

Improving Workplace Mental Health with Psychoeducation-based Manager Training

by

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Dedication

This paper is dedicated to all those who have found themselves seeking permission to be vulnerable. My wish for this project and training is that it allows you to uncover the strength that is your vulnerability.

Abstract

Research shows that working aged individuals are statistically more forthcoming with regard to their mental health within the last decade. Unfortunately, the same research also highlights the gap in addressing mental wellbeing in the workplace. Following the Covid-19 pandemic, the conversation of mental health has taken a permanent place in the media, especially among the millennial and Z generations. With these age groups making up the bulk of our workforce in the decades to follow, it is imperative that businesses and organizations follow suit to remain relevant and desirable employment opportunities. Through manager trainings that are delivered in person, grounded in connection, and focused on psychoeducation, we can reduce stigma surrounding mental health through vulnerable and courageous leadership and increase communication and wellbeing across businesses and organizations.

Keywords: psychoeducation, leadership, mental health, stigma, resource utilization

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Chapter 1: Introduction

It is estimated that the average person spends forty hours a week at their workplace. For many working aged individuals, the time spent with colleagues and leaders far outweighs the time spent with family and friends. Many millennial aged folks find that their work community makes up a considerable portion of their social circle. Throughout the last century we have seen a sizeable cultural shift in North America, regarding how society views and communicates about mental health and how it is treated in the workplace. Research points to the effect that burnout and poor mental health can have on employee wellness, productivity, and associated costs. Now, businesses and organizations have increased efforts to reduce stigma surrounding mental health and increase employee resources such as benefits programs (Coduti et al., 2016). With regard to increasing costs, employee mental health can be directly correlated to productivity loss and an increase in disability or medical leaves (Dimoff & Kelloway, 2019). In recent years, I have seen the business sector catch up to society's prioritization of mental health, placing emphasis both on employee benefits and resources and supporting mental health conversations in the workplace. However, even with an increase in access to resources, improved health benefits plans and workplace programs, there continues to be a gap when it comes to the education and training leaders. Further, according to the World Health Organization, the most effective way to implement suicide prevention and awareness is to create change within all sectors of society, including business and labour (2021).

In this capstone project, I will present research findings to support my argument that psychoeducation can be an effective method of increasing wellness in the workplace, specifically by educating people leaders. Psychoeducation can be delivered in a variety of forms. For example, it can look like classroom or webinar delivered education around mental health, a

doctor explaining the root of mental health symptoms and benefits of medication to a patient, peer to peer education, or even a tv show that depicts facts and busts myths around mental illness (Australian Institute of Professional Counsellors, 2014). All of these examples share a common goal of reducing stigma surrounding mental illness, which is one of the reasons for popularization of psychoeducation in the 20th century (Australian Institute of Professional Counsellors, 2014). Providing managers with psychoeducation-based training can create a culture of openness and improve psychological safety, ultimately providing a greater impact on wellbeing and productivity.

Purpose Statement

In this paper, I will examine the culture and stigma surrounding mental health in the workplace, and the opportunity to address this issue through leadership training for managers that is rooted in psychoeducation. Further, I will outline the impact that we can have on driving change within our society's mental health crisis by implementing change within the business sector. Additionally, I will argue that further than large scale shifts in company culture and increasing employee benefits, the true driver of change lies in manager training and their attunement to the needs of the employees they lead. Using psychoeducation-based leadership training, we can directly reduce stigma and increase accessibility to resources by implementing change directly within the employee-manager relationship. I will support this purpose statement by presenting the following:

- 1) A literature review outlining statistics on mental health in the North American workplace and an outline of the advances in mental health awareness across generations X to Z.

- 2) A deeper dive into the history of psychoeducation, its use as a modality of therapy and its' position in reducing stigma in workplace mental health.
- 3) An outline of the role of the leader in creating psychologically safe work environments and reducing stigma at a systemic level.
- 4) A framework for a proposed manager training, along with suggestions on next steps and building further education offerings. This training will be in person, focused on attunement and rooted in psychoeducation.

Theoretical and Conceptual Frameworks

This paper centers around the importance of including psychoeducation in training for managers. Many therapeutic modalities include or have views on psychoeducation, and as Marlow et al. share, “it is neither exclusively behavioral, cognitive, nor affective in its focus” (2017, para. 1). In turn, psychoeducation as a modality itself draws on the work of many theoretical frameworks and is not based off any one school of thought. In this paper, I will examine the research supporting psychoeducation through various theoretical frameworks including Cognitive, Behavioural and Systemic. Further, I will take on lenses of Cognitive-Behavioural theories and intersectionality.

Contributions to the Field

As society shifts toward a more inclusive culture of acceptance around mental health, a gap remains in the way that managers and leaders handle mental illness in the workplace. Counsellors are witnesses to a person's entire human experience and their intersectional location in the world. Arguably, a major part of clients' life experience occurs in their work environment. As a member of society, one commonality among most people is their participation in an organization, whether it is employment focused or other.

The research discussed in this paper draws a connection between the success of businesses and organizations with their ability to support their employees as a whole person. In order to see continued positive change in the stigma reduction around mental health, there needs to be continued movement on a systemic level. In my opinion, this goes far beyond improved wellness platforms and benefits packages for employees. In any organization, change is driven by people leaders and follows a 'trickle-down' effect. Therefore, in order to have the greatest impact and create lasting change in the collective, it must begin with direct shifts in the mindset of leaders.

My desired outcome for this project is that it can add to the unfolding conversation surrounding mental health in the workplace, ultimately acting as a conversation starter, a reason for the reader to pause and reflect, and act as a small cog in the wheel that continues to propel this conversation forward. Further, the purpose of the project is to provide a framework for an initial mental health training for managers, that is rooted in psychoeducation as well as future considerations for building on trainings, to support maintenance inspire continued change at the systemic level.

Reflectivity and Positionality Statements

As a member of the millennial generation, I have had the position to observe the shift in perspectives regarding mental health between the generations on either side of me. As a person with a depressive disorder, growing up with Generation X parents had its difficulties when it came to their unconscious biases surrounding mental health, a view that had been passed down from their parents in the boomer generation. Further, my position as an educator, childcare worker and retail manager have allowed me to witness the shift in mental health competency that is being driven by the younger generations.

My personal position to this work is not only as a manager but also as an employee who is experienced in accessing workplace mental health offerings. As a young adult, I was not armed with the skillset to communicate my mental health needs to the leaders and role models in my life. This included parents, teachers, coaches, university professors, and managers. I have since learned that vulnerability is a fine-tuned skill that is strengthened only by leaning into it. Upon strengthening my own self-awareness and vulnerability, I have developed skills in asking for help, and leaning into vulnerability regardless of what position I am in. However, being vulnerable from the position of a leader is exceptionally difficult, as society has created a picture of what a manager should look like.

After a substantial amount of self-reflection and development in my career, I found that leading from a position of vulnerability and outwardly identifying with my mental health needs has allowed me to hold space for my peers and direct reports, giving them permission to do the same. In this I have witnessed the expedited growth among my teams, reflected in increased productivity, improved attendance, and stronger communication. Further, I have experienced leadership by managers who struggle to acknowledge their own vulnerability or lack the courage to ask for support when they are in need. The impact of this leadership can be detrimental to developing a safe and productive work environment. I have experienced the strain that this rigid leadership puts on teams, unsurprisingly resulting in lower productivity. Further, I have witnessed the damage caused by leaders who are unable to have tough conversations with their teams about mental health. The impact of this can be catastrophic because whether or not they intend to be, a manager's reaction plays a consequential role in an employee's willingness to ask for or accept support.

After prying the door open, my goal is to continue in my own self development on vulnerability and continue to nudge that door open for everyone around me. I believe that we can achieve this for all leaders by offering in person training that brings together a) the awareness of being in touch with our own mental health needs and b) the education needed to understand what crisis looks like and how to effectively intervene with psychological first aid.

