wished to limit any negative portrayal of themselves given through responses which might appear socially undesirable, by adding mitigating phrases. Such as P37 talking about the timing of the introduction of stringent sickness absence policy changes in the current period of austerity since 2010:

‘That makes me sound absolutely awful\(^{12}\) just saying out loud then.’
(P37, M, 3\(^{rd}\) sector org.)

Similarly, Participant 22 (F, public org.) rationalising her management of an employee’s behaviour; ‘I know it sounds awful, but he’s, actually, become a much nicer person’.

Non-verbal gestures were used to illuminate participants’ thoughts and sensitive evaluations about other people’s illness and included eye-rolling and eye movements, open hand/arm gestures to project meaning to me, and various facial expressions to convey emotions such as sadness or scepticism. For example P19 (F, private org.) found trying to support an employee with CFS personally frustrating; ‘a really quite difficult situation, it caused a lot of frustration I think on both sides.’ Although this was captured on the audio recorder, her facial expression - which belied her personal emotional discomfort in trying to adequately support an employee she personally liked with the

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\(^{12}\) Emphasis added to denote participant’s tone of voice
demands of the business – was not and was therefore noted in the interview fieldnotes.

This situation was indicative of many interviews leading to a key finding that what was not said in the interviews, or sites of silences as highlighted in Chapter 4 section 4.7.2.3, was as pertinent and telling as what was said. This was exemplified by P27 (M, private org.) and his feelings of ‘mental torture’ detailed at the start of this Chapter. This was accompanied by non-verbal signs of discomfort which included head shaking from the participant and a facial expression of frustration, further exhibitive of emotional toil echoed by many within the study. Non-verbal gestures were also used by many to denote/imply when participants were discussing difficult cases and questioning legitimacy of conditions. In one interview there was a moment of silence and then the participant\(^{13}\) said ‘you fill in the blanks!’ when talking about the gendered response to illness. Silences (as discussed by Poland and Pederson, 1998, see page 219) were also used by other participants to convey ‘you know what I mean’, which in some instances I found particularly difficult to manage.

For some participants the post interview discussion, it was interpreted, was an opportunity to retain a sense of integrity by managing any negative impression they might have portrayed of themselves. Examples of this were concerns about how they had come across on the recorder i.e., P15 was concerned so as not to appear too brutal in his dealings with staff and similarly with P20, that she had come across too hard.

6.5 **Participant’s Gender, Age and their Supportive Role**

Counter to expectation, there were few observable differences in male and female experiences of supporting those with LTCs within the sample population. It was observed that the gender of the participant was not a particularly strong differentiator in their reports of their approach to supporting employees, either emotionally and/or materially. Prior to data collection however, it was assumed that results of this study would conform to cultural gender specific stereotypical beliefs (Hochschild, 1975) in that female participants would be more expressive of empathetic and compassionate feelings towards those with illness, and male

\(^{13}\) Participant not identified for confidentiality reasons
managers less so. Although this perceived gender difference in emotional response is a matter of much debate (Kring and Gordon, 1998, Fischer, 2000) and one which was not evidenced in this study. One participant gave an interesting response to being asked about their sickness absence management process. Participant 2 (F, private org.) drew a gender distinction in that they had just instituted a process for reporting acute sickness absence in which female employees had to call a female manager if they were absent through sickness, and men to speak to male managers. The participants’ rationale for this was to avoid male managers being more lenient with regard to absences for menstrual problems. This was because:

‘women calling up with women’s problems found men easier to wrap round their finger and get away with not coming in. Speaking to a woman manager who knows this herself makes her more likely to say take a paracetamol and come in.’ (P2)

Contrary to expectations, it was found that six of the male participants came across as very empathetic, sensitive, caring and more emotional than the female participants. It is noted that two of the male participants were tearful during the interviews when discussing particularly difficult cases they had dealt with. Both were in instances where the employee had died (see section 6.2.1 above), one from a terminal illness and one where an employee (again well liked) had died suddenly from an embolism and where the manager was dealing with the family and co-workers:

‘so it just shows doesn’t it when you’ve got somebody you could point the finger at and say ‘you could do with falling off the planet’, and there is a young lad like that with such potential.’ (P35, M public org.).

Similarly, there were those who came across as very empathetic and sympathetic towards their employees. For example Participant 33 (M, private org.) was very aware that:

‘when somebody comes back in that we need to sort of have the kid gloves out a little bit because they might be sensitive and feel a bit emotional, yeah, and we will always, without being too obvious, go a little bit further to make sure they’re okay.’ (P33)

P33 also referred to the little things that make a difference when someone returns to work from a long period of absence. Such as making sure that somebody is there to greet them when then they walk through the door in the morning.
Responses did seem to be somewhat different when comparing younger and older respondents. Those in the 50’s age group (n = 5 male, n = 5 female) came across as more pragmatic in their approach to managing people, bringing maturity and experience to their role. Participants drew on life experience in their support for those with LTCs and a number of them emphasised this suggesting that they put ‘themselves in someone else’s shoes’ (P11, F, 3rd sector org.). They also suggested that they managed co-workers in this way by getting them to think about how they would feel if they were experiencing a LTC as Participant 25 (F, public org.) and Participant 10 (M, private org.) indicate:

‘You know what that feels like. So we remind staff about...that, that’s what it feels like.’ (P25)

‘I say but put yourself in that position. I say just because you’re not ill today doesn’t mean to say you’re not going to be ill tomorrow. So put yourself in that position, you know, so just gentle...you know, don’t adopt an arrogant approach.’ (P10)

### 6.6 Status of Participants in Organisation and Perceptions of Illness

Overall, participants reported similar personal experiences and perceptions of supporting employees with LTCs regardless of occupational status, sector, size of organisation or industry type. Interestingly, when talking about their own or other employees’ perceptions of illness experience higher up the organisation hierarchical structure, two managers mentioned that it appears to be easier for those senior managers further up the hierarchy to manage their own condition in the workplace. Contrary to this however, one manager said that there was less social support at senior levels and therefore it was more difficult to be absent through illness. Participant 13 (M, private org.) stated that:

‘I think in some respects, the higher up the organisation your support network decreases to some extent because...you're not on a peer-to-peer level with so many people, and it's not necessarily...I mean you can still have a laugh and a joke with people, but if you're a senior manager you might not talk about work related issues that you might talk about socially with somebody else, because it wouldn't be appropriate.’ (P13)

Participant 27 (M, private org.) mirrored this observation suggesting that at a senior level it is more difficult to manage a condition because of the perceptions of weakness around certain conditions such as stress, he added that:

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14 Most of the participants are employed in organisations structured as per MacGregors’ (1960) concept of Theory X authoritarian management style, based on hierarchical levels of management for employee control and discipline.
'People who are senior tend to be quite ambitious, tend to have... tend to have kind of worked sort of quite hard and they have certain expectations of themselves, and I think then there are expectations on them, as a result of that as well. So I think it’s probably a lot more difficult to be honest.’ (P27)

This perspective is consistent with the literature concerning the expected normative behaviours of the management role as discussed in Chapter 3, Section 3.1.5.

6.7 Chapter Summary

The metaphor of Tightrope Walker was used in Chapter 5 to describe participants feeling of balancing many demands, interests and obligations in supporting those with LTCs. This Chapter has explicated those aspects on the side of the tightrope to which participants report they experience a personal response, influenced by the wider socio-cultural context, when needing to be supportive. These include private thoughts, evaluations and feelings about supporting the employee, the employee’s personality and the genuineness and legitimacy of conditions. Indeed P27 (M, private org.) went to lengths to assert that he too does have emotions and feelings and that he was an individual in this respect and that basically he was not ‘...the faceless view of the company’. This Chapter has therefore focused on the second substantive theme derived from the data that employers and managers also experience internal pressures stemming from personal private feeling acts associated with supporting those with LTCs.

In the next Chapter I will move on to interpreting and discussing the findings of this study as detailed in both this and the preceding Chapter. Findings will be examined in relation to current empirical literature and the theoretical frameworks as introduced in Chapter 3.
CHAPTER 7: Discussion

7.0 Introduction

This study has responded to evidence from the employee perspective which indicates that the employer’s and manager’s role is a pivotal yet empirically under researched determinant of workplace success for those with LTCs. Findings detailed in the preceding results chapters of this thesis suggest that participants tasked with providing this key supportive role perceive it as one of a difficult ‘balancing act’ of often contradictory and incompatible demands and pressures concomitant with both their managerial and individual social roles. Adopting a qualitative approach to this research revealed complex and often emotional challenges facing participants in needing to be supportive, which is reflective of existing work into the role of managers and the return to work process for those with LTCs (MacEachen, Clarke, Franche and Irving, 2006; Holmgren and Ivanoff, 2007; Grunfeld, Rixon, Eaton and Cooper, 2008; Munir et al, 2009; Amir, Wynn, Chan, Strauser, Whitaker and Luker, 2010; Bevan 2010b; Tiedtke, Donceel, Rijk, and Erckx de Casterl, 2013; Haafkens, Kopnina, Meerman and van Dijk, 2011; Coole et al, 2012). In contrast to previous research however, findings from this study highlight the emotional consequence to managers arising from their perception of being tightrope walkers, which is typified by feelings of conflict and emotional disquiet.

In this Chapter I therefore move on to examine and discuss these findings and consider their implications for socially supportive managerial relations upon which employees suggest they depend. In interpreting and explaining these findings, I draw upon the theoretical frameworks of emotion and work introduced in Chapter 3. Firstly, I use Merton and Barber’s (1963) theory of Sociological Ambivalence to explain the finding noted above, that managers express feelings of conflict in response to balancing many complex demands. I then go on to examine the emotional consequence of ambivalence expressed by participants in relation to their ‘private’ personal feelings through the lens of Hochschild’s (1983) theory of Feeling Rules and Bolton’s (2005) Typology of Workplace Emotion Management. Findings from this process are then discussed in relation to the literature detailing the employees’ perspective of
working with a LTC outlined in Chapter 2. This is followed by a discussion of
the possible implications of these findings for all stakeholders; the government,
employees and employers alike, in the light of political and conceptual changes
relating to work and illness in the UK. Finally, I will consider possible
directions for future research before going on to reflect on the strengths and
limitations of my study and providing concluding comments.

7.1 Feelings of Ambivalence

Participants were keen to convey how difficult they found it to manage an
employee with a LTC, with all bar one concurring over the perceived need to
balance multiple demands and pressures and the associated tensions this brings.
This perception is consistent across all industry types, sectors and sizes where,
as evidenced in Chapters 5 and 6 of this thesis, participants encapsulated their
supportive role as one of being a tightrope walker. A metaphor similarly used
by Holmgren et al (2007) to indicate that supporting those with a LTC presents
additional demands and burdens for the manager often considered non-
normative to their everyday role. This finding accords with existing research
(MacEachen et al, 2006) into the line-manager’s supportive role which
recognises that many other factors are experienced when managing those with a
LTC. These encompass such things as co-worker needs, the medical world
(Holmgren et al, 2007), the employee’s social and material needs (MacEachen et
al, 2006), employee’s personal characteristics (Coole et al, 2012), business
needs and organisational culture (Tiedtke et al, 2013) and manager’s lack of
condition specific experience or knowledge (Amir et al, 2010).

What is apparent from the data is the sense of conflict expressed by participants
in response to the need to balance these many demands and pressures. Findings
indicate this feeling originates from: a) incompatibilities between the obligations
and demands of the manager’s role and personal feelings and evaluations about
supporting another person who is ill consistent with their status as an individual
and b) incompatibilities between the multiple functions and interests of their
management role. Viewing these conflictual feelings through the lens of Merton
and Barber’s theory of Sociological Ambivalence as outlined in Chapter 3
(Section 3.4), suggests that participants experience ambivalence in response to
the conflict between ‘incompatible normative expectations of attitudes, beliefs
and behaviour assigned to a social position’ (p6). More succinctly, ambivalence arises when the role holder is faced with normative expectations that are contradictory (Coser, 1966).

The respondents in this study, can be viewed as expressing the type of incompatibility consistent with Merton and Barber’s (1963) theory of ambivalence (see Chapter 3, Section 3.4) by expressing the contradictions between and within the normative expectations\textsuperscript{15} of their social positions. Participants exemplified this conflict by describing ambivalence arising from contradictory demands (occurring in specific response to supporting those with LTCs) both within their status as a manager (intra-role conflict) and between the expectations of their status as an individual (inter-role conflict).

In the first instance, intra-role conflict was interpreted from participants’ expressions of balancing external demands, interests and obligations arising within their professional ‘public’ role as a manager as detailed in Chapter 5. Participants attest to the observation of Heiss (1990) in that they encounter demands, potentially outside of their normative everyday duties, but concomitant with their role as a manager, which are often contradictory and incompatible. These include balancing the employee’s needs and condition with those of the organisation, whilst also dealing with the medical world, adhering to disability/equality legislation and managing other (co)worker’s responses to illness.

