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"Well, Now They Know": How Mental Illness Identity Management Strategies Influence Leaders' Responses

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Abstract

The high prevalence of mental illnesses and their significant social and economic impact highlight the need for organizations to provide resources to support employee well-being. Given that leaders are key in connecting employees to such resources, understanding their responses to employees with mental health issues is crucial. Using vignettes and semi-structured interviewing, we explored how 15 leaders responded to employees with mental health issues depending on the identity management (IM) strategies they used. Through an inductive approach, we identified the emotional and cognitive processes behind leaders' intentions to behave in three scenarios: when an employee shows warning signs of mental health issues, when they disclose their condition, and when they cover it up by using a personal problem as an excuse. Our findings show that a strategy that denotes transparency and active coping is more likely to lead to positive interpersonal outcomes and a higher level of social support. However, unintended stigma can turn this support into a double-edged sword, leading to negative professional outcomes. We further identified leaders' training needs regarding mental health management in the workplace. We conclude by discussing theoretical and practical implications of our findings.

Keywords: disclosure; diversity; identity management; mental illness; stigma

1. Introduction

"The worst part about having a mental illness is people expect you to behave as if you don't." So wrote Arthur Fleck in his notebook, smiling ironically as his mental health continued to deteriorate. Although he is merely a fictional character in Todd Phillips' (2019) film *Joker*, his remark portrays the plight of many individuals struggling with mental illnesses and the stigma these carry. In fact, this stigma, which can be perceived from society or through self-stigma, remains a significant barrier not only to recovery but also to employment and promotion opportunities (Follmer & Jones, 2018; B. Hogg et al., 2022).

Furthermore, mental illnesses are not uncommon. They annually affect over one billion individuals worldwide and are considered a leading cause of disability (Arias et al., 2022). In Germany alone, it has been estimated that more than 1 in 4 adults experience a mental illness each year (Jacobi et al., 2014, 2016). Among these, the most frequent disorders include anxiety and affective (e.g., depression) disorders, with prevalence rates of 15.4% and 9.8%, respectively. Mental illness shapes individuals' emotions, cognitions, and behaviors and, if left untreated, can significantly impair their ability to navigate social and work environments (American Psychiatric Association, 2013; Follmer & Jones, 2018).

Apart from its influence on individuals, mental illness also has a significant economic impact on organizations and society, with total costs estimated at 147 billion euros

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per year nationwide (Deutsche Gesellschaft für Psychiatrie und Psychotherapie, Psychosomatik und Nervenheilkunde, 2023). This includes both direct costs, arising from healthcare and social benefits, and indirect costs, such as losses in productivity due to impaired performance, absenteeism, and *presenteeism* (i.e., attending work while ill) (Arias et al., 2022; Deutsche Gesellschaft für Psychiatrie und Psychotherapie, Psychosomatik und Nervenheilkunde, 2023; B. Hogg et al., 2022; Martin et al., 2015). Furthermore, mental illness is currently the leading reason for early retirement and the second most common cause of sick leave in Germany, accounting for 17% of days of disability in 2020 (Deutsche Gesellschaft für Psychiatrie und Psychotherapie, Psychosomatik und Nervenheilkunde, 2023).

These significant costs highlight the need for organizations to develop sustainable strategies, policies, and initiatives to protect and appropriately manage mental health in the workplace. In this regard, leaders play a crucial role in the success of such policies, as they are the bridges between the organization and its employees. They have a substantial impact on the health and well-being of their teams, and their attitudes towards mental health issues can further influence the duration of employees' sick leave, their successful return to work, their willingness to use available organizational resources, and metrics such as productivity, engagement, and job satisfaction (Dimoff & Kelloway, 2019b; Martin et al., 2015; Rudolph et al., 2020). However, to appropriately manage and address employees dealing with mental illnesses, leaders must first be aware of their condition, which is not an easy task.