As someone who makes excellent use of extended health benefits and workplace accommodations for mental health (stress leaves, Employee Assistance Programs, counselling benefits), the breadth of my experience in this area has allowed me to speak from multiple lenses throughout this paper. Having eight years of experience both as a manager and as an employee of a large organization has provided me with valuable insight and unique considerations and ultimately is what drew me to this topic. In this paper, I have drawn from my personal experience to guide my research question of what can be done to address mental health in the workplace and create safer, more inclusive work communities.

Having lived experience with shame about mental health and feeling like an inadequate employee, this work is deeply meaningful to me. One lesson that I continue to learn time and again throughout my career is in the recognition of my needs and the ability to ask for support. I believe this lies both in the development of my self-awareness, and also in the accessibility of these conversations, an environment created by leaders and managers. The most effective I have ever felt as a manager has been in the quiet moments of courage, that take place specifically between the moment I drop my ego and the moment that I ask for help. It is a skill that I have by no means mastered and requires practice and choice in each and every moment. I have seen few leaders demonstrate the power of vulnerability as it pertains to mental health, be it related to

stress and burnout, anxiety, or depression. However, in these rare moments, I have experienced the most effective leadership and utmost respect for my leaders.

It is, however, important to acknowledge that while the consideration of giving employees permission to “ask for what you need” is a beautiful thought, it can be extremely challenging to do so. Further, it would be an incredibly large undertaking to expect managers to meet the individual needs of each employee with regard to their mental health. Throughout the findings laid out in chapter two, it will become clear to the reader that a sensible place to start lies with effective training for managers that focus on attunement, vulnerability, and intentional listening. We certainly cannot expect our managers to act as therapists, nor should we. However, by inviting employees to be themselves and assume the position of supporting ‘whole person development,’ we also invite the parts of people that require support. Additionally, in the same way that managers lead, coach, and inspire employees to having breakthroughs, we also assume the risk of employees having breakdowns. When we invite those parts in, we need to be prepared to support them. Through psychoeducation, we can arm our people leaders with the knowledge of psychological first aid and inspire the courage to be in the real conversation with their teams, even when it is vulnerable.

Definition of Terms

Acceptance and Commitment Therapy (ACT)

Acceptance and commitment therapy is an intervention that focuses on self-management, accepting difficulties and a focus on personal values. (O’Donoghue et al., 2018).

Boomer Generation

Includes people born between the years of 1946 and 1964. As of 2023, this generation includes the age group of 59 years old to 77 years old (American Psychological Association, 2018).

Burnout

A term coined in the 1970s by American Psychologist Herbert Freudenberger. Defined as having three parts: emotional exhaustion, depersonalization, and decreased sense of accomplishment (Nagowski, E. & Nagowski, A., 2019).

Cognitive Behavioural Therapy (CBT)

A therapeutic intervention that assumes that psychological problems result from unhelpful ways of thinking and behaviours, where focus is on challenging the unhelpful thought patterns. Further, CBT is considered to be one of the most effective therapeutic interventions and is backed by empirical evidence (American Psychological Association 2018).

Disability Harassment

The *Canadian Human Rights Act* (1998) protects Canadian employees against discrimination due to disability, including those defined by mental health and addictions. In a workplace setting, this could look like a manager withholding certain tasks or responsibilities from an employee who has just returned from a stress leave or medical leave. For example, a manager refuses to allow an employee to take on meetings with specific clients when they return from stress leave, even though the employee has communicated that they are ready, and/or their doctors note, or return-to-work (RTW) plan specifies that they are able. Often, the withholding of duties can come from a managers' intention to make transitions easier on a returning employee. However, the impact of disability harassment can cause employees to question their own readiness, or worthiness at work.

Generation X

Includes people born between the years of 1965 and 1980. As of 2023, this generation includes the age group of 43 years old to 58 years old (American Psychological Association, 2018).

Generation Z

Includes people born between the years of 1997 and 2012. As of 2023, this generation includes the age group of 11 years old to 26 years old (American Psychological Association, 2018).

Intersectionality

A term coined by Kimberle Crenshaw (2017), defined as a lens for analyzing how a person's various identities intersect, creating both power and privilege.

Leader

In this paper, I will use the words 'manager' and 'leader' interchangeably, to refer to the employees that have direct reports and are responsible for managing others.

Mental Health Stigma

Mental health stigma is understood as negative or discriminatory attitudes against an individual or group, based on perceived characteristics, such as mental illness (American Psychiatric Association, 2020).

Institutional Stigma. Occurs when prejudices are embodied by laws or institutions (American Psychiatric Association, 2020).

Public Stigma. Refers specifically to discriminatory attitudes that others, or the general public, have toward people with mental illness. These attitudes can be subtle or obvious (American Psychiatric Association, 2020).

Self-Stigma. Refers to the negative attitudes or internalized shame that people with mental illness have toward themselves. (American Psychiatric Association, 2020).

Millennial Generation

Includes people born between the years of 1981 and 1996. As of 2023, this generation includes the age group of 27 years old to 42 years old (American Psychological Association, 2018).

Psychoeducation

This term was originally coined by North American researcher C. M. Anderson in the 1980's to support clients with schizophrenia by increasing their understanding of their condition (Bauml, et al., 2006). Within the context of this paper, psychoeducation can be defined simply as providing information about mental illness, which can occur in a range of formats and settings.

Active Psychoeducation. Includes the active involvement of a therapist with the client or learner during the process, including clarification and interaction with the new information (Sarkhel et al., 2020, para. 4).

Passive Psychoeducation. Wherein education materials are provided to clients via reading, audio/video materials to learn without the therapist's assistance and on their own time. (Sarkhel et al., 2020, para. 4).

Suicide Risk Assessment

The Mental Health Commission of Canada defines a suicide risk assessment as “a multifaceted process that involves learning about a person, recognizing and addressing their needs and stressors, and working with them to mobilize their strengths and supports” (2021, p. 5). The purpose of a risk assessment is to assess for potential risks of suicidality. There are several common risk assessment tools used in healthcare today, some which require mental

health professionals, such as the Beck Scale for Suicide Ideation and others that do not, such as the Reasons for Living Inventory (Mental Health Commission of Canada & Canadian Patient Safety Institute, 2021).

Outline of Chapters

In the chapter that follows, I will provide a literature review to summarize relevant research on psychoeducation and workplace mental health. First, I will outline the history of psychoeducation and its position across various therapeutic modalities. Next, I will summarize recent data outlining the current state of mental health in the workplace and how it is perceived across different generations within the workforce. Additionally, I will cover the importance of integrating psychoeducation on mental health into the workplace. Further, I will outline the role of the leader and the importance of authentic manager relationships in supporting mental health. Last, I will examine existing mental health training for managers that have been reported on within the last ten years. Finally, in the third and final chapter of this paper I will include a discussion on findings that support a need for psychoeducational training and provide an outline for a proposed introductory manager training that includes risk assessment. Additionally, I will include future considerations, ethical considerations, and suggestions for further training.

Chapter 2: Literature Review

The following sections contain research compiled to assess the effectiveness of psychoeducation-based mental health training for leaders. The literature review starts with a discussion on the importance of psychoeducation and therapeutic modalities, followed by relevance for mental health, attitude shifts across generations, psychoeducation and workplace mental health, the role of the leader and conclude with research on existing workplace mental health training.