Balancing the employee’s needs in order to facilitate a successful working experience whilst also ensuring the business need is met, appeared to exert the greatest pressure on participants. This pressure has similarly identified by Amir et al (2010) when examining employer support of employees recovering from cancer, which further evidenced line-manager burden as a significant deleterious factor in the rehabilitative process. Employers and managers expressed a conflict in having to respond to the material needs of the employee, for example by reducing their contracted working hours or providing phased returns, with the need to meet the responsibilities of their management role. This was described

\textsuperscript{15} Normative role is defined in the Parsonian (1951) tradition and taken to mean the characteristic behaviours of persons who occupy social positions. “Roles” are conceived as the shared normative expectations that prescribe and explain these behaviours’ (Biddle, 1986, p70).
as the pressure to provide value to the organisation within the constraints of the employee’s reduced capacity for production. In this respect, there are similarities between the attitudes expressed by participants in this study and research conducted by Bellaby (1990) into pottery factory workers, in which it is posited that employees’ illness is negatively viewed as a threat to employers and managers through reduced productivity and financial cost, especially in manual organisations. This was often illustrated by participants’ discussions of ‘sympathy BUT’ where their initial positive comments about attending to employees’ material and non-material needs were moderated by further discussions around the economic and commercial needs of the organisation which, as illustrated in Chapter 5, often do not coincide.

Indeed, participants’ perception that they often feel caught ‘in the middle’ between the prescribed responsibilities of their managerial role within the commercial and bureaucratic needs of the organisation, other (co)workers and the limitations of the employee, was indicative of their feelings of ambivalence. This was encapsulated by some as the conflict between practising a good ‘duty of care’ to employees commensurate with the people management function of their role (Peach-Martins, 2009), and at the same time, managing the employee’s output concomitant with the productivity control/leadership function of their role (Bass and Bass, 2008). This resonates with previous research which also identified that managers appear to experience intra-role conflict (Holmgren et al 2007, Coole et al, 2012) when having to be ‘accountable for the performance of the workers they manage’ (Bellaby, 1990, p48) in delivering value and achieving organisational objectives.

Again, this finding was consistent across all participant narratives regardless of whether the manager was sited in a commercial for profit, private sector organisation, or bureaucratically driven public or 3rd sector organisation. This suggests that intra-role (and inter-role) ambivalent feelings arise (and to what extent) in response to the manager’s predilection towards meeting the normative expectations and responsibilities of their management role. Instead of arising solely in response to economic/commercial objectives in contributing to the financial health (bottom line) of the organisation which would I proffer, have been predominantly reflected by private sector managers. Research conducted by Checkland, Harrison, Snow, Coleman and McDermott (2013) into the middle
manager’s role within the public-sector UK NHS attests to this point in discussing managers’ inter-role conflict stemming from attempting to establish personal identity whilst conducting changing managerial roles brought about by the evolving nature of the organisation. What is interesting about Checkland et al’s (2013) study is that it goes on to question how managers tangibly ‘reconcile’ (p152) these conflicting pressures on a daily basis in order to achieve their work, or indeed how this influences the wider organisation, a point which is salient for this thesis.

Managing illness in the organisational sense was also perceived as a source of ambivalence stemming from either needing to implement sickness absence policies (discussed below), or concerns over the employee’s responsibility for managing their own condition. There was a shared perception amongst participants that employees need to accept some responsibility for self-managing their condition both at work and in their personal life, in order to be able to competently do their job. Moreover, those employees seen to be helping themselves would, participants suggested, engender positive supportive responses. Ambivalence arises where the participant perceives the employee not to be working with them or ‘meeting them half-way’ (P12, M, private org.) for the mutual benefit of getting the contracted job done. This finding is interesting in the context of debates regarding where the responsibility for illness management in the workplace lies (Chapter 2, section 2.2.7). Certainly, the majority of participants in this study acknowledge their role in sharing illness management akin to the biopsychosocial model of disability (See Chapter 2, section 2.2.5). However, this finding is contrary to that of Chan et al (2010) who suggest that employers traditionally place the onus of illness management onto employees.

In comparison however, intra-role conflict appears to be less problematic for participants than inter-role conflict occurring between their management role and their role as an individual (as per Merton and Barber’s (1963) concept of multi-role occupancy Chapter 3, section 3.4). Anxieties regarding the conflicts between the pull of pressures emanating from inner ‘private’ thoughts and evaluations associated with their personal, individual social role were a significant theme as evidenced in Chapter 6. Participants expressed ambivalence by reporting feelings of discomfort arising from incompatibilities
between the normative expectations of their differing roles, for example, where acting in the interest of the organisation contradicts personal beliefs and values associated with their status as an individual (Radley and Billig, 1996).

This was particularly evident in participants’ expressions of their dilemmas in meeting the obligations of their managerial role to provide value to the organisation, with philanthropic concerns for the welfare of the employee. Tiedtke et al (2013) also reported this dilemma, finding that managers supporting employees recovering from breast cancer experienced role confusion and ‘wrestled’ (p5) between their different roles in being empathetic to employees on the one hand, and remaining professionally distant on the other.

As evidenced, many participants in this study went further in describing the incompatibilities arising between their two roles. Expressing their personal discomfort with being both simultaneously (un)sympathetic and attempting to retain professional integrity by behaving in accordance with the expectations of their management role, which is often incompatible with normative beliefs about caring for another individual who is ill consistent with the individual role (Berry and Meyer, 1995).

This notion was particularly evident when needing to implement punitive organisational sickness absence procedures which contradicted the way in which the manager would ethically wish to manage the employee as per Chapter 6, section 6.2.1. The finding that participants experience conflict between normative expectations of their role as an individual in behaving sympathetically, and structural/bureaucratic constraints of the organisation/law associated with their management role, reflect those of Cunningham et al (2004). Cunningham et al (2004) identified from case studies of four large organisations, that there may be tensions at the micro-organisational level between disciplinary procedures and the desire of line management to be supportive and sympathetic. In essence, line managers may wish to be supportive but are constrained by the disciplinary policies of the organisation.

However, the degree to which employers and managers in this study experience ambivalent feelings also appears to be influenced by those dimensions considered less tangible, such as the participant’s personal beliefs about the employee’s personality and moral evaluations about the legitimacy and
genuineness of conditions (described in Chapter 6). Ambivalence was more likely to be expressed by participants where the employee was liked, and hence participants felt a greater tension between their role responsibilities to the organisation and personal empathy towards the employee. This resonates with the work of Tiedtke et al (2013) who concluded that feelings about the supportive situation are not felt to the same extent by individual managers and that this is related to differences in the type of organisation, employee’s (personality) and the managers themselves.

Likewise, expressions of ambivalence appear to be proportional to the participant’s ability to empathise. This was reflected in the level of emotional distress communicated by participants, either explicitly or implicitly expressed, where some participants appeared to be inherently more disposed towards ambivalent attitudes (Pratt and Doucet, 2000). However, as discussed later in this Chapter, participants’ structural position must also be considered an influencing factor in their expressions of (the absence or presence of) emotion given that traditional conceptualisations of the manager’s role eschew emotionality in favour of rationality (Ashforth and Humphrey, 1995).

Participants were asked whether the employee’s length of service was an important factor in the nature and type of support provided. Whilst some participants agreed that it was, the majority indicated that the employee’s personality and their affinity to them was a more of a contributory factor to the level and type of support afforded. Hence length of service was not seen to affect participants’ feelings of ambivalence in this study, a finding which differs to that of Coole et al (2012) from an examination into the manager’s supportive role following return to work after stroke. The influence of the employee’s personality is pervasive to the participant’s supportive role despite their discussions to the contrary, as evidenced by the contradictions captured across and within narratives elucidated in Chapter 6, section 6.2.2. Coole et al (2012) have similarly identified the importance of personal characteristics to the supportive role, describing the benefit to participants of employees who are ‘popular’, have good communicative relationships with others and are enthusiastic and well motivated to return to work, employee attributes also desired by managers in this study. The finding that employees’ personality has a bearing on employers’ and managers’ supportive role (Chay, 1993; Yoon and
Thye, 1998) is important when considering the type of support they provide and, according to Bowling, Beehr, Swader (2005), consequently that which employees receive.

Participants ambivalent feelings explicated in this study can be summarised aptly by Donati (1998) who suggests that the source of sociological ambivalence (SA) comes from incongruence created when participants have ‘personal thoughts but at the same time have to share the values/objectives of the organisation’ (p105) and ‘having to be many things in one role’ (p105). Likewise it is clear that some participants experience difficulties in balancing the pressures associated with the functions of their role in managing both productivity and people (Peach-Martins, 2009). Priorities to productivity influenced by obligation to the management role, or to people influenced by personal beliefs associated with the individual role, could tip the balance either way. This is indicative of Kahn, Wolfe, Quinn, Snoak and Rosenthal’s (1964) definition which explains inter-role conflict as: ‘simultaneous occurrence of two (or more) sets of pressures such that compliance with one would make more difficult compliance with the other’ (p19).

Unaccounted for in the role conflict types discussed above are non-normative expectations such as the finding in this study that supporting LTCs is often considered non-normative to the manager’s role, which creates ambivalence between those functions considered normative to the role. Thoits (1990) explains that when required to deviate from norms and make non-normative role transitions, as when having to manage illness, people feel ambiguity over appropriate behaviour and feelings in their new roles – a phenomenon reflected by most participants in this study. Nevertheless, the finding of emotional ambivalence is not reported to any great extent in recent studies which have identified managers’ concerns over the conflict of balancing the employee’s needs with those of the organisation for example (Holmgren et al, 2007; Amir et al, 2010, Tiedtke et al, 2013 and Coole et al, 2012). Indeed this terminology is utilised in only one study, that of Amir et al’s (2010) examination into the return to work of employees with cancer, who noted the possible implications of employers’ ambivalence for retaining or recruiting staff.
Whilst Merton and Barber’s (1963) theory is particularly amenable to interpreting participants feelings of role conflict at the structural level (or at the behavioural, social relational level) (Coser, 1966), it does not account for the emotional consequence of ambivalence at the micro-level of the individual, or explain the conflict between feelings rules (Hochschild, 1983) and social roles epitomised by participants in this study. Indeed this is a particular criticism of SA theory by Heiss (1990) who perceives the theory as being too simplistic. Similarly those conducting research into workplace emotions claim that it does not address how managers emotionally cope with the many and sometimes conflicting demands made of them (Pratt and Doucet, 2000). I would further add that this is even truer when it comes to the intersection of social role-reations and health and illness.

7.2 Personal Feelings – Moving Beyond Ambivalence

Evident from the data is participants’ personal emotional discomfort reported in response to feelings of ambivalence as outlined above. Participants expressed role ambivalence when, in accordance with Pratt and Doucet’s (2000) suggestion above, inconsistent and conflicting role demands are made of them. They also demonstrated emotional ambivalence (Rothman and Wiesenfeld, 2007) arising from tensions between the many emotions implicated in being both a manager and an individual, in supporting those with LTCs. Merton and Barber’s (1963) theory explains why the experience of ambivalence experience occurs between the normative expectations and behaviours of social roles. However, it does not explain feelings of emotional disquiet evoked by this ambivalence nor between the normative feelings associated with particular social roles. This is important in the context of these findings because participants express that conventional norms (Dressler, 1973) dictating their response to supporting another person’s illness appear to contradict the way they are expected to feel and act in accordance with organisational structure/culture and their managerial role (Pratt and Doucet, 2000).

This phenomenon can therefore be more accurately explained using Hochschild’s (1983) terminology of ‘feeling rules’ as described in Chapter 3, section 3.1.3.1, which dictates how people know which emotions they are supposed to feel, or should feel, in response to specific social situations - in this
case displaying and/or conducting the right emotion/behaviour when the employee has a LTC. Participants clearly expressed emotional discomfort arising from incongruence between private feeling rules in knowing how they morally should, or would support those with a condition, versus their perception of how they are required to support an individual in accordance with the prescribed public feeling rules of their managerial role/organisation. This was expressed as an incompatibility between ‘doing the right thing’ for the employee and meeting the needs of the business, which often engendered feelings of guilt.

Many participants demonstrated this discrepancy when rationalising their treatment of employees in accordance with organisational procedures counter to personally held moral and cultural values (Sloan, 2007). A sense of guilt was manifest in expressions about how terrible they felt or suggesting that they have to practice ‘tough love’ as (P36, M, public org.) termed it. This incongruence is also evident in the finding that participants experience pressures in balancing and managing a combination of conflicting feelings (Rothman and Wiesenfeld, 2007). These include negative feelings about employees whom they dislike or suspect of being less than genuine but having to be empathetic and support them nevertheless in accordance with organisational and socio-cultural norms (Chapter 6, section 6.2.2).

Conversely, incongruence also arose when feeling empathy and sympathy towards the employee but being obliged to behave towards them as prescribed by the organisation, which some perceive as harsh. Emotional response to ambivalence was also typified by participants’ expressions of guilt when deciding where their priorities lie (Tangney, 2002), either to the employee or to their role/organisation. Previous research by Pratt and Doucet (2000) found that rural physicians working as part of a larger health care organisation in the USA had similar experiences in attempting to be both healers and business managers. This highlights respondents’ emotional discomfort when attempting, as found in this study, to (un)successfully reconcile the two.

As discussed in the section above and evidenced in Chapter 6, the extent to which participants expressed an emotional consequence was related to the level that personal moral evaluations (Sloan, 2007) impinged on their supportive role. This appears to be influenced by their level of affinity for the individual
(personally liked) (Chay, 1993; Yoon and Thye, 1998) and evaluations regarding legitimacy and tangibility of conditions. In many instances the participants’ described a clash in private feelings acts (Hochchild, 1983) between how they would wish to support an individual with whom they have strong ties (such as a friend or relative) by being caring and sympathetic (Richardson et al, 2007; Umberson and Montez, 2010). And at the same time, being cognisant that this level of concern is not appropriate within manager/employee distal relationships, or as a fellow social interactant. This phenomenon was similarly noted by Lupton (1996) and Meier, Back and Morrison (2001) about the doctor-patient relationship.