On the one hand, employees themselves may be unaware of their own mental health issues or may not recognize them as such (Dimoff & Kelloway, 2019b). Moreover, even if an employee displays warning signs of a mental health condition, these can often be ambiguous or inconclusive, and leaders may not adequately assess them as a health risk (Pischel et al., 2022). In this respect, approaches such as health-oriented leadership particularly emphasize the need for leaders to learn to recognize and address early warning signs in order to take appropriate health-promoting actions within their teams (Dimoff & Kelloway, 2019b; Pischel et al., 2022).

On the other hand, the highly stigmatizing nature of mental illnesses makes it difficult for employees to disclose them. For example, they may experience negative interpersonal outcomes, such as exclusion and mistreatment, and even economic consequences, such as decreased hiring, limited promotion and career development opportunities, and lower salary expectations, if their condition is known (Colella & Santuzzi, 2022; Follmer & Jones, 2017; Hennekam et al., 2020). To minimize these risks, employees must decide whether and how to disclose their condition by enacting specific identity management (IM) strategies (Follmer & Jones, 2022). These strategies may involve behaviors meant to reveal, conceal, or even hint at the existence of a mental health issue (K. P. Jones & King, 2014), and leaders need to know how to navigate them to provide help for their teams in a timely manner.

Although mental illness IM in the workplace has been recognized as a relevant subject for leaders and organizations, this area of research is still lagging behind that of other stigmatized identities, such as gender or race, and several gaps have been identified (Colella et al., 2017). First, extant research has mostly been conducted outside of the fields of management and organizational psychology, with workplace experiences and processes remaining under-researched (Elraz, 2018; Follmer & Jones, 2018). Second, many studies in the field have been carried out without a guiding theoretical framework, which has resulted in a relatively surface-level understanding of employees with mental illness (Follmer & Jones, 2018). Third, previous studies have primarily focused on the experiences and outcomes for the stigmatized employee, neglecting to account for the interpersonal consequences that IM strategies may have (Lynch & Rodell, 2018). Indeed, IM is an inherently social process, and previous studies in the area of concealable stigmatized identities suggest that the reactions and responses from the recipients of disclosure (i.e., confidants) matter greatly (Barth & Wessel, 2022; Johnson et al., 2020; K. P. Jones & King, 2014). In particular, the perspective of leaders has been underrepresented and is sorely needed to further understand how employees can effectively manage their stigmatized identities in the workplace and achieve their desired outcomes (Follmer & Jones, 2018). Finally, although other qualitative studies have investigated leaders' experiences regarding employees with mental health issues (see, for example, Jimmieson et al. (2021), Kirsh et al. (2018), Ladegaard et al. (2017), Martin et al. (2015, 2018), Porter et al. (2019), Suter et al. (2023), and Tengelin et al. (2022)), none have, to our knowledge, explicitly explored how the use of specific IM strategies can influence their responses.

Drawing on IM theories and semi-structured interviewing, this exploratory study aims to address these gaps by investigating the effects of mental illness IM strategies on leaders' perceptions. In doing so, we hope to provide insights to management research and HR practitioners to better prepare and support leaders in dealing with these challenges as they emerge. Specifically, we formulate the following overarching research question:

> **RQ1.** How do leaders respond to employees with mental health issues depending on the IM strategies they use?

2. Theoretical Background

2.1. Understanding mental illness

Mental illness is an umbrella term used to refer to all diagnosable mental health disorders that involve a "clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning" (American Psychiatric Association,

2013, p. 20) and is usually coupled with distress or difficulties navigating social, work, or other life domains (American Psychiatric Association, 2013). Different types of mental disorders exist, with the *Diagnostic and Statistical Manual of Mental Disorders*, DSM-5, listing more than 150 conditions organized into 22 diagnostic categories (Marty & Segal, 2015; McCarron, 2013).