Psychoeducation and Therapeutic Modalities

The term psychoeducation was popularized in North America by researcher C. M. Anderson in the 1980's to support clients with schizophrenia by increasing their understanding of the condition (Bauml, et al., 2006). Anderson placed additional importance on psychoeducation for the families of patients with mental illness as it contributes to the psychosocial wellness of the patient's environment (Bauml, et al., 2006). Psychoeducation has gained multiple definitions throughout the last decade. Ekhtiari et al. define psychoeducation as "an intervention with systematic, structured, and didactic knowledge transfer for an illness and its' treatment, integrating emotional and motivational aspects to enable patients to cope with the illness and to improve its treatment adherence and efficacy" (2017, para. 1). Psychoeducation as a tool can take many forms and be delivered within many settings, in both group and individual formats. Further, psychoeducation may occur within the family counselling format, as introduced by Anderson in the initial use of psychoeducation for clients (Sarkhel et al., 2020). Dating back to Anderson's theories in the 1980's, psychoeducation for the support circle of patients aids in reducing stigma and improving coping. In one of her first published articles, Anderson et al. hypothesized that using a psychoeducation-based model would aid in supporting the families of

those with psychiatric disorders, by improving their knowledge about the illness, confidence to support and ability to react constructively to the patient (Bauml, et al., 2006). As such, support for patients and families is at the heart of the use of psychoeducation as we can better equip the public with not only understanding mental illness and reducing stigma, but also recognizing the warning signs, increasing allyship and appropriate community response (AIPC, 2014). Further, many efforts in psychoeducation exist as educational programs for caregivers and friends, aimed at increasing knowledge to reduce stigma and support patients suffering from mental illness (AIPC, 2014). How then, should the work environment be any different?

As outlined by well-known trauma researcher Bessel van der Kolk (2014), healing begins with the understanding of our own human reality. Combining elements of education and cognitive behavioural therapy, psychoeducation is used across several modalities with the common goal of increasing knowledge and reducing stigma (Sarkhel et al., 2020). As the name suggests, psychoeducation has roots in both education and psychology (Marlow et. al., 2017). Within the context of the education system, teacher education models have adapted the psycho-educational model in training future educators. Educators who support psychoeducational models believe that before a teacher can provide support to a student with behavioural or socio-emotional challenges, they first need to establish a relationship and educate themselves on what is occurring for the child that might be producing said behaviours (Marlow et. al., 2017). Further, students are supported in understanding themselves, their behaviours, and their position in the world through the psychoeducational model (Marlow et al., 2017). Under this model, teachers view education and modeling as the antidote to disruptive behaviour, rather than punishment or consequence (Marlow et al., 2017). For example, rather than keeping a child in at recess as a result of their disruptive behaviour in class, a teacher practicing the psychoeducational model

would create the means for the child to learn what acceptable behaviour could be replaced instead (Marlow et al., 2017). Further, psychoeducation within the educational framework can look like providing parents with education on their child's specific learning or behavioural needs.

Cognitive Behavioural Therapy

Many therapeutic modalities are strengthened when practiced in conjunction with psychoeducation. In cognitive behavioural therapy (CBT) for example, psychoeducation can be used to strengthen the clients' understanding of their thought patterns which in turn supports their challenging of negative or incorrect beliefs, a common component of CBT (Bernal et al., 2019). Further, research shows that psychoeducation for the friends and families of patients receiving CBT can lead to a more positive outcome, especially for parents who are supporting children and adolescents with mood disorders (Bernal et al., 2019). In a Canadian study that compared the effectiveness of CBT alone versus combining parent psychoeducation with CBT for adolescents with depression, results found that the addition of parent psychoeducation decreased depressive symptoms and had a positive effect on family systems (Bernal et al., 2019). CBT-based psychoeducation groups can assist clients with deconstructing perceived biases of their illness and accept the possibility of recovery (Bernal et al., 2019). In turn, group delivery formats can further decrease negative self-stigma as group members view their individual battles as a shared experience rather than being alone in it (Bernal et al., 2019).

Trauma Therapies

Psychoeducation has become an effective tool in several therapeutic modalities and is particularly effective within the treatment of trauma, when delivered appropriately for each individual client. Through psychoeducation, therapists can provide clients with an understanding of how traumatic experiences have affected them and assist in the recognition and treatment of

post-traumatic stress symptoms. Within the context of trauma therapy, psychoeducation is often delivered verbally from the therapist to the client and at the beginning of treatment (Briere & Scott, 2014). According to Briere and Scott, trauma therapists often cover several major topics in psychoeducation about trauma, which include common myths, prevalence, typical human response, and the reframing of symptoms (2014). Further, Briere and Scott mention the inclusion of human behaviour in some trauma-specific psychoeducation, where clinicians might use the information to explain a perpetrators possible motive for their behaviour that led to the trauma for the victim or client (2014). Lastly and of great importance, creating client safety plans is also considered a psychoeducational practice as the therapist provides education on available resources. For example, this would be important in supporting clients at risk of experiencing ongoing trauma such as those experiencing interpersonal violence (Briere & Scott, 2014).

Acceptance and Commitment Therapy

Acceptance and commitment therapy (ACT) can be strengthened when used in conjunction with psychoeducation. ACT traditionally focuses on increasing mindfulness as a base for creating self-driven change, accepting challenges, and supporting clients to live into their values (O'Donoghue et al, 2018). O'Donoghue et al. comprised a study that examines the effectiveness of combining ACT with psychoeducation for the treatment of bipolar patients (2018). Their research found that combining group-delivered psychoeducation with group-delivered acceptance and commitment therapy has been proven effective (O'Donoghue et al, 2018). Specifically, psychoeducation and ACT have become a common therapeutic combination in treating bipolar disorder, with the goal of assisting patients in understanding their disorder, therefore increasing coping skills and empowering patients to make informed decisions (O'Donoghue et al., 2018). As mentioned above, psychoeducation for families of patients with

psychological disorders is crucial, and O'Donoghue et al. name the specific importance for families of patients with bipolar disorder (2018). One important callout that O'Donoghue et al. make is the importance of creating inclusive psychoeducation, catered to the individual client and sensitive to their beliefs and experiences with their disorder (2018). Even when delivered in a group setting, it is imperative that psychoeducation remain inclusive and digestible for the target audience and delivered in a format that supports the learner, or client. The goal is for clients to integrate the information and create congruence between their personal experience and the educational facts.

Across all therapeutic modalities, a common tool for integrating psychoeducation into therapeutic treatment is in providing homework to clients. This can take the form of psychoeducational workshops, handouts, or journal prompts with follow ups at the next counselling session. As defined by Sarkhel et al (2020), these examples would be considered “passive psychoeducation” within which psychoeducational materials are provided to the client and/or family for them to study on their own time (para. 11). In contrast, “active psychoeducation” occurs when a therapist delivers psychoeducation directly to the client and assists with the integration and understanding of the information (Sarkhel et al., 2020, para. 11). Thus, it should be noted that psychoeducational handouts and homework are most impactful in conjunction with the processing that occurs in therapy (Briere & Scott, 2014).

In general, research shows that the use of psychoeducation can strengthen the impact of therapeutic modalities, especially within CBT, ACT, and trauma specific therapies. It is a tool that assists in providing insight to patients managing illness and is backed by research in the effectiveness of supporting relapse-prevention in addictions (Sarkhel et. al, 2020). Specifically, psychoeducational strategies aid in reducing stigma and negative self-perceptions and increasing

empathy and connection among patients and their families. In its' most basic effort, psychoeducation can inspire self-awareness in clients by increasing their understanding of their experience.

Relevance for Mental Health Today

On average, one in five Canadians will experience mental illness in their lifetime. (Tremblay et. al., 2021). With twenty percent of the population likely to experience depression or anxiety and a whopping seventy percent likely to experience trauma, the importance of the education of humankind and relevance of this material is clearly implied (Tremblay et. al., 2021). Themes of balance, mental hygiene and support seeking are at the forefront of our culture and can be seen in the growth of the psychology field. Originally introduced in 1922, the “mental hygiene movement” has gained traction in the early 20th century as the millennial and Z generations have catapulted the importance of self-help, mental wellness, and personal development (Sarkhel et. al., 2020, para. 1). Mental hygiene refers to fostering cognitive wellness, by attending to the needs of the brain or mind in the same way that we do the body (Tremblay et. al., 2021). It can also be seen as a preventative health measure for mental illness, much like the way that eating healthy foods and exercising is a preventative measure in heart health (Tremblay et. al., 2021). While recent data depicts Generation Z as reporting the highest stress levels, general stress and mental health issues have increased across the generations (American Psychological Association, 2018).