Alternatively, participants also expressed guilty feelings when they followed their own socio-cultural and moral scripts\(^{16}\) in putting the employee’s needs before those of the organisation and the responsibilities of their role. Many participants also denoted the incongruence between private feelings rules and those prescribed by their position when suggesting that they attempt to remain emotionally detached in accordance with the professional boundaries of their role (Brotheridge and Lee, 2008). Yet they went onto contradict this by expressing their personal distress at the situation, often displaying physical manifestations through their body imbued with emotion (Freund, 1990) such as facial expressions and tears. The notion of boundaries is important to the employee’s perception of workplace support and will be discussed later in this Chapter.

Again, the extent to which emotional discomfort is felt appears to be dependent on the individual participants’ propensity for empathy (Shaubroech and Jones, 2000) and also their underlying personal values, both regulated by cultural norms (Clark, 1997; Sloan 2007). This observation was also made by Tiedtke et al (2013) in analysing managers’ response to return to work for women recovering from breast cancer. Other studies exploring the managers’ role do not venture to discuss the influence of personal feelings and moral judgements

\(^{16}\) Social scripts are defined as the pre-established/socialised schema by which individuals know the required behavior appropriate and expected for any given situation (Gioia, and Poole, 1984). Goffman (1959) theorised that scripts guide how the individual should behave or interact in situations and that people are aware of which scripts are appropriate for which situation. Thus scripts ensure that individuals enact the required performance but also allow them to understand events and social situations.
in managing those with LTCs but tend to imply their presence when discussing employer attitudes (Holmgren, 2007; Grunfeld, 2008; Amir et al, 2010).

Fearful feelings and attitudes were also prevalent across the interviews, reflecting those found by Amir et al (2010) into management support of return to work for cancer survivors. These stemmed from a range of conflicting factors including anxieties about contravening disability discrimination legislation (OPSI, 1995 and 2010) and the need to engage with an employee on a personally sensitive matter. Having what participants termed ‘difficult conversations’, where having conversations involves bringing in private feelings of the individual personal role that may contradict the prescribed obligations of the manager’s public role.

As evidenced in Chapter 6, many participants expressed their own or other managers’ reticence in having conversations with those with LTCs/disabilities for fear of saying the wrong thing and anxiety over making a mistake leading to contravening the disability and equality legislation, a theme common to rehabilitative research (Cunningham et al, 2004; Stevens, 2002; and Coole et al, 2012). Many feared the threat of the employee taking them to employment law tribunal and subsequent repercussions for their organisation and their own job. The fear of the risk of legal action in today’s, ‘claim culture’ as cited by many participants, is consistent with a study by Kaye, Jans and Jones (2011) which suggests the fear of legal liability is a significant barrier in employers’ recruitment and retention decisions of those with disabilities. Although Kaye et al’s (2011) study was conducted in the USA there are significant parallels with those concerns of the participants in my study where fear is similarly expressed about certain types of LTCs/disabilities and how to ‘handle’ them (p531).

7.2.1 Personal Evaluations

This fear is also evident in the way participants communicated personal evaluations, feelings and thoughts about the situation and those they employ, central to the theme of Getting Personal. Evaluations concerning the employee’s personality have already been discussed in Section 7.1. However, participants’ anxieties over discerning legitimacy, tangibility and genuineness of conditions cut across all interviews and presented a significant concern for them.
This finding is widely reported in the literature examining employer views of mental health and stress conditions (Eakin et al, 1998; Royal College of Psychiatrists, 2008; Perkins, et al, 2009 for example). Tangibility and genuineness of conditions was often discussed in comparative terms of what constitutes a serious, ‘real’ condition and were also evaluated on the presence or absence of visible physical symptoms (Vickers, 1998). Those conditions visually asymptomatic such as mental health conditions and stress courted more scepticism and aroused further concerns about genuineness and legitimacy. Vickers’ (1998) research into chronic illness at work and unseen symptoms also highlights the stigmatising effect of evaluations such as these, evident in participants’ ‘off the recorder’ communication discussed below.

Discerning whether a condition is genuine or whether the employee is acting legitimately was a source of much frustration for the majority of participants, which is an issue most notably documented by Bellaby (1990, 2005). Sensitive personal thoughts and moral evaluations influenced by the wider organisational and socio-cultural context (Sloan, 2007) were most evident in these expressions and discussions regarding legitimacy, and especially when recounting thoughts about mental ill health and stress conditions. This process was also evidenced by Dodier (1985) in an examination of white-collar workers moral evaluations about sick employees. This finding is important for the employee perspective of working with a LTC, which will be discussed later in this Chapter. Suffice to say that when making moral evaluations about people and their condition, participants made non-verbal gestures seemingly to avoid capturing their shame and guilt on the recorder or for fear of contravening the law/social norms (discussed in the next section).

As detailed in Chapter 6, this often seemed to imply unsympathetic/undesirable thoughts around experiences of legitimacy and genuineness of conditions or when discussing particular cases about employees’ personal characteristics. This supports Waldron’s (2000) suggestion that emotions related to moral evaluations arise when unspoken relational values and obligations are violated, such as in the manager/employee relationship where employees appear unable to perform the function of their prescribed role. For example, where there are questions over the legitimacy of the condition or the genuineness of the employee. However, non-verbal expressions also occurred in instances where
participants had particular compassion, empathy and sympathy for the employee as also evidenced in Chapters 5 and 6.

Expressions of guilt about making personal moral evaluations (Tangney, 1995) counter to the normative expectations of their role were also noted in off the recorder discussions when reflecting on what had been imparted during the interview. Similarly, this occurred in several cases when discussing personally sensitive matters deemed too contentious to discuss on record (Lee, 1993) for which participants asked me to assure their confidentiality and not to relate onwards. Zapf (2002) would suggest this identifies emotional disquiet which can occur when an employee is required to express non-genuine emotions felt in a particular situation, as when having to act in accordance with the demands of their role and the organisation, counter to socialised personal emotional and moral norms (Tangney, 2002). This manifested in descriptions about how awful participants felt about what they had said or the impression they had given, specifically when wanting to appear sympathetically supportive or explain their negative thoughts about legitimacy.

7.2.2 The Unsaid

The incongruence between personal feelings and those prescribed by the management role/organisation was most evident in non-verbal communication, which emerged as a substantive theme throughout the interviews. This phenomenon was examined using Clarke’s (2005) Positional Situational Analysis map as described in Chapter 4 and by including fieldnotes and memos in data interpretation and led to the finding that participants were trying to convey sensitive thoughts and feelings, often taken to be more telling than what was said. The unsaid, as discussed by Poland and Pederson (1998) refers to those moments of silence in interviews which are often overlooked when conducting qualitative data analysis but which are an integral component of the participant’s story and are therefore ‘profoundly meaningful’ (p294). According to Poland et al (1998), it is important to include such elements because focus purely on verbal narration of what the participant wants to impart lacks the context in which meaning is constructed. Similarly Clarke (2005) terms the unsaid as sites of silence, those things that are not verbalised but co-construct the situation or what seems present but unarticulated. As discussed in Chapter 4
this is particularly important for this study where due to the sensitive nature of
the research, much was unsaid and/or alluded to.

By using non-verbal gestures and back channelling questions to me in the vein
of ‘do you know what I mean?’, it is inferred that participants were conveying
their private feeling acts and thoughts (evaluations, judgements and prejudices)
about those matters considered taboo (Elam and Fenton, 2003). Such as when
questioning the genuineness of conditions (especially when discussing mental
health conditions) counter to perceived social desirability norms (Spector, 2004).
Further, that participants’ were expressing thoughts not considered politically
correct. In this sense participants were censoring their words which aligns with
findings from a study into employer recruitment and retention practices of
employees with long-term illness by Goldstone et al (2002), who found that
there may be some measure of ‘political correctness’ in employer responses
when questioned about their attitudes. However, this does not account for non-
verbal implied meanings and attitudes. Ekman and Frieson (1969) proffer an
explanation through their research into deceptive behaviour, which would
suggest that, even though the participants were not conscious of communicating
authentic (see below) thoughts, either positive or negative, these often emerge
through body language and eye-gestures as ‘leakage or deception clues’ (p88).

Alternatively, Robertson (2012) introduces the suggestion that people carry
socialised prejudices and biases around with them every day which
subconsciously affect their behaviour within the social arena. Robertson (2012)
suggests that ‘unconscious bias’ or ‘our unintentional people preferences’ (p9)
leads to stereotyping those who are less similar to us and categorising them
accordingly, as in the case of those who are disabled or have LTCs. This can
manifest subtly in actions or words, and was evident here in participants’
descriptions of legitimacy and assumptions around capability for work and
reluctance to have difficult conversations. Robertson’s (2012) concept will be
returned to later in this Chapter when examining findings in the context of the
employee perspective of the return to work process.

This reluctance to put into words personal private thoughts and feelings further
evidences the concept that participants experience not only role conflict but also
ambivalence between roles and feeling rules (Hochschild, 1983). Further, that
they are attempting to hide their private authentic inner feelings\textsuperscript{17} about the supportive situation by conducting emotion work to manage emotions triggered by thoughts that could be perceived as sensitive or socially undesirable - and which are in direct conflict with how they are supposed to feel and act as prescribed by both the normative expectations of their role and the organisation.

7.3 Managing Ambivalent Emotions

The findings discussed above led me to conclude that both SA theory (Merton and Barber, 1963) and Hochschild’s (1983) theory of feelings rules, are by themselves, insufficient to fully explain participants emotional experiences in supporting those with LTCs. In particular, that these findings seem to suggest participants engage in emotion management work to cope with both the uncomfortable consequence of ambivalence and discrepant feelings, brought about by the reality that managing those with LTCs does not fit clear normative ideals (Thoits, 1990).

This is consistent with Donati’s (1998) observation that Merton and Barber (1963) omit the influence of non-normative role expectations in their theory, as per the statement ‘when in social relations (specific or generalised) a symbolic dynamic prevails which is not retrievable by the functional framework’ (p102). Employee illness is interpreted here as a symbolic dynamic, and distinguished as evoking emotions specifically related to managing and reacting to other people’s health and illness, as a product of their social roles. This was identified by participants’ assertions that feelings of balancing arise regardless of whether the employee comes to the organisation with a pre-existing condition or if they develop the condition whilst in their employ. This suggests that participants in this study experience difficulties and emotions invoked specifically in response to their employee’s condition - which it is theorised are a separate and distinct phenomena of experience to other socio-emotional workplace experiences as described in Chapter 3, section 3.1.5.

\textsuperscript{17} Fineman (2003) however, sounds a note of caution in discussing feelings that are authentic and inauthentic (p21) which, from a social constructionist epistemology, along with the notion of a fixed ‘self’ are fluid and contextual, dependent on socio-cultural influences, the situation and the interaction. Therefore in the context of this study, the question of authenticity and the extent to which participants were truly authentic or manipulating their ‘acts’ (Goffman, 1959 – see Chapter 3 section 3.3.5) for my benefit must be considered.
In this context, participants in the study engage in what Hochschild (1983) terms emotion work and emotion management. Fineman (2002) suggests that emotional work is the effort individuals put into ensuring that their feelings are appropriate for both situations and outward presentation to others. Evidenced by the participants in this study is their need to manage emotions arising in response to ambivalence occurring as a result of emotional discomfort. This arises from: a) incompatibilities between the obligations and demands of the manager’s role and personal feelings rules and evaluations about supporting another person who is ill, consistent with their status as an individual and b) incompatibilities between the multiple functions and interests of their management role.

In accordance with Morris and Feldman’s (1997) theories regarding the antecedents of emotion work, participants’ emotional responses in this sample therefore appear to both construct ambivalence and be a result of it. To elucidate this further, employers and managers imply through their narratives that they engage in emotion management work specific to balancing their employee’s illness or condition, and that this occurs tacitly but not harmoniously, within their ‘normal’ managerial role. This implies that supporting those with LTCs requires them to engage in additional emotion management work, conducting deep acting to alter feelings and conform to feelings rules (Peterson, 2007) which are subsequently hidden from public view via performance/impression management. Those with task orientated identities such as managers,Thoits (1990) suggests, cope with the negative feeling of ambivalence by conducting emotion work and emotion management.

7.4 Emotion Management in the Workplace - Bolton’s Typology

Bolton’s (2005) Typology of Emotion Management in the Workplace detailed in Chapter 3, section 3.3, is therefore a useful explanatory framework in which to examine this finding. Bolton (2005) builds on a growing body of work which recognises that organisations are entities with feelings (Albrow, 1997); that employees as social beings bring with them emotions which should be included in the analysis of organisations and not ignored as incompatible. To reuse Fineman’s (2003) argument, Bolton recognises that people are at the centre of
organisations and that ‘all organisations are emotional arenas where feelings shape events and events shape feelings’ (p1). To this end Bolton (2005) emphasises the importance of the social interactedness of the public and private worlds of the employee, where individual agency over emotions is retained and not all emotions are controlled by the organisation. Therefore devising a typology to account for the ways and in what situations these emotions are governed, managed and regulated, and in accordance with public and private feelings rules as defined by Hochschild (1983).