Depending on the severity of the symptoms, the National Institute of Mental Health (NIMH) further categorizes mental illness into *any mental illness* (AMI) and *serious mental illness* (SMI). The former refers to disorders that have no interference to moderate or even severe interference in everyday life, while the latter encompasses only conditions that result in severe impairments in an individual's normal functioning (National Institute of Mental Health, 2023). In Germany, the overall 12-month prevalence of AMIs among the adult population is estimated at 27.8%, with anxiety disorders (e.g., panic disorder, generalized anxiety disorder) and unipolar depression being the most frequent, at prevalence rates of 15.4% and 8.2%, respectively (Jacobi et al., 2014, 2016).

Although each mental disorder has its own unique set of symptoms, they can be broadly classified based on how they affect individuals into physical, emotional, cognitive, and behavioral symptoms (Follmer & Jones, 2018). *Physical symptoms* affect the body and its physiological responses and could manifest, for example, as sleep disturbances, appetite changes, or muscle pain (Greden, 2003). *Emotional symptoms* affect moods and emotion regulation and could manifest as extreme mood changes, excessive nervousness, or increased irritability, among others. *Cognitive symptoms* affect mental processes of learning, reasoning, and communication. Examples include problems concentrating, difficulty understanding others, and deficits in working memory (Harvey & Bowie, 2016). Finally, *behavioral symptoms* affect how one acts and might manifest as fidgeting, pacing, avoidance of social activities, or procrastination (American Psychiatric Association, 2013; Follmer & Jones, 2018).

Even though mental illness can hinder an individual's ability to fully meet workplace demands, most conditions can be treated and managed with the assistance of a trained professional (American Psychiatric Association, 2015; Follmer & Jones, 2018). In this regard, numerous options are available and may involve a combination of psychotherapy ("talk therapy"), medication, and/or other techniques (American Psychiatric Association, 2015). However, as the specific symptoms and needs vary across disorders and individuals, there is no single answer to treating and accommodating mental illness, and each case should be analyzed on its own.

2.2. The role of the leader

Leaders play a critical role in the experiences of employees in the workplace, particularly in the case of those who have a mental illness. They can shape the workplace climate and working conditions and even inspire and encourage specific employee behaviors (Dimoff & Kelloway, 2019b; Kaluza & Junker, 2022). Furthermore, leaders are in a position where they can provide direct and indirect support by, for example, offering workplace accommodations, connecting employees to available company resources, or even encouraging them to seek out professional help, which could prevent the worsening or chronification of mental illness (Dimoff & Kelloway, 2019b; Evans-Lacko & Knapp, 2018; Pischel et al., 2023). Considering this, health-specific leadership approaches, such as Franke et al.'s (2014) *health-oriented leadership* (HoL) model, have recently been developed to explain how leaders can influence employees' (mental) health and well-being, going beyond classical leadership concepts (Arnold & Rigotti, 2021).

2.2.1. Health-oriented Leadership

The concept of *health-oriented leadership* (HoL) posits that leaders' attitudes, values, and behaviors can have a significant impact on the health and well-being of employees (Franke et al., 2014; Kaluza & Junker, 2022; Rudolph et al., 2020). Specifically, the HoL model proposes two mechanisms through which leaders can positively affect employees' well-being: promoting *self-care*, which involves the concern for one's own health, and engaging in *staff-care*, which encompasses leaders' concern for the health of their employees (Franke et al., 2014). Both mechanisms further include three components: *value*, *awareness*, and *behavior*. *Value* refers to the importance that leaders ascribe to employee health. *Awareness* alludes to leaders' ability to evaluate employees' stress levels and perceive warning signs of impending health issues. Finally, *behavior* considers engagement in health-promoting actions, such as ensuring healthy work conditions, encouraging healthy working behavior, and providing relevant information about safety and health (Franke et al., 2014).

Following the *conservation of resources* (COR) theory, individuals need resources to protect and maintain their health (see Hobfoll (1989, 2001)). These resources can be internal, which derive from one's own cognition and personal characteristics, or external, which involve social and organizational elements (e.g., social support) (Franke et al., 2014). Within this framework, HoL in itself can be understood as an external resource for employees, which can help them promote and maintain their well-being and prevent psychological and physical strain (Arnold & Rigotti, 2021; Kaluza & Junker, 2022). In fact, previous research has shown that employees experience lower levels of burnout, depression (Santa Maria et al., 2018), and strain (Franke & Felfe, 2011; Klebe et al., 2021), have fewer health complaints (Franke et al., 2014; Klug et al., 2019; Köppe et al., 2018; Santa Maria et al., 2018), better health outcomes (Franke et al., 2014; Klug et al., 2019), and report higher well-being (Santa Maria et al., 2018), when their leaders exhibit a HoL style.