In this new era of self-awareness that is the 21st century, the fascination with human behaviour can be seen in the media and literature, with authors like Gabor Maté and Bessel van der Kolk filling the shelves of readers, not limited to those with an educational background in psychology. In fact, much of the North American population has taken interest in self-help

culture and the conversation around trauma and mental health have grown exponentially. From podcasts and audiobooks to social media accounts and television, there are countless media forms available that focus on improving relationships, cleaning up communication, and general mental wellness. Relatedly, we have seen a global fixation with tragedy and unusual human behaviour, as demonstrated by the growing interest in true crime. In fact, as of 2021, nearly every podcast listed in the top 100 are related to human behaviour in some way, be it relationships, sexuality, or a true crime podcast (Winn, 2021). With so much of the population seeking an understanding in human behaviour, trauma and mental health, the conversations begin to show up in every facet of our lives, including the workplace.

Attitude Shifts Across Generations

Even when not explicitly defined, much of our culture revolves around wellbeing and has an underlying interest in human behaviour. This is especially true for working-age individuals, which for the purpose of this paper includes Generation X, millennials, and Generation Z. Research indicates that Generation Z are more invested, aware, and outspoken regarding their mental health (American Psychological Association, 2018). In fact, The American Psychological Association (APA) finds that Gen Z are more likely than any other generation to seek support for mental health (American Psychological Association, 2018, p. 4). Further, the same survey reports a higher percentage of mental health diagnoses for Gen Z (2018). Compared to previous generations, they are more likely to report a diagnosis of anxiety or depression and generally have a higher percentage of diagnosed mental health issues and behavioural disorders (American Psychological Association, 2018). Of course, this can be partially attributed to Gen Z's willingness to seek professional help, therefore opening the door to possible diagnoses, and increasing the statistics purely by widening the survey pool.

The variance in the general acceptance of mental health across generations is clearly demonstrated in the APA's survey results, outlined in Figure 1.

Figure 1

Professional Help Seeking Across Generations



(American Psychological Association, 2018, p. 4)

As depicted in Figure 1, the APA (2018) finds that members of Gen Z are most likely to seek professional help for their mental health and more than twice as likely to seek help compared to 'older adults,' which the APA refers to as the generation before boomers (2018, p. 4). Millennials are close behind, and are only two percent less likely than Gen Z to seek professional mental health support, as outlined in Figure 1 (American Psychological Association, 2018, p. 4). Across the survey results, Generation Z and millennials are the most closely linked

in their responses around mental wellbeing. This is interesting compared to the variance between the millennial and X Generations, where the variance in Figure 1 shows that Gen X are nine percent less likely to seek professional mental health support. Of all of the generations surveyed by the APA, the largest variance in attitudes toward mental health are between millennials and Generation X.

At the time of the survey, over 90% of respondents between the ages of 15 and 21 reported feeling mentally distressed in the last month (American Psychological Association, 2018). Some possible factors for this include Gen Z's connectedness to the world and the ability to find news at their fingertips and influences from social media. Further, according to the same survey by the American Psychological Association, Gen Z are most likely to seek support for mental health, including attending counselling and speaking to a doctor (American Psychological Association, 2018). With this in mind, it is predictable that the focus on mental health culture and quality of services available will be of high importance to the Gen Z workforce, with millennials close behind.

Within the next 20 years, millennials and Gen Z will make up the bulk of our workforce and step into leadership roles previously occupied by older generations. Therefore, we can predict the emphasis on inclusion and mental wellbeing for this next generation of leaders across the workforce. Further, it is likely that businesses and organizations that are taking steps to increase psychoeducation and emotional literacy in the workplace will be more desirable for employees.

One important call out from Tremblay et al. (2021) is the fact that mental health occurs on a continuum and is not defined as the presence or absence of mental illness. Viewed on a spectrum, mental health is something that every person deals with for the entirety of their lives.

Therefore, the conversation of mental health will be ever-present and there is no one person untouchable by this topic. Be it a personal experience with trauma, a family who has been touched by a personality disorder, a teammate with social anxiety or a co-worker who deals with seasonal depression. The examples are endless and as such mental health touches everyone. With the workplace being where most people spend at least 60% of their day, the likelihood of mental health challenges showing up at work is very high and we would be remised to believe that we can keep these parts of our lives them separate. As the traction of the mental hygiene movement continues and more leadership roles are filled with members of the millennial and Gen Z generations, one can expect to see more empathetic leadership. This necessary shift is not a matter of weeding out leaders who are not emotionally attuned, but rather meeting each individual where they are and walking alongside them into an authentic, emotionally strong leadership style (Stern, 2022).

Psychoeducation and Workplace Mental Health

Traditionally, conversations of mental health in the average North American workplace have been somewhat of a taboo occurrence. However, just as the 21st century has seen a societal shift in the way we talk about mental health, there has been an increase in reported mental health issues in the workplace, and our willingness to share openly about it (Coduti et al., 2016). In support of this societal shift, the World Health Organization names the workplace as playing an important role in early intervention for mental illness (Camacho-Rubio et al., 2022). In fact, the workplace is considered an ideal place for intervention and harm reduction, according to Camacho-Rubio et al. (2022). With depression and anxiety disorders being a considerable factor for high employee absence rates, organizations would certainly benefit from creating opportunities for early intervention (Boysen et al., 2018).

Burnout

In a large business or organization, it can be difficult to create mental health support with reach to every employee. One area of mental health that is becoming less stigmatized and more freely spoken about and researched is burnout, a term first coined by Herbert Freudenberger in 1975 (Nagowski & Nagowski, 2019). As a possible precursor to mental health problems, Freudenberger defined burnout as having three parts: emotional exhaustion, depersonalization, and decreased sense of accomplishment (Nagowski, & Nagowski, 2019). An alternative definition of burnout is “a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed” (Lam et al., 2022, p. 1). From books to blogs, burnout has become less stigmatized and more frequently discussed and accommodated. Burnout has been found to prevail in “helping” jobs, such as teachers, in humanitarian aid work and as high as 52% of medical professionals (Nagowski & Nagowski, 2019, p. xiii). In their book *Burnout*, sisters Emily and Amelia Nagowski point to the research linking burnout to the negative impacts on our relationships, work, physical health, and mental health (Nagowski & Nagowski, 2019). They link burnout to the stress cycle and the activation that occurs in our stress system on a day-to-day basis (2019). Further, Nagowski and Nagowski call out the importance of not only treating the symptoms of stress with strategies like physical activity and affection, but of dealing with the root of stress itself. According to Lam et al. (2022), workplace mental health programs have historically been designed to offset burnout, which in turn promote employee productivity and decrease possible financial loss.

Resource Utilization

Alongside the societal changes mentioned above, there has been an uptick of support programs or mental health campaigns in businesses and organizations (Dimoff & Kelloway,

2019). From Olympic sport organizations to government agencies, the conversation of mental health and reducing stigmas has grown across fields. The mental well-being of employees is becoming increasingly important in the workplace and poor mental health in employees affects productivity as well as costs for employee healthcare and disability leaves (Coduti et al., 2016). Research has found that organizations who provide mental health support to employees see the return on investment through increased employee wellness and satisfaction, increased productivity levels and a decrease in costs for mental health related absences (Dimoff & Kelloway, 2019). Many organizations support employee mental health by partnering with an external organization offering employee support services, often referred to as an Employee Assistance Program (EAP). EAPs are third party organizations that provide complimentary access to short term support services, such as brief therapy, financial advising or connecting employees to local childcare options (Dimoff & Kelloway, 2019). Unfortunately, research also shows that these resources are underutilized due to a variety of reasons, including perceived stigma in the workplace and lack of awareness of available benefits and resources (Dimoff & Kelloway, 2019). In a statistic provided by Dimoff and Kelloway, research shows that less than 4% of employees in the U.S. who have access to an EAP use this service (2019). This gap in accessing resources may occur do the lack of awareness of available programs, stigma surrounding access, or the lack of manager engagement. However, when EAP's are utilized, research shows that employers receive a return of investment of up to \$6.47 for every dollar spent on EAP services per employee, out of a data pool of employees with various mental health conditions seeking counselling through their EAP (Coduti et al., 2016). Further, while it may not seem cost-effective to increase resources in order to cover for an absent employee who is on

disability leave, the cost of them working at a lower capacity is greater than the cost of having a present and healthy employee in the role (Gast et al., 2022).