Bolton (2005) posits that in managing emotions, social actors are able to traverse effortlessly between performances, crossing continually between the boundaries of their private and public worlds. For participants in this sample this appears to cause further emotional incongruence evidenced by the uncomfortable feelings of conflict arising between and within the external ‘public’ managerial, and inner ‘private’ individual worlds of their social roles when supporting those with LTCs – commensurate with the two emergent substantive categories detailed in Chapters 5 and 6.

Bolton argues that managers are capable of transmuting their personal private feelings as per Hochchilds’ (1983) theory of feelings rules detailed in Chapter 3, section 3.1.3.1, and are able to manage and mix all forms of emotion management according to both organisational rules and otherwise. According to Bolton (2005), managers are able to draw on different sets of feeling rules and sources of motivation as per Table 1 (Chapter 3) in order to maintain professional integrity or match the feeling to the situation. However, this does not account for those feelings arising from emotional ambivalence at the structural level as per Merton and Barber’s theory of SA. Brook (2009 ) raises similar concerns about Bolton’s (2005) theory suggesting that it ‘minimises’ (p546) the structural antagonisms inherent in employment relationships arising from the commodification of labour power as per Hochschild’s (1983) theory. Structural antagonisms were evident in this study between the functions of the participants’ management role in being managers of both people and productivity (Peach-Martins, 2009), which they perceive as often incompatible in the case of LTCs.
As is evident from the descriptions of their experiences, transmutation of feelings for managers in this sample, as described in Chapter 3 (Hochschild, 1983), is not easily achievable when the antecedent is employee’s illness. Further, that mixing and managing all forms of emotion management i.e., between the two substantive categories emergent from the data (between normative expectations of their roles and feelings rules), instigates a further state of emotional ambivalence which managers perceive as uncomfortable. Supporting those with illness/disability therefore appears to be an exception to the rule. As is identified when examining participants’ feelings of emotional ambivalence using Bolton’s (2005) typology of emotion management (See Chapter 3 section 3.3) rather than being able to ‘bleed into one another’ (p98) feeling rules and motivations are often conflictual, contradictory and therefore ambivalent and are described as:

7.4.1 **Category – Being Tightrope Walkers (External Pressures)**

**Pecuniary and Prescriptive Emotion Management:** Formal feeling rules. Participants are the outward face of the organisation and suppress or induce their personal emotions during personal interactions with employees. Participants expressed their conflict of being in the middle between externally imposed rules of conduct as the face of the organisation and managing those with LTCs to provide value, thereby fulfilling the requirements of their own role and retaining their job. Participants described their conflict between conducting normative and non-normative expectations intra-role for commercial or bureaucratic ends. In conducting prescriptive emotion management, participants described their difficulties in balancing the needs of the employee with the ways they are prescribed to feel and act by their organisation, the law and by their profession as a manager. Participants are motivated by the instrumental need to keep their job and retain their status (integrity), but as described in Section 7.4 above feel conflict between what they are organisationally/legally prescribed to do and their personal private feeling acts as to how they would personally wish to manage the situation whilst also maintaining the appearance of the professional.
7.4.2 **Category – Getting Personal (Internal pressures)**

**Presentational & Philanthropic Emotion Management:** Informal feeling rules. Findings accord with Bolton’s concept that these are spaces for being human and participants support this in their descriptions. Draws on social feeling rules which Bolton suggest form in those spaces not formalised by the organisation such as friendships and ‘off stage’ (Goffman, 1959) performances as in informal interactions. Participants have the capacity to provide acts of sincerity to provide (un)sympathy/empathy to employees but this causes conflict between the prescribed feeling rules of the organisation/law. Philanthropic emotion management suggests that managers can go beyond organisationally prescribed rules and offer a little extra or a gift of kindness which is performed as a sincere act – akin to some participants reporting they ‘went the extra mile’ when supporting those with LTCs.

Bolton offers the notion of Goffman’s (1961) ‘juggler and synthesiser’ (p101) to explain the skill and ability of individuals to mix and manage occasions where contradictions occur through the ‘blending of different roles and blurring of boundaries’ (p101). Likewise at times when actors question organisational rules which become contested, reported by participants as tensions in ‘balancing’. Further, when individuals become aware of discrepant feelings Bolton (2005) suggests they can decide how much effort to put into their emotion management performance. I would question this notion in the case of supporting employees with LTCs, where participants are also bound by legislative rules, organisational structure and cultural norms, governing their actions and emotional display.

However, the finding from this study is that when managing illness, participants find it difficult to manage the emotions commensurate with their multiple role identities of manager and individual (Goffman, 1959). This is similarly reported by Nettleton, Burrows and Watt (2008) in their study of GPs feelings which identified ambivalences between their professional role as a doctor and personal feelings associated with treating patients. Nettleton et al (2008) expressed this as the GPs’ need to strike ‘a balance between the rational and the emotional self.’ (p34). In this context participants in this study find it difficult to ‘juggle and synthesise’ (p101), resulting in ambivalence as reported. Participants express that they find it difficult to perform prescriptive, pecuniary and
presentational emotion management in fulfilling the demands of their role when illness is present. Further that they find it difficult being tightrope walkers when supporting those with LTCs, and do not find it emotionally easy to be many faceted or indeed as Brotheridge and Lee’s (2008) article implies to ‘do it all’.

By making the assumption that polymorphism is inherent in the manager’s role, it denies and/or takes little account of personal emotional agency in the role counter to Bolton’s (2005) assumptions. This implies that managers are perceived as, and expected to be, devoid of emotional agency. Further, that they are immune to the consequences of emotions that arise from the hypocrisy required in performing multiple roles, as per prescribed emotional scripts dictated by the managerial role (Fineman, 2003). They are not viewed as interactional social actors but as empty figures, shaped and assigned to a particular box (Bolton, 2005). Workers who exercise agency outside of the box assigned to them are viewed as not fitting in. Findings from this study support this notion where expressing emotions was difficult for participants and at times conducted off recorder.

This also accords with Flam’s (2002) assertion that managers are under pressure not to show anxieties, worries or their fears, as evidenced by the off recorder discussions and contradictions contained within and across the narratives. One participant explicitly expressed how difficult it was to show emotion in an ethos of a ‘macho culture’. These findings corroborate the traditional conceptualisation that emotional vulnerability is seen as a weakness in managers and showing ambivalent feelings may be taken as a sign of not being in control (Foy, 1985). This situation is created to a certain extent by the commonly held pejorative view of the place of emotions in the managerial role where Ashforth and Humphrey (1995) suggest that emotionality is seen as ‘the antithesis of rationality’ as discussed in Chapter 3 section 3.2.5. Thus promulgating the suppression of emotions in the workplace perpetuating the revered rationality expected of the manager (Putnam and Mumby, 1993) where managers’ capacity to manage their own emotions is considered intrinsic to their ‘normal’ role. This aspect of the manager’s role will be discussed further in the Chapter in the context of the employee’s perspective. However, as elucidated above, supporting and managing those with LTCs is not a ‘normal’ expectation for many of those in the sample.
7.4.3 Extending Bolton’s Emotion Management Typology

Bolton’s typology asserts that managers are skilled in ‘juggling’ (p101) all the emotions at any given time, that they are highly efficient in managing emotions and that they are therefore able to present many ‘faces’ (p164). My findings suggest that this concept is problematic for participants in this study when faced with myriad emotions emanating from their need to support those with LTCs in the workplace. Whilst there is mention of the circumstances and consequences of where feeling rules collide for example, conflict between pecuniary and prescriptive emotion management (p128), Bolton (2005) does not dwell in depth on matters of disquiet, ambivalence and the way that emotion work interacts. Findings from this study indicate that emotions associated with supporting those with LTCs can and do interact, and often not in positive ways. This results in an emotional consequence for participants, which then requires further presentational emotion management. As noted in Section 7.3 above, an additional emotion management type is required to account for micro-level emotion work and emotion management specific to ambivalence arising from supporting those with LTCs in the workplace. I therefore propose that Bolton’s typology be augmented to include emotion management emerging as a response to the ambivalent feelings that supporting employees with LTC’s creates between and within both roles (SA) and feeling rules, sitting between Hochschild’s (1983), Merton and Barber’s (1963) and Bolton’s (2005) proposals.

Vince and Broussine (1996) in a study examining employees’ emotional reaction to organisational change, identified the sometimes intense contradictory emotions at middle-management level. They further discuss the psychological concept of paradoxical tension experienced by managers, and identified the concept of ‘paradox’ as being important to exposing the emotional implications of dealing with change within organisations. They defined paradox as:

‘The tensions between clarity and uncertainty, the ‘self contradictory’ nature of individual emotions and organizational action, are constantly present in any process that attempts to deal with change’ (p7).

This fits with the overarching finding from this study, that employers and managers find supporting those with LTCs one of a difficult balancing act where consequential emotions surface in response to dealing with change in their
normative role expectations. They experience tensions between clarity and uncertainty and the contradictory nature of individual emotions and organisational action.

My overarching theoretical framework therefore, grounded in and constructed from my interpretation of participants’ experiences, is that they experience paradoxical emotion management in their role as a supporter of those with LTCs. The current research indicates that Bolton’s typology could therefore be extended to include ‘paradoxical’ emotion management in the workplace to account for the management of emotions arising from ambivalent feelings between roles and feeling rules specific to managing illness, as per Table 6 below:

I suggest here that the concept of paradoxical tension is not a surprising finding given that, along with others, Mintzberg (2009) and Mullins and Christy (2013) posit that conflict is normative to both ‘organisational life’ (Mullins and Christy, 2013, p62) and the role of the manager. However as discussed in Chapter 3, section 3.1.4, there is little mention in the literature, as far as can be ascertained,
which specifically points to the management of employees’ LTCs as a potential source of intrinsic managerial/organisational conflict. Rather, research is more likely to report on the negative consequence to the manager’s health of stress stemming from workplace conflict (Spector and Bruk-Lee, 2008) than on employee ill health as an antecedent to this.

7.5 Paradoxical Emotion Management – Implications for Stakeholders

7.5.1 The Employee

Research from the employee perspective as detailed in Chapter 2, suggests that they perceive three significant barriers to a successful working life: unsupportive relations, stigma and disclosure and employer perceptions and discrimination. Of these, unsupportive managerial relations are considered the greatest barrier to work and therefore provided the impetus for this research, specifically orientating it towards examining the social context of work. These barriers will now be examined in relation to findings from the employer’s and manager’s perspective of supporting those with LTCs. This provides some tentative insights into explaining why employees perceive what they do, before moving on to examine whether the aims for this study have been met and proffering potential areas for future research.

7.5.1.1 Unsupportive Relations

According to Nordqvist et al (2003), social relations at work are one of the most important aspects of what keeps those with chronic conditions in the workplace. The considerable body of research into the employee’s experience of working with a LTC/disability similarly concurs that support from managers is one of the main enabling factors to work (Frieson et al, 2001; Detaille et al, 2003; Lysaght et al 2008, for example), and is considered fundamental to workplace coping and personal self-management of conditions (Gallant, 2003; Townsend et al, 2006). Foster (2007) makes the point that employees with LTCs are reliant on the goodwill of their employers and managers for fostering a socially supportive climate at work and for successful adjustments, which she claims is a matter of ‘personal lottery’ (p79). Results from this study partially agree with Foster’s (2007) assertion but direct the reader to consider those things which add new
insight to the notion of ‘personal lottery’, such as the emotional consequence to managers arising from their perception of balancing a complex set of often conflicting demands.

The finding that managers experience paradoxical emotion management may contribute to their sense of burden as discussed in Section 7.1 of this chapter, which it is theorised, influences their capacity to provide a supportive climate. MacEachen et al (2006) speculate from a review of international qualitative literature on return to work after injury, that supervisors may view their role in the return to work process as an unwanted burden. Proffering that the conflicting priorities it presents leads them to view return to work as an obstacle to production, as evidenced by participants in this study.

To date, existing research has not focused on the impact to the social context of work of the emotional difficulties managers face in supporting those with LTCs, as evident in the preceding sections of this Chapter. I propose therefore, that the discomfort caused to managers by conflicting emotions and role hypocrisy is manifest to employees, either perceived through non-verbal leakage (Ekman and Frieson, 1969) or open disclosure of thoughts, causing them to perceive of negative relations – whether intentional by the giver of support or not. As previous research into the social consequences of emotional ambivalence in teams by Rothman and Wiesenfeld (2008) would suggest, the manifestation of emotional ambivalence (whether consciously or inferentially via non-verbal leakage) maybe interpreted negatively by the receiver. Rotheman and Wiesenfeld (2008) further suggest that this can have adverse social consequences such as relationship conflict and negative interpersonal reactions which, it is offered, could influence the employee’s perceptions of the supportive climate at work.

Building on this notion, Van Kleef, Homan and Cheshin (2012) point to the social-functional approach to emotion which holds that ‘emotions do not only influence those who experience them, but also those who observe them’ (p313) but it should be said that this is applicable to positive as well as negative emotions. From Burkitt’s (2012) perspective, he argues that thoughts are coloured by emotions and that therefore they are bound to influence they way people interpret situations, make choices in the social context and police their
own actions. Both Rotheman and Wiesenfeld (2008) and Burkitt’s (2012) theories about the role of emotions in social relationships therefore offer one possible explanation as to the employee’s interpretation of their manager’s emotional ambivalence, and hence their perception of unsupportive relations.