Besides being a resource in themselves, leaders can also help employees by providing and connecting them with other external resources, such as relevant organizational programs, psychological support options, or temporary workplace accommodations (e.g., through reduced workload or working

hours). In this regard, leaders are in an excellent position to act as a bridge between the organization and its employees, as their formal standing allows them to be aware of existing organizational policies, programs, and initiatives and to promote and encourage their usage within their team (Dimoff & Kelloway, 2019b).

2.2.2. Recognizing warning signs

One key takeaway from the HoL model is that for leaders to offer adequate and well-timed support for struggling employees (i.e., *staff-care behavior*), they need to first be able to perceive warning signs of mental strain (i.e., *staff-care awareness*), which start to develop before the onset of a mental illness (Pischel et al., 2022, 2023). However, awareness may be muddled due to employees trying to hide their condition or, in some cases, due to employees themselves being unaware of their compromised mental health owing to emotional and cognitive strain (Dimoff & Kelloway, 2019b; Pischel et al., 2022). Moreover, even if an employee displays warning signs of an underlying mental health condition, these can often be ambiguous or inconclusive, and leaders may not adequately assess them as a potential health risk, dismissing them as poor motivation or the employee "having a bad day" (Dimoff & Kelloway, 2019a; Pischel et al., 2022).

In this regard, Dimoff and Kelloway (2019a) proposed a Signs of Struggle (SOS) checklist with five categories of behavioral warning signs that leaders should be able to perceive in a workplace setting: *expressions of distress*, *withdrawal*, *reduced attendance*, *degradations in performance*, and *extreme behaviors*. *Expressions of distress* encompass emotional behaviors, such as crying at work, mentioning problems at home, or complaining about work. *Withdrawal* behaviors include social- and work-withdrawal, such as reduced participation in social activities with coworkers or less engagement in organizational citizenship behaviors. *Reduced attendance* includes lateness and increased absenteeism, regardless of the cause. *Degradations in performance* involve changes in work quality or quantity, such as failing to meet goals or deadlines or simply not performing to one's usual standard. Finally, *extreme behavior* includes more severe distress conducts, such as neglecting personal hygiene or intending to harm oneself, which require swift intervention.

The above mentioned factors were shown to be significantly correlated with participants' self-reported strain, with the individual factors of *withdrawal*, *extreme behaviors*, and *degradations in performance* showing an even stronger connection with strain. These findings suggest that the items in these categories are both recognizable by others and representative of behaviors likely displayed by distressed employees at work (Dimoff & Kelloway, 2019a). In a similar line, a recent study conducted by Pischel et al. (2022) proposed that leaders became aware of employees' deteriorating mental health through perceived changes in performance and socioemotional behaviors and showed that leaders' awareness was significantly higher when employees displayed impairment in both areas, as opposed to impairments in the performance or socioemotional spheres only.

Given that leader awareness is crucial for taking appropriate action, we expand our main research question by incorporating the following sub-question:

> **RQ1a.** How do leaders respond to employees displaying warning signs of mental health issues?

2.3. Muddying the waters: Managing mental illness stigma

Leader awareness is, however, just one side of the coin. Given the stigma surrounding mental illness, even if a leader realizes that one of their team members is displaying signs of an emerging mental health issue, the employee could choose to downplay or even deny having a problem. As Erving Goffman (1963) noted, individuals with a concealable stigma are constantly faced with the decision "to display or not to display; to tell or not to tell; to let on or not to let on; to lie or not to lie; and in each case, to whom, how, when, and where" (p. 42). To understand the challenges behind mental illness disclosure in the workplace and what drives individuals to conceal or reveal, we must first understand *social identity theory* (SIT) and *stigma theory*.