These types of employee services are a growing consideration for job seekers. Comparing benefits packages across companies is a typical consideration and these may include wellness days, hours flexibility, paid sick-time and coverage for long- and short-term leaves of absence. Companies also boast varying extensive coverage for health and wellness via extended health benefits, which is typically provided in a dollar amount per clinical area, per calendar year (Dimoff & Kelloway, 2019). For example, in the Vancouver-based retail company that I will refer to as 'Business A,' the annual coverage for counselling services is \$2500.00 per calendar year. With the increase in wellness-based programs and offerings, Canadian companies have seen a decrease in employee wellness related financial loss, such as the cost of disability pay and sick leave (Dimoff & Kelloway, 2019). These costs are a major consideration to businesses, with the Centre for Addiction and Mental Health (CAMH) reporting mental illness to be one of the leading causes of paid disability in Canada, next to substance abuse (2022).

Even with a sizeable amount of annual coverage for employees to privately pursue mental healthcare, the issue at the center of the workplace for Business A is the lack of in-house support and training for employees and managers to create a more inclusive and psychologically safe environment. According to a 2019 survey of working Canadians, 75% of people reported they would not disclose mental health problems at their workplace due to stigma, fear of job-related consequences, or judgement (CAMH, 2022). There are a multitude of reasons for this, with stigma or fear of being misunderstood behind the bulk of the responses.

According to a poll from the American Psychiatric Association, one in three people would avoid help seeking for mental health due to fear of retaliation or disability harassment at

work. (Borenstein, 2020). On a positive note, from the same study, more than half of the surveyed employees reported being comfortable assisting a co-worker struggling with mental health (Borenstein, 2020). However, most of these employees also reported not knowing what resources to provide or where to turn for support within their workplace (Borenstein, 2020). Further, while genuine stigma towards mental health remains a core issue, there is also the barrier of perceived stigma by those with mental health problems and their overestimation of the negative impacts to disclosing or seeking support (Gast et al., 2022). As Gast et al. point out, research shows that while 55% of people with diagnosed depression reported an expectation of being rejected due to the mental illness, only 26% of employees actually experienced rejection. The unfortunate reality is that simply the fear of being stigmatized will deter employees from seeking support, regardless of the actual beliefs of their employer.

In cases where an employee requires time off of work for mental health, like an absence for physical injury or illness, employees can be put on short- or long-term disability leave. These leaves of absence can be paid or unpaid, depending on the employees extended health benefits or access to employment insurance and often come at a cost to the employer. Unfortunately, it is not uncommon for employers to be disincentivized by both financial factors and required workload accommodations while supporting employees returning to work from disability leave (Coduti et al., 2016). Therefore, as Coduti et al. observe, creating “psychologically healthy workplaces” is in the best interest of both the employee and employer (p. 329).

One could argue that the work environment is not or should not be the place for people to reach out for mental health support. In fairness, there should be clear boundaries established at in the workplace to protect both employees and managers from potentially harmful conversations. However, with a look at the working lifestyle of a millennial in North America, many if not the

majority of working individuals spend more time with their colleagues, peers, or managers than their innermost support circle. For example, in a retail or office atmosphere, employees spend an average of 40 hours per week with their colleagues, whereas they might spend a mere fraction of that connecting with family, friends or partners. It is unsurprising then, that the workplace is where conversations about mental health continue to occur – whether this is in an employees’ disclosure of their need for support or a manager noticing the decline of an employees’ performance and wellbeing. In a positive working relationship, a person should feel comfortable disclosing their accommodation needs to their manager as they pertain to mental health, in the same way that they might ask for an accommodation for a physical illness. In order for these conversations to be productive and so employees receive appropriate support, there is a need for psychoeducation-based training in workplace environments. One of the key impacts of psychoeducation in trauma therapy is the impact that it offers clients to not only understand their experiences but realize that they are not alone in them, which can alleviate feelings of stigmatization and open the door to healing (Briere & Scott, 2014). If we take the same idea and apply it to workplaces like Business A, the opportunity for a shared understanding and ultimately inclusion is unmeasurable.

The Role of the Leader

Manager/leader relationships are a key component in employee’s feelings of psychological safety and have a direct impact on support-seeking behaviours (Nielsen et. al, 2010). As the first point of contact for their team, managers have a direct influence on the work environment and perception of company culture. Evidence suggests that managers who lead through vulnerability, or who are in touch with their own emotions, can be more successful leaders and foster happier, healthier teams (Stern, 2022). There are various reasons that support

this hypothesis and the first is that emotionally vulnerable leaders may be more likely to acknowledge their own limitations and mistakes, creating a better learning experience and demonstrating the acceptance of asking for help (Stern, 2022). Demonstrating self-awareness and openness to feedback and growth is important for effective leadership. In her book, Carolyn Stern (2022) refers to this leadership style as “inside-out leadership” (p. 5). While being emotionally vulnerable, or as Stern says, ‘emotionally strong’ does not guarantee effective leadership, it certainly aids in reducing stigma and encourages psychological safety in the workplace. Of course, the flip side of the argument is the danger of having an emotionally immature or volatile manager, which can absolutely become damaging, hence the importance of boundaries.

In order to respond with empathy and create a truly psychologically safe environment, managers must practice boundaries, vulnerability and flex their emotional intelligence muscles, which does not come naturally to all people, or all leaders. There are and will continue to be people leaders who have climbed the managerial hierarchy, booting others out of their way, and emulating a ‘tough’ mentality. These types of leaders are commonly depicted through media and stories with the characterization of an overbearing boss, painting a picture of a to-be-feared leader (Stern, 2022). They often demonstrate the idea that vulnerability is a weakness, as depicted by Meryl Streep in *The Devil wears Prada*, or Leonardo DiCaprio in *The Wolf of Wall Street*. These characters reflect how our society has traditionally viewed the persona of a successful leader. So, it is unsurprising that the current paradigm shift feels like an uphill battle at times. Regardless of whether the idea of rigid leadership is a learned narrative or a core belief, there are many managers and people leaders who shy away from vulnerability and add to the negative stigma surrounding it. As outlined by Carolyn Stern (2022) in her book *The*

Emotionally Strong Leader, this outdated style of leadership not only impacts the wellbeing of employees but ultimately the success of the organization. Perhaps this slough of leaders is simply missing the permission to shift into a new way of being that has not been the norm in the common workplace until most prominently within the last decade (American Psychological Association, 2018). The task at hand is in continuing to rewrite the narrative of what strong leadership looks like. The argument is not that one must hold emotional vulnerability as a core value or have a mental health diagnosis in order to powerfully empathize and support others, but rather that we need to tap into the universal experience of feeling (Stern, 2022). As Carolyn Stern (2022) articulated, “Before we are employees, managers, or senior leaders, we are human” (p. 13). In the same way that a person without allergies can still recognize the signs of anaphylaxis and administer an Epi-Pen, managers do not need to experience mental health problems to be able to recognize the signs and symptoms and respond appropriately. The gap then, lies in the psychoeducation and training for leaders to support employee mental health and create a psychologically safe workplace.