Alternatively, Gerhardt (1989) puts forth the theory that successful social relations are dependent on the physical and mental health of the actors involved. Here, Gerhardt (1989) argues that the reciprocal nature of relationships which is created through the process of subjective meaning creation is contingent on each actor’s biopsychological health. Following this analogy therefore, it can be seen that line-manager’s emotional wellbeing is important for them to conduct successful social relations upon which employees with LTCs depend (Aas et al, 2008). It is speculated therefore that employees will feel less socially supported by those managers who respond negatively to the experience of paradoxical emotion management but conversely feel better supported by those who manage it positively. To illustrate this point, Scott, Colquitt, Paddock and Judge (2010) found that employees with an empathetic manager experienced higher levels of wellbeing and lower levels of bodily complaints, which they posit could be due to higher engagement of social support from empathetic managers. Nordqvist et al (2003), in a study of Swedish workers returning to work after long-term sick leave, found that above anything they wanted supervisors to provide a positive emotional atmosphere in the workplace. Devins and Hogarth (2005) make the point that employees are more likely to stay in a job if their employer is attentive and aware of their emotional needs.

To this end, in his article on the links between social ties (relationships) and health, Uchino et al (2012) proffers the notion that negative social ties are associated with health risks and can add to an individuals’ distress at the time when support is most needed, for example when coping with their condition at work (Gallant, 2003). Findings suggest that support for self-management of conditions is not a distinct concern for participants in this study, being perceived as part of the wider supportive ‘package’ and therefore part of the ‘employee’s needs’ to be balanced. However, as described in Chapter 2, work relationships, strong or weak, proximal or distal are proven to be pivotal for successful self-management (Munir et al, 2005a; Gallant et al, 2007).
Moreover, the importance of the strength of the ‘weak’ tie as in the distal employee/manager relationship is implicated in providing access to broader information and help for symptom management (Jackson et, 2012). This could be compromised in negative ties (as interpreted by the employee) stemming from the employers’ and managers’ duty to remain distant when attempting to maintain normative professional boundaries (Friedson, 2001), when balancing the demands of their role or in their reticence in engaging in difficult conversations as evidenced. Further weakening the strength of the relational tie and hence perceptions of support for self-coping mechanisms. Employees are reliant on the intangible goodwill of employers, managers and co-workers in providing a socially supportive environment (MacEachen et al, 2006) in which to manage their condition, however this may be not be forthcoming if goodwill in the workplace is undermined by negatively held emotions.

Indeed, managers in this study clearly elucidated their need to manage their emotions to maintain the professional manager/employee relationship, given that supporting those with illness is an emotive situation. Many participants were conscious of not blurring the boundaries between the need to be sympathetic towards employees whilst also having to fulfil the obligations of their role to the business. A few suggested that they communicate clear boundaries to employees with LTCs and attempt to detach themselves emotionally, specifically to appear objective and to maintain professional integrity. However, it is likely that the desire to maintain boundaries between the professional and the personal and detach from the negative emotional situation, also has the affect of alienating the employee (Keifer and Barclay, 2012). This offers another potential explanation as to the employee’s experience of unsupportive relations. Hugman (1991) in his work on power relations between the manager and employee in the workplace argues that boundaries are used by managers to maintain the instrumental power relationship and to avoid becoming too closely linked with the employee. Participants in this study reflect Hugman’s (1991) observation, although suggest that boundaries are hard to maintain in the case of employees with LTCs because of the emotive associations with illness.

However, as discussed in Chapter 3 section 3.2.5 the matter of emotions is generally considered non-normative to the management role (Ashforth and Humphrey, 1995) and outside of traditional behavioural expectations in which
managers are to be seen to be coping (Sachs and Blackmore, 1998). Brotheridge and Lee (2008) suggest that the stereotyped vision of the traditionally detached manager is slowly being replaced, but that vestiges still remain. Nevertheless, in the dominant paradigm of what Ashforth and Humphrey (1995) term the norms of rationality, emotional display in the managerial role attracts connotations of dysfunction, being pejoratively viewed, and must therefore be suppressed (Smollan, 2002) and controlled (Ashforth and Humphrey 1995). Flam (2002) in discussing emotions in organisations notes that the myth of rationality cannot be sustained, as emotions play an integral role in managers’ decision making processes.

Many of the participants also perceive that they are cognisant of employee’s non-material, socio-emotional support needs and that they provide and/or agree that having open and honest communication and good working relationships are key to successful employment for those with LTCs. This is in contrast to Narraine and Lindsay’s (2011) argument that managers and co-workers rarely perceive social barriers as workplace barriers. Managers in this study described, amongst other things, keeping in contact with the employee when away from work, fostering a supportive environment on return to work and providing emotional support. This highlights a dichotomy in differing perspectives of socially supportive relations at work, being a contrast between the participants’ perception that they implement or agree on the importance of the social aspect of work, but which is not reflected in previous research from the employee’s perspective which mostly describes such support as lacking.

A Department for Work and Pensions (DWP, 2011) report into line manager’s attitudes towards health, work and wellbeing provides an explanation for this finding. It suggests that employers’ and managers’ may consider themselves providing non-material social support, or intend/wish to provide this support but fall prey to ‘a gap between theory and company practice because of what they saw as competing priorities such as day-to-day targets and getting the job done’ (p7). These are demands which participants most frequently describe as invoking ambivalent feelings between the employee’s needs and their commercial responsibilities to the organisation. It is also likely to offer some explanation towards Bevan’s (2010b) finding from research into employees working with an inflammatory health condition such as arthritis, in which he
found that employers tend to overlook the psychosocial aspects of the employee’s return to work process considering only the physical demands of the job which need to be met.

Participants in this study confirmed this notion in their descriptions of balancing many needs, where the commercial, bureaucratic and political demands of being tightrope walkers assert considerable pressure and are distracting from their supportive role. Although as evidenced, many find this personally uncomfortable to reconcile in deciding where their priorities lie, to the employee or to the organisation. This may go some way to explaining the employee’s perception that employers often overlook the social context of work and focus only on providing employment and nothing more (Cartwright and Holmes, 2006). However, this observation is based on the wider literature capturing the employee perspective as detailed in Chapter 2, and not on the perspective of the employees employed by the participants in this study who may offer a different experience. Further investigation of this dichotomy of mismatched expectations would be beneficial for all stakeholders interested in the rehabilitative process for those with LTCs.

Finally, the anxiety expressed in having difficult conversations contradicts both the participants’ desire for openness and honesty in the workplace and their perception that they provide a socially supportive environment, as described in Chapter 5. This is consistent across the majority of narratives, which may also contribute to employees’ feelings of not being socially supported when managers find it difficult to converse with them about their condition. This finding accords with those of Robertson (2012) in his study of manager and staff relationships at a large, private UK telecommunications company. Robertson’s (2010) study highlighted that managers and co-workers were anxious about having difficult conversations with staff and colleagues where talking about their condition was involved, with the potential for causing offence by saying the wrong thing (as will be discussed below). Many participants in this study shared Robertson’s (2012) concern that relationships which are critical to business success, can be damaged by misunderstandings and anxiety arising from a lack of openness. This is consistent with the finding that to mitigate anxieties, many participants reported that they rely on organisational sickness absence management policies and procedures - leaning heavily on rules,
regulations and legislation in these instances - to counter their reticence of engaging with individuals in an open and honest way. Again this is raises an interesting dichotomy when one of the key findings from this study is that participants suggest that good, open communication is central to a successful working experience.

7.5.1.2 Employer/Manager Perceptions and Discriminatory Attitudes

The observation as to the prevalence of non-verbal communication throughout participant interviews is interpreted as being indicative of their personally sensitive moral evaluations and attitudes towards employees and their conditions. Indeed ‘the unsaid’ (Poland et al, 1998) was a considerable factor in the analytical evaluation of findings, as discussed in Section 7.4.2 above. Discriminatory attitudes towards those conditions considered serious and tangible or with physical symptoms were less evident. However, undesirable attitudes and scepticism towards those conditions with non-visible symptoms such as mental health conditions or stress were frequently conveyed, as illustrated in Chapter 6. In this respect participants’ narratives attest to the employee perspective identified by Kemp et al (2008), that employees with a mental health condition are more likely to say their employer was unhelpful than were employees with a physical condition.

Attitudes towards legitimacy and genuineness of visually asymptomatic conditions such as these were often bound up with frustrations or (mis)assumptions about employees using the condition for non-legitimate reasons, such as obtaining a GP Fit Note (Chapter 2, section 2.2.5). These also emanate from misunderstandings, fear and ignorance around mental health and stress conditions found in the wider socio-cultural context of the UK (MIND, 2013). Participants expressed that these conditions present a particular challenge for them, being difficult to manage. With many discussing the implications of the stigma attached to these conditions (Sainsbury Centre for Mental Health, 2007; The Royal College of Psychiatrists, 2008), which appears to pervade organisational culture (Irvine, 2011). Findings from the employer’s and manager’s perspectives in this study therefore explain the concerns of the employees who encounter these negative attitudes (Patel et al, 2007). According to Munir et al (2005a), this also supports employees’ reticence to disclose their
condition. A theme similarly captured from the manager’s perspective and also by Coole et al (2012), which underpins frustrations from both sides. Where the employee’s decision not to disclose their condition adds to line manager burden when having to placate other staff resentful of supporting a coworker they see as ‘fit but sick’ (Pinder, 1996). Indeed the non-verbal communication bellying managers’ negative attitudes allude to what Wilson-Kovacs et al (2008) defines as ‘under the radar’ organisational culture, perpetuated by normative custom and traditions dictating informal behaviour (Dawson, 1996). Robertson (2012) further suggests that these biases affect social relations, as evidenced by the employee perspective, and in this vein found that ‘in reality, more than one in five [managers] have biases which were operating unseen and unintentionally, below the fairness radar of managers’, (p1).

Of more concern in this respect for those employees (re) entering work with a LTC, is the influence of the wider socio-cultural environment on organisational attitudes and behaviour. The extent to which the current media perpetuated rhetoric of incapacity claimants which demonises them as ‘skivers’ and ‘scroungers’ - which Jolly (2013) suggests in these times of post 2010 austerity, is increasingly synonymous with disability - influences employers’ and managers’ evaluations towards those with LTC/disability must therefore also be considered. This is important when, according to Dodier (1985) the moral position of the employee is assigned by others in the organisation, which has a profound effect on continuing employment.

Aligned to this is the need to support managers in having difficult conversations as previously mentioned. Many in this sample suggest that they or other managers find it particularly difficult to engage with the employee about their illness, often to the detriment of the employee. Robertson (2012) offers that the fear of saying the wrong thing leaves employees anxious and confused, but also creates social distance in working relationships where it is well known that close relationships between employees and their managers fosters a supportive environment benefitting employee performance. This was particularly evident in this study when describing concerns over supporting those with mental health conditions, where participants were fearful of dealing with employees through lack of knowledge about the condition (Wilson-Kovacs, 2008, Coole et al, 2012; Tiedtke et al, 2013) but also awareness of issues around stigma and therefore of
contravening discrimination legislation (Henderson, Williams, Little, and Thornicroft, 2010).

7.5.2 The Employer/Manager

Managing conflict is considered an intrinsic part of the managerial role (Bass and Bass, 2008). Although response to conflict is individual, the consistency to which participants experience intra-role conflict across interviews (apart from one negative case) would suggest that in this study at least, the feeling of emotional ambivalence is homogenous to the management role when associated with managing illness. However, what is most distressing for individuals, argue Wharton and Erickson (1993) in their study of the boundaries between work and family life, is the amount of emotion management undertaken when experiencing multiple role conflicts. Research indicates that person-role conflicts (Rafaeli and Sutton, 1989) such as this are a clear threat to employee well-being (Kahn et al., 1964; Caplan, Cobb, French, Harrison, and Pinneau, 1980; Kahn et al., 1964; Zapf, 2002) where the negative implications of engaging in emotion work (Lively, 2007) cause stress and alienation from their job. Morris and Feldman (1997), Van Djik and Kirk-Brown (2006) and Spector and Bruk-Lee (2008) amongst others, examine the psychosocial cost and consequence to the manager of continually conducting emotion management in ambivalent situations. They suggest the perpetual transmutation of the private emotional system in displays of authentic (self) versus inauthentic (self) emotions in the commercial setting (Hochschild, 1983) results in burnout, stress and lack of job satisfaction.

Certainly several participants in this study described how stressful they find the supportive situation, pulled between multiple external and organisational demands and moral evaluations of ‘doing the right human thing’. However, the extent to which stressful feelings were expressed in this study again appeared to be dependent upon the individual’s socialised response to ambivalence as noted above (Spector and Bruk-Lee, 2008). These were also influenced by the wider socio-cultural context in which they occur and the extent to which organisational structure and culture exerts a pull, along with individual proclivity towards traditional conceptualisations of the managerial role in respect of emotions versus rationality (Brotheridge and Lee, 2008). Hochschild (1983) makes an
interesting observation and asks that in this situation who benefits and who pays – a matter worthy of future research.