2.3.1. Mental illness as a (concealable) social identity

According to SIT, individuals tend to categorize themselves and others as members of certain social groups that have an ascribed emotional significance or value (Tajfel & Turner, 1986). This membership, known as one's *social identity*, shapes one's sense of self and the way we perceive the world, relying on intergroup social comparison to make a distinction between the ingroup ("us") and the outgroup ("them") (Haslam, 2004; M. A. Hogg & Terry, 2000). Notably, an individual maintains multiple social identities at any given time, but the extent of their salience depends on how central an identity is to one's self-concept and specific contextual cues (Ragins, 2008; Roberts, 2005).

Some social identities may be visible to others, as is the case with race and gender, while others are not readily observable and may be concealed, such as sexual orientation and religious affiliation (Follmer et al., 2020; Lynch & Rodell, 2018; Roberts, 2005). In the case of mental illness, visibility is mainly influenced by the severity of the symptoms and the extent to which they interfere with an individual's behavior. However, even if others notice these signs, they can often be attributed to other causes, such that the mental illness itself remains hidden unless the individual chooses to disclose it (Colella & Santuzzi, 2022). In this sense, mental illness represents a complex type of concealable social identity.

The social categories to which one belongs also influence other's perceptions and subsequent treatment (M. A. Hogg & Terry, 2000), which adds to the complexity of managing a concealable identity. On the one hand, if disclosing the identity makes the individual more like their colleagues, disclosure would likely result in positive outcomes. On the other, if disclosure enhances differences between the individual and their colleagues, the individual is more likely to experience adverse outcomes, such as rejection or discrimination (Follmer et al., 2020; M. A. Hogg & Terry, 2000).

2.3.2. Mental illness and stigma

Stigma is a characteristic or attribute that "marks" the bearer as someone who deviates from what a society considers normal or desirable (Goffman, 1963; E. E. Jones et al., 1984). Link and Phelan (2001) further conceptualize stigmatization as a process that occurs in four stages: *labeling*, *stereotyping*, *separation*, and *status loss and discrimination*. In the first, people distinguish and label human differences that are deemed socially relevant. As a result, an individual is labeled as belonging to a specific, often oversimplified, social group. In the second, the labeled social group is linked to undesirable characteristics or behaviors, which results in negative stereotypes. In the third, the given social labels result in an "us vs. them" mentality, separating labeled individuals from those who consider themselves to be normal. In the fourth, the labeled individuals experience devaluation, rejection, and overall discrimination, leading to unequal outcomes. This conceptualization was later expanded by Link et al. (2004) to account for the *emotional reactions* that the stigmatization process entails. Specifically, both the stigmatizer and the stigmatized are likely to experience negative emotional responses. The former may feel "anger, irritation, anxiety, pity, and fear" (p. 513), while the latter may experience "embarrassment, shame, fear, alienation, or anger" (p. 513).

The degree to which a stigmatized identity is perceived as deviant or flawed varies across social contexts and circumstances. To explain this phenomenon, E. E. Jones et al. (1984) proposed six dimensions of stigma: *concealability*, the extent to which the identity is salient or detectable by others; *course*, how reversible is the stigmatizing condition over time; *disruptiveness*, the extent to which the condition may disturb or strain interpersonal interactions; *aesthetics*, the extent to which an identity is displeasing for others; *origin,* the extent to which the stigmatized individual is perceived as responsible for their condition; and *peril*, the extent to which others perceive the individual as a threat to their well-being, be it physical or emotional (Link et al., 2004). Although these dimensions shed some light on which aspects of an identity might be a source of stigmatization, the relevance of each dimension depends on the condition under study. Furthermore, additional dimensions might be required to explain the stigma behind specific identities (Feldman & Crandall, 2007).