Dimoff and Kelloway (2019) argue that the role of the leader in increasing utilization of mental health resources lies in the recognition of employee suffering and the encouragement of help-seeking. Beyond the benefits packages that new employees receive in onboarding; leaders are a direct access point to company provided resources and play an important role in the awareness of and accessibility of them. Further, people leaders should have the confidence and soft skills to initiate uncomfortable conversations and achieving this requires managers to tap into their own emotional self-awareness. According to Dimoff and Kelloway, the leaders’ behaviour during the support-seeking stages and in warning sign recognition have a direct impact on an employees’ likeliness to use company resources. It should be noted that today’s leaders are

tasked with higher expectations of creating inclusive environments and catering to the unique needs of teams, with more intersectional diversity than have ever been in history (Stern, 2022). The needs of each employee varies on their own intersectional experience and location in the world and the views that they bring with them.

Accommodations and Bias

On a similar note, managers need to be understanding and accepting of employee accommodations and avoiding unconscious biases around doctor-supported employee accommodation requests. One issue that tends to arise in this area is disability harassment, which can be defined as discrimination that occurs as a result of an employee's disability, including physical health, mental health, and addictions (The Canadian Human Rights Act, 1998). Discrimination, as we know, can occur in a very obvious, or very subtle manner. For example, a common example of disability harassment would be a manager withholding tasks from an employee because they "don't think they are ready," or "do not want to overload them" after the employee returns from a mental health-related leave of absence. In many cases, the effort to not overwork the returning employee stems from a caring place. However, disability harassment occurs when a manager continues to withhold role responsibilities from an employee, even after they have communicated their readiness to resume work and have provided a note from a medical professional supporting this.

Often, the managers can hold a negative perception toward an employee's accommodation request. This might occur where there is not a mutual understanding of the employee's experience and limitations, and most commonly appears around invisible illnesses or mental health needs. For example, a manager might be more understanding of an employee having an accommodation request to use a standing desk due to a back injury, then an employee

who requests to work from home one day per week to accommodate their social anxiety disorder. This specific example could be directly mitigated by offering the manager psychoeducation on why the employee with anxiety might require the accommodation and how it may in fact increase their productivity and benefit the team, and the organization. So, why is it that one can sooner empathize with physical pain, then emotional pain? One possibility is that the more commonly shared human experience is not only feeling physical pain but also acknowledging it, whereas with emotional pain and mental health, we seem to be hardwired to mask or hide our experiences. In the latter, it is unsurprising that our leaders require extra training in acquiring the necessary skills required to provide empathetic and attuned leadership.

Research on Existing Workplace Mental Health Training

Example 1: Single Day Training in Germany

Gast et al. (2022) examined the impact of a one-day mental health training for managers at a large organization in Germany and the impact that it had on employee's mental health. The training included a mix of theory, or psychoeducation, on mental illness as well as stress related issues and the impact of burnout (Gast et al.). Following the theoretical learning, the training included individual self-reflection and a group discussion to promote connection among learners (Gast et al., 2022). The training incorporated tools from solution focused brief therapy, where participants brainstormed solutions for employee scenarios and cognitive behavioural therapy, where they were asked to reflect on their thoughts and feeling around the material (Gast et al.). To draw the material all together, participants practiced attending to the mental health concerns of employees, using case studies to put their skills into practice on how to approach these issues (Gast et al.). Further, the training included roleplays of difficult manager-employee conversations regarding stress and mental health, followed by reflective teams. Important to note

is that the focus was placed both on the experience of the employee but also of the managers' experience, to increase awareness of self-efficacy for the managers in training (Gast et al.). Finally, the last component in the training was outlining a clear path to external support services available to employees, including company benefits (EAPs) and public health services.

In determining the success of the training, various factors were studied including the associated costs to mental health related absenteeism, stigma reduction as a result of education, and the managers stress related to navigating conversations around mental health with their employees (Gast et al., 2022). Through questionnaires, the impact of the training was deciphered using various scales such as the Mental Health Knowledge Schedule and the Social Distance Scale (Gast et al., 2022). The study found a clear direct correlation between knowledge-based stigma reduction and manager psychoeducation on mental health and stress (Gast et al., 2022). In the data collection phase, results on changes to manager stress levels were not clearly outlined. In addition to supporting those who report to them, psychoeducation can provide important insight to managers on managing their own expectations, emotions, and wellbeing, ultimately becoming a crucial part of self-care (Goodtherapy, 2016).

Example 2: Three Hour Leadership Training in Canada

In a study completed by Dimoff and Kelloway (2016), research showed that a single three-hour mental health training for managers had a substantial positive behavioural change for managers, which was consistent at a three-month check in following the training. The study focused on two Canadian companies, with less than 200 employees (Dimoff & Kelloway, 2016, para. 16). In each company, leaders were assigned at random into either a training group or a controlled group, and findings were collected via self-reports from both managers and employees at the respective companies (Dimoff & Kelloway, 2016.) As outlined by the authors, the training

was designed with the following goals in focus: “(a) early recognition of warning signs, (b) identification of resources, (c) appropriate engagement or action, and (d) ongoing monitoring or evaluation” (Dimoff & Kelloway, 2016, para. 13). Structured around lecture-based modules and group discussion, the training also incorporated active learning strategies such as case studies and interactive videos. Throughout the training, leaders received feedback from trainers, as well as peer to peer feedback (Dimoff & Kelloway, 2016). Further, there was a focus on early detection, not diagnosis. Thus, the learners should be able to read warning signs and point the employee in the right direction and are not encouraged to hypothesize on any type of diagnosis. To assist with this, trainers created a 20-item checklist of signs and symptoms, designed to help them tend to the unique needs of their employee. Important to note is that the checklist included only observable behaviours, such as ‘crying at work’, to remove the possibility for any bias or assumptions (Dimoff & Kelloway, 2016).

Impact was measured by examining both the leaders’ behaviour and perceptions as well as the employees/those led by them. Notably, employee behaviours had a more significant shift compared to leader behaviours as a result of this training, as demonstrated in the figures to follow. As depicted in Figure 2, the group of leaders who took part in the training, or the “experimental group” had a shift in behaviours, most notably as improved communication about mental health and resource facilitation (Dimoff & Kelloway, 2016).

Figure 2

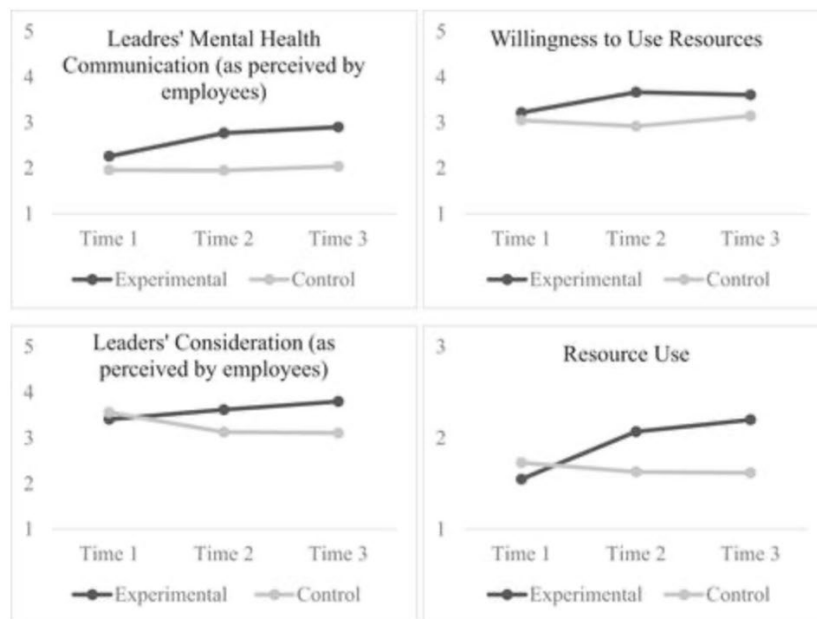
Changes in Leader Variables Over Time (Dimoff & Kelloway, 2016)



Figure 3 portrays changes to the employee variables. Most notable is the improvement of employee willingness to use resources and an uptick in resource utilization, a primary focus and proposed outcome of the training. Further, changes to leader communication and consideration were measured by the employee’s perception in addition to leader’s self-reported developments. This measurement creates an authentic lens to measure leader’s behavioural shifts and differs from previous research on manager mental health trainings, which tend to rely heavily on self-reporting evaluation tools (Dimoff & Kelloway, 2016).