In this sense, managers are increasingly expected to be able to be many things to many people and accordingly manage their emotions arising from this diversity in roles (Van Kleef, Homan and Cheshin, 2012). Interpreted from participants’ experiences in this study, I argue that they find this very difficult when emotions arise from the part of their role responsible for supporting and managing employees with illness (Berry and Meyer, 1995) and therefore paradoxical emotions may impact on the decisions they make towards supporting those with LTCs. Indeed as Lyon (1996) postulates, emotion has a role in the organisation of actions and it is through actions that social relations are generated and structured. One can perceive of the negative impact of manager’s emotions therefore on their actions and hence the nature of social relations in the workplace. It can also be seen that this situation is self perpetuating however as managing illness invokes (negative/positive) emotions which influence the supportive situation which in turn invoke more emotions. To reiterate Fineman (2003, p1), ‘all organisations are emotional arenas where feelings shape events, and events shape feelings’. Especially as Lyon (1996) aptly summarises that ‘feelings arise in the context of social relations’ (p70) and that emotion provides the link to health and the social world through the body. Yet the concept of health, emotions and the workplace or social-relational bases of illness as Lyon (1996) would suggest, have yet to be brought together and examined from the perspective of those supporting ‘other’s’ health in the workplace.

7.5.3 UK Government Welfare Reform

The overriding concern for the relevance and applicability of the findings of this study is the implication for the UK Government’s controversial welfare reform policy to move people off incapacity benefits and into work (as detailed in Chapter 2), given that as more people are assessed ‘fit for work’ through the ATOS work capability assessment system, and that many more will be working for longer with a LTC. Concerns around the suitability of the working environment and those who will potentially employ them must be addressed. As (Aas et al, 2008, p344) assert, for those returning to work following a period of absence from the labour market, ‘social support is crucial’, but the argument for
this research is whether employers and managers are ready to provide this support and under what circumstances? Findings from this research would suggest that many employers and managers may not be adequately equipped to provide necessary support, despite the fact that managing people (Peach-Martins, 2009) is an integral function of their managerial role.

By not focusing on social factors alongside the physical aspects of work for those with LTCs/disability (Shaw, Tveito and Boot, 2013), there is a concern that workplaces will not be ready to support them, thereby undermining UK back-to-work initiatives and rehabilitation schemes. For the prospective employee this also means risking further damage to health, having to remain in unsuitable positions or the unnecessary slide towards the ‘revolving door’ of work and welfare (Bevan, 2010a). Shaw et al (2013) argue for the inclusion of the employer perspective in interventions seeking to integrate employees with chronic health conditions in the workplace, which is a cross cutting theme through the wealth of research which documents the employee perspective. As previously highlighted, the most successful back-to-work and rehabilitation programmes are those with an element of personalisation and which utilise the interdependence of relationships between all stakeholders; the employer, employee, government and healthcare professionals alike (Soklaridis, Ammendolia and Cassidy, 2010; Higgins et al, 2012). Findings from this study accord with those of Higgins et al (2012) systematic realist review of the management of long-term sickness absence, which asserts that the quality of relationships between managers and staff is one of the conditions to getting ‘all stakeholders on side’ in getting people back into work.

Many would agree that current UK policy initiatives to get people back into work and off benefits have been introduced without clear understanding of what this means in reality to those charged with employing and managing them (Gregg, 2010). In accordance with existing research, back to work initiatives which (re)introduce individuals into the labour force will not be wholly successful unless the matter of the social context of work is addressed by including employer’s and manager’s perceptions of the consequences of being ‘many things to many people’ in their supportive role. The evidence suggests that those employees who feel inadequately socially supported will leave work and return to the benefit system counter to government aims (Waddell and
Burton, 2006, Bevan, 2010a). Consequently, in agreement with existing research (Amir et al, 2010; Coole et al, 2012) there is a need to raise awareness of the additional emotional (and physical) burden that managing illness imposes on participants’ normative daily role. This influences the social context of the workplace and deters employers from employing those with LTCs, as explicitly described by some participants in this sample.

7.6 **Aims of Research – Present and Future**

I turn now to consider whether the findings of the current study have met the aims of the research as stated in the Introductory Chapter of this thesis. I also look towards the future in highlighting potential areas for further research. Commensurate with UK Government objectives detailed in Chapter 2, this study has explored employers’ and managers’ views and experiences of employing and/or working with individuals with LTCs. This was in order to examine the influence of the management role in enabling employees with LTCs to be recruited into and retained in the workplace. To this end, perceived barriers and enablers to successful working for those with LTCs from the management perspective have been identified and discussed (detailed in Chapters 5 and 6 of this thesis) in accordance with this aim.

Consistent with the second aim of this research, findings also detail how participants’ perceptions are influenced according to the condition type, which was often framed around discussions of tangibility and based on the presence or absence of symptoms (discussed in section 7.1 of this Chapter). Findings indicate that participants’ views are also influenced by their affinity with the employee and perceptions of legitimacy and genuineness. A key finding from this research is that managers’ perceptions of supporting those with LTCs are consistent across sectors, industry types and sizes, contrary to prior assumptions related to the commercial and bureaucratic objectives of public and private organisations, discussed in Chapter 6.

With regard to the third aim of this research, findings have indicated that incompatibilities between the nature of the managerial role, structural dynamics of the workplace and the normative expectations and beliefs of the participants’ individual role invoke an emotional response which has the potential to have a
bearing on workplace supportive relations (discussed in section 7. 7 this Chapter). Employers and managers in the study demonstrate mixed and often conflicting feelings about their supportive role, where managing LTCs is interpreted as non-normative to their everyday role as a manager. Finally, organisational sickness absence management policies were found to influence the management of LTCs evidenced through participants experiences of conflict when required to implement them, illustrated in Chapter 5.

The primary research questions for this study have therefore been answered in achieving the aims of this research. Firstly, that the experiences and perceptions of employers of supporting people with LTCs in the workplace have been explicated and discussed in relation to how they influence supportive workplace relationships. Secondly, that many participants view the working experience for those managing a LTC through the lens of their own obligations and responsibilities to the organisation and what it means to them, as would be expected. Some do however concern themselves with what it means for the employee to have a successful working experience as documented in Chapters 5 and 6. Lastly, in response to the final question, of how employers’ experiences and perceptions of illness vary according to occupational status, type, size and nature of industry and organisation. All bar one participant reported similar personal experiences and perceptions of supporting employees with LTCs in relation to the tensions of balancing. However, participants sited in SMEs were more likely to report concerns about the financial consequences of supporting those with LTCs, commensurate with what is currently known about small workplaces and employee ill health (CBI/Pfizer, 2011; Davidson, 2011; PwC, 2013).

7.6.1 Future Research

This study replicates existing empirical research which has identified that a general lack of knowledge about conditions and a lack of confidence and skills in how best to support employees is also a concern (Cunningham et al, 2004; Wilson-Kovacs et al, 2006) contributing to participants feelings of conflict. An interesting finding from the study is that these feelings are often exacerbated by having to support employees with LTCs who managers perceive are experts in their condition. As expressed in Chapter 5, this undermines the manager’s status
and integrity as a professional (Friedson, 2001) and their confidence and capacity for dealing with supportive social relations. The solution to this, many participants suggested, is the need for training to increase knowledge about conditions, especially mental ill health and stress conditions, which also cover how best to provide condition specific support to employees.

Coupland, Brown, Daniels and Humphreys (2008) advocate that to understand some of the barriers to improving working conditions it is necessary to understand the ‘discursive processes that constitute emotions in an organisation’ (p348). Although as highlighted in Chapter 3, the fact that there is little existing research into health related emotions experienced by managers in the workplace is not surprising given the traditionally held view of the rational manager (Ashforth and Humphrey, 1995). However, it is easy to understand how ambivalence occurs especially when emotions are born of the interdependencies between workplace social actors (Burkitt, 1997). Future research could therefore explore ways in which employers and managers can talk about their tensions and difficulties in supporting those with LTCs. Raising awareness of emotional consequences and giving them safe ‘space’ in which to express their feelings of ambivalence, away from potential repercussions of damaging their integrity or risking harm to their job. In this respect, illness as an antecedent to managers’ emotion management in the workplace has thus far not been explored or defined in the literature (Morris and Feldman, 1997).

As this thesis has shown, this aspect is worthy of further research because managers are expected to control their emotions in response to an emotive situation, which those in this cohort express is difficult to achieve. Brotheridge and Lee (2008) note the ambiguity in the workplace around rules governing the display of emotions which tend to leave managers caught among conflicting forces and potentially contradictory emotions as exemplified by participants in this study. Therefore there is a need to raise awareness to employers and managers through training, of the potential for paradoxical emotion management within the managerial role when supporting those with LTCs. Managers can then account for this emotion management when providing support to those with LTCs, and so that they themselves can be supported. Managers’ capacity to manage their own emotions is considered intrinsic to their role but managing
illness appears to present a contradiction to the accepted normative rule of rationality (Ashforth and Humphrey, 1995).

To this end, a current initiative being introduced into the UK’s National Health Service (NHS) aims to get staff talking on a regular basis about their difficulties and stresses encountered in caring for patients. Called Schwartz Centre Rounds after the founder of the American organisation that devised the initiative, they aim to help employees feel more supported, less isolated and better able to cope with the emotional pressures of their work (DoH, 2013). Ultimately this will benefit patients and employees alike. I suggest that an intervention such as this would be beneficial to employers and managers across all industries, not just healthcare organisations.

Finally, in attempting to explore the employer’s and manager’s role in what makes work ‘work’ for those with LTCs inline UK Government aims (Bevan, 2010b), this study has highlighted the need to consider the emotional preparedness of employers and managers in being ready to support and welcome potential employees upon (re)entry to the workplace (Smith, 1996). Beatty and Joffe’s (2006) proposal that organisations should view chronic illness in the workplace as a unique phenomenon in its own right, implementing policies and procedures specific to the management of LTCs, would therefore seem sensible in light of these findings. In agreement with the majority of existing literature from the employee’s perspective this study concurs that further research is required into a) into the social context of work but from the ‘demand-side’ perspective to further understand the discrepancy between employee and employer/manager perceptions of social support and b) further investigation into the socio-emotional impact to managers of being Tightrope Walkers, which has the potential to influence the socially supportive context of the workplace.

7.7 Strengths, Limitations and Reflections

As evidenced at the start of this thesis there is limited empirical research available either qualitatively or quantitatively, which examines employer’s and manager’s perceptions of the social context of work. There is much less work available on their perception of their role in providing social support at work upon which employees with LTCs/disability suggest they depend for a
successful working experience. This study therefore supplements the limited existing research in the area which argues for the social context of work but has taken a quantitative approach to research.

By taking the more nuanced and in-depth approach to understanding the experiences of participants through a qualitative methodology, this research has accessed those sensitive thoughts and reflections which are difficult to elicit quantitatively about such an emotive subject. Interviews allowed for topics salient to the participant to be explored (where time allowed) leading to a more complete picture of workplace life for the manager in supporting those with LTCs. Further, this study adds to existing research into the socially supportive nature of the workplace by identifying the potential for employee support to be undermined by socio-emotional dimensions which arise from conflicting pressures stemming from managers perceived to ‘be many things to many people’.

This research therefore complements that conducted from the employee perspective by identifying potential areas of future research to examine the incongruence between employee and manager perceptions of supportive relations, and indeed the consequence of paradoxical emotion management on social support. In addition, this research has also identified areas from the participant’s perspective which will benefit all stakeholders. The employee’s in understanding their role in the supportive relationship and the broader return to work process, and to the Government in highlighting areas which it is anticipated will contribute to return-to-work and rehabilitation initiatives which seek to successfully retain people with LTCs in the UK labour force.

Despite this, this study is limited from a number of aspects. Firstly, participants were self-selecting and therefore the potential for response bias must be considered. Participants often came to me with specific experiences to discuss and therefore the notion of rehearsal effect or representational decisions must be factored into the reports of their experiences and the subsequent analysis (Reissman, 1993). At times it felt as though the interview was a form of counselling and an opportunity for the participant to conduct moral repair by sharing their feelings of shame and guilt about other people’s illness in a redemptive way (Frank, 1997), albeit by providing a listening ear rather than
working though problems. Therefore the matter of social desirability bias is considered (Bryman, 2012) where participants may have monitored their response so as to present socially acceptable responses. Although, as discussed in this Chapter, participants were less guarded when using gestures to convey thoughts and feelings. It was suspected that the managers had offered to talk to me specifically as an opportunity to share their concerns and difficulties and it is reflected upon to what extent this directed theoretical analysis towards emotion management. In this context, my interpretation of the data relied on participants’ subjective interpretation of events and perceptions (Yin, 2011).

Correspondingly I reflect upon the extent to which the definition of LTC referred to throughout this research (Section 1.0.1, Chapter 1), and the overarching use of the term LTC, influenced participant responses and perceptions. For example, to what extent did the terminology influence participants to generally discuss experiences related to those conditions considered to be health conditions (diabetes for example), rather than to discussing those related to employees with what may be considered a disability (restricted mobility for example). I question if it would have been pertinent to explicitly use examples of disabling conditions within the definition where given on the Participant Information Sheet (Appendix 4) and verbally (if requested by the respondent), rather than only health conditions. However, given that one of the aims of the study was to elucidate what employers and managers consider to be a LTC (with little prompting), it is an interesting observation that disabilities were little mentioned. Alternatively, this may be a consequence of participant’s lack of exposure to supporting those with a disability in the workplace. Again this reflection leads to the confusing and interchangeable nature of the terms LTC and disability, both medically and under UK equality law, for which a unified and consistent definition is required.

