Our mental models of mental health are off-base

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Not so long ago, mental health was considered a strictly personal matter that should be kept out of the workplace. Thankfully, times–and organizational priorities–have changed. Increasingly, managers are

expected to be mindful of how their decisions and actions will affect employees' emotional well-being.

But the rapid removal of the stigma against mental health conversations at work has revealed how ill-equipped most organizations are to engage this difficult topic. And it's not for lack of listening to the experts. The academic research on mental health in the workplace exhibits a consistent pattern of conceptual confusion, according to Matthew Cronin, professor of management at George Mason University School of Business.

Cronin recently co-authored an interdisciplinary review of 556 scholarly articles on workplace mental health, drawn from disparate fields including management and psychiatry. His collaborators were Emily H. Rosado-Solomon of Babson College, and Jaclyn Koopman and Wyatt Lee of Auburn University.

Cronin's paper focuses on two significant blind spots in the research literature that both reflect and reinforce flawed mental models of mental health.

First, the terms "mental health" and "mental illness" are often used interchangeably. However, they may refer to radically different realities for sufferers. Mental health is a near-universal concern–as an indication, consider that up to 30 percent of men and 40 percent of women will experience a period of depression before the age of 65. On the other hand, mental illness is a clinical phenomenon that affects fewer people far more profoundly.

The lifting of the stigma around mental health may not always apply to incidents of mental illness, which are often viewed through an ableist lens.

To be sure, the two can be closely associated. A serious mental illness will almost always result in poor mental health, for example. But mental health can also decline for a host of reasons totally unrelated to mental illness (the breakup of a romantic relationship, the physical illness of oneself or a loved one, etc.).

Why is it important for managers to know the difference between mental health and mental illness? "Part of the manager's job is to understand, 'what can I solve and what can't I?'" Cronin says. "When do I say, 'Listen, this goes beyond what I can do'?"

By way of example, Cronin describes a hypothetical scenario of an employee showing up to work intoxicated. "If that's because you're 22 and stupid, that's got a different solution than if you're 40 and long-term and serious in your alcoholism. 'I need you to de-stress yourself because this is a tough time' is different than saying 'I need you to manage the genetic anxiety that you have as part of your family's predisposition'."

The second blind spot relates to how physical and mental health are treated in the research literature. Unlike threats to physical well-being, mental health tends to be addressed reactively, with researchers focused on how to alleviate, rather than prevent, poor mental health. Proactive methods based on principles of good "mental hygiene" remain a surprisingly underexplored area.

This is not due to the immaturity of the field. As the paper explains, research into mental and physical health at work have roughly the same historical origin point (the post-World War I period).

Physical safety has improved, Cronin says. "I work with these large-scale construction projects, and they do not sacrifice [physical] safety. It's safety first, then quality, then schedule…It is time to redouble our efforts in the mental health realm so that organizations can treat mental

hazard with the same care that construction does for physical hazard."

How can researchers resolve these blind spots, so that organizations can be more sophisticated about their employees' well-being? Regarding blind spot number one (the conflation of mental health with mental illness), Cronin recommends closer alignment between management scholarship and medical knowledge. "One of the frustrating things is that we, as a field, did not look to clinicians and say, 'Okay, well, what should we be doing?' Instead, we just built it ourselves and didn't pay a lot of heed," he states.

Fixing blind spot number two (the double standard between physical and mental health) would require researchers to adjust to the inherent tensions of the mental health field.

"A pain-free environment is just not feasible. That's not how it works…We hear a lot about psychological safety, for example–we want people to feel like they can make mistakes and not be lambasted for it–but that also means I should be able to say things you don't want to hear," Cronin says.

Given these nuances, researchers should also look at combining individualized and standardized approaches, instead of treating isolated interventions (such as mindfulness training) as quick fixes.

"Between the one-size-fits-all answer–'Hey, you guys go do yoga'–and a very detailed, complicated plan for you and you alone, there's a whole lot of room," Cronin advises.

The findings are published in the journal *Academy of Management Annals*.

More information: Emily H. Rosado-Solomon et al, Mental Health

and Mental Illness in Organizations: A Review, Comparison, and Extension, *Academy of Management Annals* (2023). DOI: 10.5465/annals.2021.0211