Figure 3

Changes in Employee Variables Over Time (Dimoff & Kelloway, 2016)



The training focused on a primary learning outcome of increasing employee access to resources through training for leaders. Findings showed significant improvements in resource access, leadership communication around mental health and leader facilitation of mental health conversations (Dimoff & Kelloway, 2016). Further, this study saw improvements on leaders' ability to recognize warning signs in employees who might be struggling with mental health. However, it is noted that reduction of negative stigma on mental health were minimal, as were any changes to leader consideration of employee's mental health circumstances (Dimoff & Kelloway, 2016).

The need for a psychoeducation-based training was clearly demonstrated in these two training programs: the goal is not that managers need to step into the role of counsellors, rather they need to have the awareness to navigate the conversations and be armed with the knowledge to confidently support at-risk employees in the direction of support services. This goes beyond sharing an Employee Assistance Program (EAP) website with a struggling employee but being able to speak to the services and how to navigate seeking support. Where this is not possible, managers should have access to a support person that can take on this role of supporting the employee. Demonstrated in the Gast et. al. study is the importance of putting "aces in their places", as the training was led by mental health specialists and physicians instead of creating a training in-house by a learning development team. Unsurprisingly, organizations can be deterred by the cost of bringing in external experts to support with employee training, especially in a company where they have created in-house learning development teams. Historically, organizations have placed great importance on workplace safety training as a means to reduce injury and illness, ultimately lowering the costs that are related to employee accommodation requests, workers compensation claims and disability leaves (Coduti et al., 2016). The focus

however is beginning to transform from preventing illness to promoting wellness, both in physical and psychological wellbeing (Coduti et al., 2016).

While it may be challenging to conceptualize a concise and effective training that will resonate with all leaders, a psychoeducation-based model draws upon research and creates a unique access point into what might be viewed as challenging or based in personal strengths. Further, a training that stems from research and education, rather than based on ‘company values’ is more likely to be successful with a diverse learning group.

It is not uncommon for large organizations to adopt a way of speaking that depicts the company culture and creates consistency in communication. However, in some cases, this cultural jargon diminishes the power of what is being said and can be viewed as exclusive or elitist. On the contrary, one could argue that the use of a common jargon in a large organization connects employees and can guarantee the mutual understanding across all employees, regardless of location and background. In the case of Business A, the use of cultural jargon is well established and often pointed out, both by employees and clients. With that said, psychoeducation-based training eliminates the use of cultural jargon, increasing the probability of successful learning to a diverse group. In the case of mental health training and psychological first aid, I would argue that training should be provided in the same jargon that experts in the field of psychology have been working to create.

Managers do not necessarily need to be broken open and forced to feel uncomfortable emotions in order to shape them into emotionally attuned and successful people leaders. Rather, they should first and foremost be *armed* with the knowledge of what to watch out for and *trained* in how to address it, while also being given the tools to increase emotional intelligence. The training should be built on evidence-based information, delivered unambiguously, and served in

a way that connects participants on the raw experience of being human. An important consideration of mental health first aid training is establishing boundaries and practicing self-awareness so that leaders are braced to have tough conversations. Going back to the age-old advice of applying your oxygen mask first, leaders need to be aware of their own emotional needs and capacity to support others. Dan Siegel (2013), leader in mindfulness research articulates the important of presence in his book:

“Presence involves being aware of what is happening as it is happening, being receptive to our own inner mental sea, and attuning to the inner life of another person. Being present for others means we resonate with what is going on in their inner worlds, creating the essential way we feel their feelings.” (p. 56)

Case Study: Business A

In seeking relevant examples, I extended my research to focus on a large Canadian company that I have personal affiliation with, having been an employee for most of my adult life. This business, which I will refer to as “Business A” funds monthly required workplace safety training via team meetings and individual online training, typically 30 minutes in length. The cost of one of these monthly trainings for retail employees (approximately 20,000 globally) at 30 minutes per employee, is above \$200,000.00 per month, depending on employee salary. If some of these resources were allocated to mental health first aid for leaders, the impact could be extraordinary. In the following chapter, I will present a framework for a mixed-modality mental health first aid manager training, that is based in psychoeducation and designed for large businesses and organizations. This training was designed with Business A in mind and focuses on employee wellness, both physical and mental. Further, I created this training with an intent to

fill the gaps that I have personally witnessed as an employee with a mental illness. My position gives me a unique standpoint.

Chapter 3: Discussion and Applied Practices

Discussion

Studies outlined in the literature review support the argument that manager support and active participation is crucial in managing employee mental health in the workplace (Boysen et al., 2018). Among the literature explored in this paper, it is clear that mental health in the workplace is being more diligently researched alongside the growing recognition of the importance of employee wellbeing and mental health. However, with the mental hygiene movement having only gained attention within the last two decades, the body of available empirical research on the success of psychoeducation-based training is evolving at a strong pace but is ultimately still limited. Among the articles that specifically look at mental health training, such as those by Gast et al. (2022), Dimoff and Kelloway (2019) and Boysen et al. (2018), psychoeducation-based trainings for managers have a substantial impact on improving mental health in the workplace.

As leadership development coach and author Carolyn Stern (2022) puts it, emotions are the true superpower for great leadership. The hidden costs to businesses and organizations lie in the employee who is unable to ask for support, and so continues to show up for work, at a lower mental threshold and therefore produces less optimal results (Gast et al., 2022). The return on investment for training managers in mental health is greater than the current state in which barriers to seeking support and mental health stigma remains. By investing in trainings that allow leaders to tap into their own emotions, we can empower them to lead through vulnerability. In this next section, I will include a discussion about the proposed manager training, which can be found in the Appendix A at the end of this paper.

Future Considerations

Based off the findings outlined in this paper and the discussion points above, I propose a standalone workshop for managers, based in psychoeducation. The goal for this training is to create a system-level change for a specific organization, referred to in this paper as Business A. As we know, to ensure change at the system level, change needs to come from the core of the system; the primary reason for why this training focuses on implementing change directly within the employee-manager relationship. Further, consistency and maintenance, including further trainings to maintain mental health literacy, is a key component of creating lasting change.

Structure of Proposed Training

As outlined in Appendix A, the training will be organized around six learning outcomes and three themes, the first of which is focused on resource utilization. As Dimoff and Kelloway (2019) point out in their extensive research, leaders have a significant impact on resource utilization, both in their knowledge of available employee mental health resources and the encouragement to use them. Additionally, I would argue that the leaders' transparency of their own use of these resources can further encourage access. On that note, the next theme is vulnerable leadership. Both engaging with this material and committing to the work requires our leaders and learners to be vulnerable. The final and most distinct theme of the training is psychoeducation.

Psychoeducation: Integration of Materials

As Briere and Scott (2014) point out, psychoeducation is best integrated by the client when delivered in person and in context, rather than solely via media, handouts or in a book. With that said, this training will be most effective when delivered in person, using active psychoeducation and include plans for further training and check ins. As defined by Sarkhel et al

(2020), active psychoeducation refers to the process of delivering psychoeducation in person, with the therapist, or trainer assisting on integration of the material. Unfortunately, as various workplaces have begun to see the value of providing mental health support and trainings, it is common for trainings to occur through impersonal means, such as online training or via handouts. While this is certainly the most cost-effective form of dispersing information, especially in a large organization, it removes the intimacy piece required for the appropriate integration of the materials. Where online trainings fall short is in the inability for the learner interact on a human level with the material, including asking questions and inviting in any emotions or reactions that come up.