Secondly, the findings indicating paradoxical emotion management may be idiosyncratic to the participants in this cohort although the analysis demonstrates that findings have been grounded in the data. To establish whether it is applicable to the wider managerial and employer population, further inquiry to compare and contrast between managers who have not had experience of supporting LTCs with those who have, and inclusion of the employee perspective would be beneficial in the future. Comprehensive comparison of the
data captured in this study with that of the employee perspective would also add validity to the findings of this study, where a case study approach conducted across the hierarchy of a small sample of organisations would also be beneficial.

This is a small-scale qualitative study and as such generalisability of the findings to the wider population of employers and managers is cautioned. Whilst sampling was conducted socio-demographically and devised so as to include a wide range of demographic attributes and experiences as per the aims of the study, it is noted that the sample did not include experiences from those of diverse cultural backgrounds or from a complete range of industry types. The study was also geographically limited to the North West region of England and therefore the study does not account for, but may be indicative of, the perceptions and experiences of employers’ and managers’ support for LTCs nationally across the UK.

Thirdly, the sensitive nature of this research invited participants to make gestures which were not captured on the audio recorder and also to have off the recorder discussions to indicate their (authentic) thoughts and feelings about the situations. Whilst these have been included in my analysis through memos and fieldnotes, their use as part of the analytic process and theory building is a matter of concern to academics in the field (Bryman, 2012) where the use of anecdotal evidence in qualitative data analysis is generally discouraged as not being ethically and reliably sound.

Fourthly, I also reflect upon my own emotions during and post interview. Henry (2012) reflects on feelings of empathy during fieldwork and the emotional response to sensitive situations, Throop (2010) on the dynamics of empathy and the inter-subjectivity of empathy in relation to the lived-experience of those we are researching. Listening to participants responses was at times distressing and emotive and therefore difficult to personally manage. Bahn and Weatherill (2012) in a study of Australian Occupational Health and Safety qualitative researchers identified that there is personal risk to the researcher becoming emotionally challenged when listening to distressing narratives. Reflecting on this, I was attempting to do what the participants in the study do, which is manage my emotional response to manage both distress and reactions so as to appear impartial thereby limiting researcher bias on the interview content.
This leads me to reflect on the sensitive nature of the research where others’ opinions of those who are ill may contradict my own. This did occur in some of my interviews and I therefore reflect that it was very difficult to put this aside when analysing the data. I therefore reflected on how far this subjectivity biased my findings and acknowledged this in memos when I became aware of the situation. During interviews, I employed impression management strategies, consciously self-monitoring my responses in an attempt to convey neutrality of opinion. I will never know if this strategy was successful or how much this influenced the participant’s responses and hence the data collected.

Finally, returning to personal reflexivity as outlined in Chapter 4 (section 4.4.2) and as is the requirement of a study using GT principles, I reflect on my personal experience of the phenomenon of interest under inquiry such that it shaped my research and subsequent findings. As mentioned, during the second year of my PhD study my husband was unfortunate to need life saving surgery for a perforated bowel. Subsequent complications during the 3rd year of my PhD and further life saving surgery, has led him down the path of living his life with a LTC. I have therefore learnt from first hand experience that self-management of LTCs is not an individual concept – it is a team effort - and now appreciate from the employee perspective that if part of that team is unsupportive and social support is not forthcoming, then self-management and indeed employment is difficult to cope with and sustain. I can now appreciate the perspective of both the employer and the employee in supporting those with LTCs and those around them. I also appreciate the difficulty of employees in attempting to return to work when suffering from a condition and can understand why employees suggest that social support is pivotal to a successful working life. On the other hand, when analysing my findings, I now appreciate the paradoxes encountered by managers in supporting those with LTCs and the emotional difficulties which come into play. I therefore reflect on how going through this personal experience has influenced my analysis and to what extent. Whilst I attempted to remain impartial at all times, I am sure that this must have influenced my perspective in some way but I hope that from a positive perspective, it made me more determined to support managers so that they can better support employees to have a successful working life.
7.8 **Chapter Summary**

In this Chapter I have discussed and interpreted the findings of the study in reference to existing empirical literature and in relation to the theoretical framework presented in Chapter 3. In general, the findings of this study support the concerns of Bevan (2003) that return to work initiatives and return to work processes are likely to be less successful where ‘line managers are ill-equipped to manage absent and returning employees’ (p21). This study has highlighted the many complex concerns and challenges encountered by employers and managers in the sample, which illustrate areas where they feel ill-equipped to support those with LTCs.

Of these, the central concern across all interviews was the perception that supporting those with LTCs is one of a difficult balancing act typified by conflict, emotional disquiet and frustration. Interpretation of the two key themes emergent from the data using the theories of Merton and Barber’s (1963) Sociological Ambivalence and Bolton’s (2005) Typology of Workplace Emotion Management, identified that participants’ feelings of emotional ambivalence can be explained by both role and feelings rule conflict. In contrast to Bolton’s (2005) hypothesis however, participants’ in this study suggest that when managing those with LTCs they are unable to ‘juggle’ (p101) all the emotions at any given time. They suggest that they are not highly efficient in managing across emotion management boundaries and that they are not therefore able to present many ‘faces’ in being many things to many people (p164).

I therefore propose the concept of ‘paradoxical’ emotion management in the workplace to account for the management of emotions arising from ambivalent feelings between roles and feeling rules specific to managing illness and which augments’ Bolton’s (2005) Typology of Emotion Management in the Workplace. The finding that managers experience paradoxical emotion management may contribute to their perceived feelings of burden arising from the notion that management of LTCs/disability is non-normative to the manager’s role or emotional expectations of it, where organisations are generally run and predicated on the premise of employee ‘ableism’ (Williams and Mavin, 2012, p159), health and not illness (Radley, 1993).
7.9 **Conclusion**

Overall the findings indicate that there is common consensus amongst employers and managers in this study and that of employees as to the importance of managerial supportive workplace relations for those with LTCs. However, despite this shared aspiration, employees with a LTC frequently concur that this support is lacking, thereby presenting a considerable barrier to workplace success. This study confirms other findings (MacEachen et al, 2006), that managers struggle to translate intentions to provide support into tangible action for the employee. Data analysis revealed that this incongruence between intention and action is influenced by factors such as the extra burden and emotion management presented by managing an employee with a LTC.

The majority of participants in this study implied that the sense of burden arises from the non-normative situation of managing an employee with a LTC/disability in the workplace. Indeed the complex and sensitive nature of the situation, coupled with the longevity of the condition, invokes a difficult balancing act of many often conflicting and incompatible pressures, demands and feelings that are not usually encountered when managing employees with short-term sickness absence. Inferred from participants’ responses is the complex intersection of social roles and feelings between the public world of the manager and the private world as an individual in dealing with such an emotive situation. Consequently the resulting negative emotional response to managing this potentially ambivalent situation undermines the manager’s intention(s) to be supportive - and is hence reflected in employees’ perception of unsupportive social relations.

It is therefore evident that managers in this sample carry what Brotheridge and Lee (2008) refer to in their review of emotions in the managerial role as ‘a heavy emotional load’ (p114), made heavier when supporting those with a LTC. This thesis therefore presents a unique perspective of the role of employers and managers in supporting those with LTCs in the social context of the workplace and as such provides a foundation for further investigation.
REFERENCES


Soklaridis, S., Ammendolia, C., and Cassidy, D. (2010) Looking upstream to understand low back pain and return to work: Psychosocial factors as the product of system issues. *Social Science & Medicine, Vol. 71 (9), 1557-1566*


APPENDIX 1: Example vignettes

**Visitable symptom vignette (not disclosed):**

Linda is 35 years old and is married with two children. She has been employed in your organisation for a while now and her work colleagues have noticed that she is struggling with her job duties. Linda also appears very tired and not her usual self. She has recently returned to work following another period of sickness absence.

**Visible symptom vignette (disclosed):**

Bob is a hard-worker in his forties who copes with a long-term condition which makes day-to-day activities, such as lifting and walking, difficult for him. Bob takes time off when his symptoms prevent him from coming into work, which is not often, but does have to take more frequent breaks than others when in work. Bob works in a small team that works to strict deadlines.

**Unexplained symptoms vignette:**

Chris Blogs is 25 years old and is currently undergoing medical investigations for an illness which has caused him to have recurrent episodes of absence from work over an extended period. Some of this absence is for time off to attend clinical appointments. Others are due to his illness being particularly troublesome.

**Visible symptom vignette:**

Sally is a popular and integral member of the team who endeavours to come to work even though, on some days, it is extremely difficult for her to leave the house and make the journey. Sally is a very productive employee who goes the extra mile to manage her condition at work, often to her detriment, and her work colleagues appear to appreciate this.
**APPENDIX 2: Initial sampling frame**

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<td>Total</td>
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No. Of Companies (units) to be sampled = 24  
No. Of Participants (approx.) = 48

**Company Size:**  
Small >50 employees  
Medium >250 employees  
Large < 250 employees
APPENDIX 3: Invitation to participate letter

Donna Bramwell
Health Sciences Group – Primary Care
School of Community Based Medicine
The University of Manchester
5th Floor, Williamson Building, Oxford Road
MANCHESTER, M13 9PL

Name of Employer

Employer Address

Date

EXPLORING THE ROLE OF EMPLOYERS AND MANAGERS IN SUPPORTING PEOPLE WITH LONG-TERM CONDITIONS IN THE WORKPLACE

INVITATION TO TAKE PART IN RESEARCH

Dear,

I would be grateful if you would consider helping me with my research project on people's experience of long-term illness (or long-term conditions) at work. I am a PhD student in Health Sciences Group - Primary Care at the University of Manchester, carrying out this research for my thesis.

The number of people living with a long-term condition is set to rise in coming years which will mean that more people with long-term illness will be employed in the labour market. In light of this, we are interested in exploring your experiences, views and opinions about supporting those with long-term conditions in the workplace. Currently there is little research in this area and this study provides an opportunity for employers/and or line managers to air their views.

I have enclosed an Information Sheet which explains more about this project and what your involvement in the research would be so that you can decide whether or not you wish you to participate. If you would like to take part in this research and help us to understand your views of supporting long-term conditions in the workplace then please contact Donna Bramwell at the University of Manchester by phone 0161 306 7046 or email at donna.bramwell@postgrad.manchester.ac.uk.

Thank you very much for reading this letter and for considering taking part in the study.

I look forward to hearing from you.

Yours sincerely,

Donna Bramwell
PhD Student

Enc.
Thank you for taking the time to think about taking part in this research. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read this information carefully. It explains why we are doing the research and what will happen to you if you take part. Please ask if anything is not clear (contact details are given at the end of this form). Taking part in this research is voluntary and you are under no obligation to participate.

What is the purpose of the study?

Growing numbers of people in the UK are living with chronic illness (long-term conditions) such as heart disease, diabetes and depression. This also means that increasing numbers of people will be employed and working with a long-term condition. It is therefore important to understand what employers and line managers think of long-term conditions in the workplace in order to understand what will make a successful working experience for employees with a long-term condition. This is important for retaining or rehabilitating people back into the working environment. We would like to understand the experiences of employers and line managers who work with people with long-term illness. You need not employ or work with people who have a long-term condition in order to take part, but direct experience would be beneficial. We are also trying to find out more about people’s own experience of illness at work.

Why have I been chosen?

We would like to understand the views and experiences of a range of employers and managers from a selection of companies in the Cheshire/Greater Manchester area. You have been asked to take part in this study because you are an employer and/or manager who may have had experience of working with someone with a long-term health condition.

Do I have to take part?

No, participation is voluntary. It is up to you to decide whether or not to take part. We will describe what will be involved in the interview and go through this information sheet with you, we will then give you a copy. We will invite you to sign a consent form to show you have agreed to take part.

If you decide to take part, you can stop at any time without giving a reason. Should you decide to stop taking part, the contact details of the research team are given below.
APPENDIX 4: Participant information sheet (cont/d)

What will happen if I choose to take part?

If you would like to take part then this would involve having one interview lasting between 30 and 60 minutes and which will be audio recorded. I will have a range of questions to ask you, but our interview will be informal and not a rigid question-and-answer format. The interview will be audio recorded because it is hard to take notes of what people say, listen carefully and think all at the same time. After the interview, the whole interview is typed up. We do this to help us remember what people said and to ensure a full and accurate account of the views that are presented.

What are the possible risks of taking part?

Some people may find it distressing to discuss their experiences of working with or employing someone with a long term health condition. You do not have to discuss any issues that you do not feel comfortable doing so.

What are the possible benefits of taking part?

Although there may be no direct benefits to you personally, we hope that you find taking part an interesting experience. Taking part will give us a better idea of what makes working life successful for someone with a long-term condition. It is hoped that results of this study will help to understand how illness can be managed at work in order to inform employer training and improve rehabilitation services.

What are the possible disadvantages to helping with this research?

The main disadvantage is the time it will take. Interviews usually last up to 60 minutes but this can be as short or as long as you wish.

What if there are any problems?

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions (see below for contact details).

Will my taking part in the study be kept confidential?