Additionally, when psychoeducation is integrated into counselling, it the therapist is able to monitor the integration and use of the information that is delivered, and confirm understanding (Briere & Scott, 2014). Similarly, it is imperative that any psychoeducation-based training material is provided in a way that feels intentional for the learner and is supported with follow up training to ensure appropriate integration of information and tools. While an interest in neuroscience-based psychoeducation has piqued the interest of the media and other influences outside of the field of psychology in the last decade, it would be irresponsible to provide training on sensitive topics, such as suicide risk assessments, and not follow up with the learners.

Therefore, the psychoeducation provided within the context of this training will be delivered in a trauma-informed manner, and in digestible terms in order for the trainees to find the material relevant and relatable. Additionally, any potentially triggering material should be delivered during in-person training sessions, for a couple of reasons. First, non-verbal body language is an extremely important cue for picking up on energetic shifts in the room. When in person, the trainers can better monitor how the material is landing and ensure a trauma-informed

delivery. Next, this format also allows for immediate feedback for the trainers, as no amount of trauma-informed preparedness can ensure that a session is perfectly designed or delivered.

Connection: The Power of Storytelling

Research shows that we create stories to make sense of our world and our experiences (Maslow et. al., 2017). Stories, as we know are also at the root of human connection. With my proposed training, the trainers will encourage storytelling, in a controlled environment, to inspire participants to connect the material to their own experience. As humans, we naturally relate new information to our own experiences and seek connection through the commonality of these experiences. In person learning creates the opportunity for real-time absorption of material, supported by discussions, learner-to-learner connection, and learner-to-trainer connection. So, if the goal is that leaders connect with their employees and tap into their own experience and vulnerability in the name of connection, we as facilitators must deliver training in the same manner.

Lesson Plans: Clear Communication

Often, organizations will adopt their own ‘lingo’ or slang. One argument could be that in a large organization, using a common language creates an equitable experience, where all members are invited to communicate in terms that their peers should understand, regardless of their background or geographical location. However, given that the field of psychology has been developing a common language to communicate about mental health for many years, I feel it is important for companies to adopt the correct terminology when offering trainings about mental health. Managers need to be comfortable having vulnerable conversations about mental health with their employees, and when they administer a risk assessment in a one on one, this needs to be appropriately documented. By offering this training within the subsystems of society (say, a

large business,) we are working to collectively reduce stigma as a whole. In order to do this, it is imperative that training within these various subsystems is not limiting the impact of the learning by filtering through company slang.

On a similar note, many large organizations create trainings in-house, which is cost effective, creates more jobs within the company and ensures that all material is regulated to meet company standards and guidelines. While there are many scenarios in which a company can create the most effective training - for example, when offering a training on product, a clothing company is not likely to outsource training from an external source, given that the company is the expert in their own products.

Ethical Considerations

In addition to mental health-related costs to organizations like business A, I would like to point out the ethical responsibility of the organization to participate in early intervention of mental illness in our society. As outlined in the literature, we know that rapid intervention is extremely important in the onset of mental health disorders (Boysen et al., 2018). Therefore, one could argue that it is within an organizations' societal and ethical responsibility to provide leaders with the psychoeducation necessary to pick up on warning signs and symptoms among their employees.

With regard to ethical considerations and the proposed training, it is imperative that psychoeducation be inclusive and tailored to the audience, or learners. This includes and is not limited to ensuring trigger warnings are clearly communicated before distributing content and minimizing the trigger where possible. For example, while the end goal might be protecting employees by empowering all managers to perform risk assessments, I would not recommend introducing the training to group of managers with an immediate lecture on suicide prevention.

This training will focus on delivering tailored, inclusive education that creates space for the intersectionality in the room. By asking learners to tap into their own lived experiences, internal biases, and core values. Moreover, creating a trauma informed training means considering that with breakthroughs, come breakdowns. It would be negligent for an organization to provide training materials that are potentially triggering to some learners, such as suicide and mental health. Delivering training in person not only protects the learners but it also protects the creators of the material, from an asset protection standpoint.

Further, it would be beneficial to enroll mental health professionals in the overseeing of this training, to support with any crises that may arise. The training will be created with a “train the trainer” mindset, meaning that the people rolling out this mental health training have been informed by professionals in the field of psychology. It is crucial that the training is rooted in science and supported by professionals.

Personal Reflection

After changing the topic for my capstone project multiple times and trying to decide what area of the field I felt most curious and passionate about, I am looking back at my work with confidence that I chose the right topic. Taking a deep dive into mental health in the workplace has allowed me to combine my work as a student counsellor with my work as a retail employee and manager, a role that I have been for the bulk of my career. As these two worlds have collided, I am left feeling more inspired to drive change in my immediate environment. I see mental health in the workplace as a gap in our field and there is no question that the importance of this is gaining traction today. I am continually inspired by Gen Z coworkers, both those who have reported to me and who have stepped into leadership roles while I have stepped away to focus on school. This topic feels endlessly relevant as most members of society are part of, or

have been part of, the workforce. Working on this project allowed me to dig into conversations about mental health with friends and family, who are not at all involved in the field of psychology but had valuable and unique perspectives on my research because they are a part of various organizations and careers.

Moving forward, I plan to continue this research and ideally secure a job that would allow me to create mental health programs for businesses and organizations, or act as a consultant to improve mental health programs for businesses. My goal would be to remain an employee of Business A and offer my expertise in a role that would support creating mental health training for managers. I plan to balance this with a counselling practice, and I'm looking forward to seeing where my career takes me, especially in this developing area of the field. I will be presenting this proposed manager training to the human resources department in my company and look forward to the conversations and opportunities that may bring. Further, I am considering doing my PsyD (after a much-needed break, some student loan recovery and a few years of working in the counselling field)!

If I were to propose a topic for a dissertation, I would conduct research on manager training and take a deep dive into the employee and manager experience at Business A, or at multiple organizations. Conducting my own research would allow me to witness firsthand the possible impact that psychoeducation-based training can have on improving mental health in the workplace. I would want to conduct studies over a minimum of 1 year, to examine the impact on a systemic level for the organization.

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Appendix A

Outline for Mental Health Leadership Training

Focus

This training will focus on three main themes:

- 1) Resources utilization
- 2) Vulnerable leadership
- 3) Psychoeducation about mental health

Table A1

Learning Outcomes

1 Burnout	<ul style="list-style-type: none"> • Understand the impact of stress and burnout on emotional wellbeing and physical health and identify the warning signs in themselves and others
2 Risk Assessments	<ul style="list-style-type: none"> • Recognize the signs and symptoms of mental health crisis (i.e., suicidality) and complete a suicide risk assessment while communicating effectively with employees about mental health concerns
3 Resource Utilization	<ul style="list-style-type: none"> • Utilize the appropriate crisis management resources and provide their employee with relevant, accessible resources in a timely manner • Identify the resources for leader support, including Asset Protection, Human Resources, EAP's and Managers
4 Connection	<ul style="list-style-type: none"> • Connection to others: Deconstructing own perceived biases, demonstrate attuned listening

	<ul style="list-style-type: none"> • Connection to self: Articulate boundaries, identify own warning signs and regulation tools/techniques
<p>5</p> <p>Inclusion & Accommodations</p>	<p>Articulate the importance of HR-supported employee accommodations and how they support the organization</p>
<p>6</p> <p>Pause, Provide Partner</p>	<p>Articulate their own responsibility/boundaries for supporting employees and identify the difference between when it is time to provide coaching or to pause, provide risk assessment and resources, partner with HR. The 3 P's: Pause, Provide, Partner</p>

Table A2

Structure of Training

Part I	Small group, facilitator led, in person training module
Part II	Learners complete e-learning, with mandatory group check in and manager check ins
Part III	Small group, facilitator led, in person training module
Ongoing	Check ins from managers/facilitators