Yes, everything you tell us during interviews is completely confidential. All papers and notes will be kept in a locked filing cabinet. Typed notes, electronic audio files will be stored on a password-protected computer within a locked office at the University under the supervision of Donna Bramwell. Notes and computer files will not be played or shown to anyone outside the research team. We have to keep these files for 10 years so that research reports can be made and so that the accuracy of information can be checked. After 10 years, all information will be destroyed. When we type up the recordings made during interviews and write about the results of the research, all personal details will be removed so that no-one will know who you are. No real names will be used. We will send you a summary of what we find out in the study.

What will happen if I don’t want to carry on with the study?

You can withdraw from the study at any time. All you have to do is notify the researcher of your decision.
APPENDIX 4: Participant information sheet (cont/d)

What will happen to the results of the research study?

Results from the study may be published in social science journals and health care journals, without using any information that could identify participants.

Who is organising and funding the research?

This research is being run and funded by the School of Community Based Medicine, located in the University of Manchester and the Medical Research Council.

Who has reviewed the study?

This study has been reviewed and been given favourable ethical opinion by the University of Manchester Research Ethics Committee.

What do I need to do next?

A researcher will telephone you to see if you are willing to take part in this research. If you agree to be interviewed we will arrange an appointment at a convenient time and location for yourself. Prior to the interview we would like you to sign a consent form. If you do not want to take part, then please tell the researcher.

Thank you very much for taking the time to read this.

Further information and contact details:

If you have any questions regarding the study, please contact a member of the research study team at the Health Sciences Group - Primary Care, 5th Floor Williamson Building, Oxford Road, University of Manchester.

- Donna Bramwell, PhD Student    donna.bramwell@postgrad.manchester.ac.uk
  0161 306 7046
- Professor Anne Rogers            anne.rogers@manchester.ac.uk
  0161 275 7607
- Dr Caroline Sanders             caroline.sanders@manchester.ac.uk
  0161 275 7619


APPENDIX 5: Interview Guide

Interview Question Guide V5 - Final

- How many staff are you responsible for?

1) What are your experiences of working with staff with a long-term condition?
   a. Probe: Opinions/views

2) What do you see as your role in supporting them at work – helping them to manage their illness at work?

3) How do you manage absence?
   a. Probe: What are your policies and procedures (copy?)
   b. Probe: Have you seen a fit note?

4) Do you think there is a difference between how illness is viewed and managed pre-and current austerity environment?

5) Have you had any particular positive or negative/difficult experiences?

6) Does illness type/occupation status/length of service make a difference?
   a. Symptoms
   b. Legitimacy

7) What do you think makes it particularly successful – or not- for someone managing an LTC to work?
   a. Barriers
   b. Enablers

8) What do you consider is the most important aspect of a successful working environment/life for someone?

9) How do colleagues perceive long-term illness?

10) How do you think life outside of work affects a person managing a condition and working?

11) Do you think there is a difference between public and private sectors in supporting people with LTCs?

12) Seniority – perception of illness in senior management?

13) What would have put you off doing this interview?
Consent Form

‘EXPLORING THE ROLE OF EMPLOYERS AND MANAGERS IN SUPPORTING PEOPLE WITH LONG-TERM CONDITIONS IN THE WORKPLACE’

Centre number:  
Staff Identification number for this study: 7330195

Please initial each box

1. I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason, without my legal rights being affected.

3. I understand that my comments may be used in reports on this study and that these will be anonymous. I give permission for this.

4. I understand the interviews will be audio recorded

5. I agree to take part in the above study

________________________________________  ______________  __________________________
Name of Participant                      Date                      Signature

________________________________________  ______________  __________________________
Name of Person taking consent
(if different from researcher)            Date                      Signature

________________________________________  ______________  __________________________
Name of Researcher                       Date                      Signature
**APPENDIX 7: Lone Worker Procedures**

Standard Operating Procedure for Fieldwork Visits Conducted by Researchers

Researcher arranges an appointment for a research visit. Researcher obtains the following information:
- Name of individual visiting
- Full address including postcode
- Contact telephone number of individual visiting
- Time of visit
- Expected time of departure from visit

Researcher provides the Designated Person (DP) with a **Safety Check form** which includes the above information. Researcher is responsible for contacting the DP prior to or at expected time of departure and informing them of where they intend to go next.

**Did the researcher contact the DP prior to expected time of departure?**

- **Yes**
  - Did the researcher use the safety breach code "**tell Sid I'm going to be late**"?
    - **Yes**
      - DP to contact Emergency Services
    - **No**
      - No further action necessary by DP or Researcher until next visit.

- **No**
  - 1. DP calls mobile of Researcher at or just after expected time of departure and request a call back if no answer on both work and personal mobiles.
  - 2. If no response after 5-10 minutes, DP calls home of patient to check whereabouts of Researcher.
  - 3. If no response, DP to contact Emergency Services and inform them of last known whereabouts.
  - 4. DP to log process of actions taken, date and time.
APPENDIX 8: Example of Coding Index Cards

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<th>3RD SECTOR</th>
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<td>- LEGISLATION -&gt; EMPATHY</td>
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<td>- FINDING THE RIGHT JOB</td>
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<td>ESSENCE:</td>
<td>PASSIONATE ABOUT NORMALISING</td>
<td>- DO YOU KNOW WHAT I MEAN?!</td>
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<td>- PLAYING SYSTEM</td>
<td>- DEPRESSION</td>
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<td>- RISK HUNGRY</td>
<td>- AMBIGUITY</td>
<td>- PRESENTERISM</td>
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<td>- NATURE OF JOB NOT ALLOW RTW</td>
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<td>- PERSON NEEDS TO SELF HELP</td>
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<td>- MH STIGMA</td>
<td>- OPENNESS, CLARITY</td>
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<tr>
<td>- PERSPECTIVES/BOUNDARIES</td>
<td>- COLES MANAGING</td>
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<td>- AUSTERITY RESISTANCE</td>
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<td></td>
<td>- BOUNDARIES CLEAR ABOUT - GOOD CARE RELATIONSHIPS</td>
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<td></td>
<td>- RESPONSIBILITIES</td>
<td>EMPER -&gt; EMPER</td>
<td>- 2 WAYS</td>
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<td>- CO-WORKER</td>
<td>ENOUGH - ATTITUDE</td>
<td>HONESTY</td>
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<td>SOCIALISATION/STEADY</td>
<td>SOCIAL MODEL - BE CAREFUL, ASSUMPTIONS LABEL</td>
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<td>- ABLE TO CITE P&amp;O</td>
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<td>- PROCESSING DECISIONS</td>
<td>- DIFFICULT CONV</td>
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<td></td>
<td>- SUPPORTIVE, DIFFICULT BOUNDARIES</td>
<td>ESSENCE</td>
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### APPENDIX 9: Line by line coding example

<table>
<thead>
<tr>
<th>P No.</th>
<th>Sentence/Paragraph</th>
<th>Was coded</th>
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<tbody>
<tr>
<td>1</td>
<td>'where you do work so closely together ermm, and in, in that sense within the (name) you’ve got friendships as well as colleagues, then it brings about a closeness'.</td>
<td>Co-worker relationship (new code)</td>
</tr>
<tr>
<td>2</td>
<td>'he was saying he was staying in all the weekends and you he was really sort of like ill but then he was out at gay pride and sort of having photo’s on things like Face book that was shown round all the staff room of him taking drugs and it was sort of like well [laugh, laugh] so you’ve just given yourself enough rope to hang yourself there.'</td>
<td>Legitimising – employer questioning legitimacy of illness (new code)</td>
</tr>
<tr>
<td>3</td>
<td>'I think the firm were pretty good to him, he had a gradual, kind of, start back to the office, starting with a couple of days.'</td>
<td>Enabler: Phased Return (existing code)</td>
</tr>
<tr>
<td>4</td>
<td>'I’ve supported him by being in regular contact with him, going out to visit him a home and things like that, so that’s how I, mind you, it’s not clinical in any way, it’s just, I. Yeah, good practice. And it’s instinctive rather than following any, you know, prescribed policy or procedure.perceive as good, you know, duty of care'</td>
<td>Moralising expressing personal beliefs against org beliefs (new code)</td>
</tr>
<tr>
<td>5</td>
<td>'But in the meantime we also have to balance that off with being a frontline service provider. That means we’ve got to get it right for everybody concerned else one, the individual may be catered for but the service isn’t, or the other way round.'</td>
<td>Balancing the needs of the business and the employee (existing code)</td>
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APPENDIX 10: Fieldnote and Memo examples

Fieldnote Example:

Interview 39 - Fieldnotes

Interview took place in the morning at Ps place of work.

P was running slightly behind in his schedule but was very welcoming and very chatty.

P has lots of experience he wanted to share with me and it was difficult to get a question in sometimes but he was lovely and very enthusiastic.

P had very open body language and there was lots of mirroring, which indicated that he was comfortable with sharing his experiences and perceptions with me.

P kept looking at the audio recorder and I sensed that he was conscious of what he was saying on the tape, but then he was very honest. He did use eye movements and body language to intimate when he was talking about things he was sceptical about, or people he thought were pushing the boundaries i.e., in cases of stress or non genuine illness.

After the interview, P mentioned that it was the younger generation who are more likely to have instances of non-genuine illness and that years ago, this may have been more tolerated than it is now, i.e. when we were younger. However, we discussed the fact that absence processes are more stringent now and that this is more likely to be picked up quicker and puts people off taking unnecessary absence days.

P didn’t mention anything new in terms of themes but his assessment of the use of social media was quite interesting in that he applied a seek and ye shall find mentality so therefore chooses not to monitor this.

Memo Example:

Memo – 4/4/12

P22 has brought forward an interesting point. Is it that people's tolerance and support is affected by personality but is it that personality is affected by individual coping mechanisms and approach to illness. So if someone was positive then support would be positive? If someone is negative then support is negative. So how a person manages an illness has an impact on how they're supported. P38 suggests similar???
Example of mind mapping diagram of initial thoughts/tentative themes:
APPENDIX 12: Situational Analysis Positional Map

**POSITIONAL MAP – Discursive positions**

**OBJECTIVE – POSITIVE POSITIONS**
- Normalisation
- Explicit
- Elephant in the Room
- Ineffable
- Why can’t/don’t participants say what they mean? What is the unarticulated? Sites of silence?
- Unsaid is about reality vs perceptions
- Hidden understandings
- Personality
- Honesty
- Co-workers not voicing concerns – SD response
- Disability vs LTC
- Values – people’s unsaid socialised
- Particular issues with back pain
- NIH & Stress
- Physical vs Invisible symptoms
- Scepticism about genuine illness
- - Won’t come out and say don’t believe empee
- - Fear of social acceptance/Fear of incongruence
- - Sensitivities

**NEUTRAL**
- LTC30 ‘what do you want me to tell you off tape’
- Honesty
- Social Desirability & Impression Management
- Do you know what I mean?
- Disclosure – Why not?
- Questioning

**POLITICAL CORRECTNESS**
- Denial empee
- - Why weakness
- Loose job – stigma?
- Off the record – image might
- - Worried about how they came across
- - Damage limitation

**SOCIAL DESIRABILITY FACTOR**
- Intimidated

**SUBJECTIVE – NEGATIVE POSITIONS**

**SITES OF SILENCE**
- Taking the Mickey
- Eye movements when talking about
- Body language
- Legitimacy/genuineness & Ascertaining MC
- Discrimination
- Off the record – image might
- - Worried about how they came across
- - Damage limitation
- Off the record – image might
- - Worried about how they came across
- - Damage limitation
- Close support
- Honesty
- Social Desirability & Impression Management
- Do you know what I mean?
- Disclosure – Why not?
- Questioning

- Disability vs LTC
- Values – people’s unsaid socialised
- Particular issues with back pain
- NIH & Stress
- Physical vs Invisible symptoms
- Scepticism about genuine illness
- - Won’t come out and say don’t believe empee
- - Fear of social acceptance/Fear of incongruence
- - Sensitivities
APPENDIX 13: Final codes relational analysis diagram

Notes:
- Legislation and the Law is connected to getting Personal dimensions through fear of contravening the law by saying something they should not. Managers afraid to/cannot express personal thoughts because they may not be felt and believed in the workplace.
- Balancing conflict between external and internal domains/pressures = emotion management

[Diagram showing various categories and subcategories related to codes and relational analysis, including Co-workers, Employee managing the condition, Organisation, Legislation and the Law, Personality and Relationship, etc.]

Paradoxical emotion managing the conflict caused by the law and fear of rules
Tightrope Walker: Balancing differing needs. Participants are emotion managing the conflict caused between rules and feeling rules

Fear of the law drives private voices EIM

Public/Personal: Balancing support between public and personal domains

Visible vs. invisible symptoms = genuine and tangibility

Public/Private/3rd sector: Perceptions

SME's, Third Sector, Government/Welfare

Notes (bottom right corner): SmartDraw Academic Edition

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In trying to understand the source of conflict for managers I drew on a technique called ‘conflict clouds’ which originate from a technique used in identifying constraints to organisational performance at the system/process level (Dettmer, 1999).

By articulating what managers ‘need’ to do in their role, next to what they ‘want’ to do in their role, it becomes apparent where conflict arises. In the above example, managers cannot be simultaneously providing value to the organisation whilst being considerate of the welfare of the employee, which leads to feelings of ambivalence between and within their social roles.