In the case of mental illness, the stigmatization of individuals has been mainly ascribed to Jones et al.'s (1984) dimensions of *origin* and *peril*, plus additional dimensions of *legitimacy*, *fluctuations* (Follmer & Jones, 2018), and *rarity* (Feldman & Crandall, 2007). These dimensions set mental illness apart from other concealable identities and pose a unique set of challenges for affected individuals.

From an *origin* standpoint, a common misconception is that people with mental illness are responsible for their condition (also referred to as *onset controllability* (Colella & Santuzzi, 2022)), which leads to decreased sympathy and helping behavior, and increased discrimination (Corrigan et al., 2002; Feldman & Crandall, 2007). As a result of this perceived control, mental illnesses are often regarded as being less *legitimate* than physical conditions, underpinned by mistaken beliefs that "the condition is "all in their heads" or that individuals have the ability to "snap out of it"" (Follmer & Jones, 2018, p. 330). These legitimacy concerns are further fueled by day-to-day *fluctuations* in the severity of the symptoms, which can lead to the belief that those with mental illness are "faking it" (Follmer & Jones, 2018).

Another common misunderstanding is that individuals with mental illness are *dangerous* or unpredictable, which leads to fear and, subsequently, to higher levels of avoidance and segregation (Angermeyer & Matschinger, 2003; Corrigan et al., 2002). This perceived dangerousness can either be due to fear of potentially violent behavior or exposure to uncomfortable situations, such as interpersonal conflict (Link et al., 2004). Finally, mental illness stigma has been shown to be further predicted by the degree to which people believed a specific mental disorder to be *rare*, with uncommon conditions resulting in higher stigmatizing behaviors (Feldman & Crandall, 2007).

As we can see, stigma is rooted in others' perceptions and is therefore dependent on social cues and cultural norms (Abdullah & Brown, 2011). For example, an identity that is highly stigmatized in one country may not be stigmatized in another, as is the case with sexual minorities (see, for example, Pachankis et al. (2015)). Furthermore, being social constructs, stigmas can change over time (Ragins, 2008). Therefore, understanding the dimensions that underlie the stigmatization of mental illness in a particular social context is crucial for developing initiatives and interventions for its reduction.

2.3.3. Mental illness and IM in the workplace

Given that mental illness is a stigmatized social identity that can be concealed, individuals affected by mental illnesses must carefully decide how to manage this identity, particularly in the work context. On the one hand, disclosing their condition could result in discriminatory outcomes, both social and economic (Follmer & Jones, 2022). On the social side, they might experience exclusion, rejection, and mistreatment from their peers (Follmer & Jones, 2017). On the economic side, disclosure might result in fewer employment and promotion opportunities and decreased access to benefits (Colella & Santuzzi, 2022). On the other hand, concealing their condition could result in increased psychological stress due to the pressure to "pass as normal" and the constant fear that they could be "found out" (Pachankis, 2007; Ragins, 2008). Therefore, individuals are faced with a *disclosure dilemma*, in which they must balance these two sides to protect themselves from negative reactions from others while being authentic to themselves (Griffith & Hebl, 2002; K. P. Jones & King, 2014).

Multiple models have been proposed to explain how individuals manage and disclose their stigmatized identities (see, for example, Chaudoir and Fisher (2010), Clair et al. (2005), K. P. Jones and King (2014), Omarzu (2000),

Pachankis (2007), and Ragins (2008)). Although each explores different aspects of the disclosure process, most focus on uncovering the individual and organizational factors that drive the stigmatized individual's decision to conceal or reveal (Follmer et al., 2020) and tend to neglect the immediate interpersonal reactions to disclosure (Barth & Wessel, 2022). Furthermore, some were developed for social rather than work contexts, which can limit their applicability (K. P. Jones & King, 2014). As the present study focuses on leaders' reactions to stigma management strategies enacted by their employees, we will briefly outline three models that explicitly consider the interpersonal consequences of disclosure and stigma management.

One of the first conceptual models proposed to explain disclosure in the workplace context was developed by Clair et al. (2005). This model considers that an individual's disclosure decision is partly driven by their propensity toward risk-taking, self-monitoring, developmental stage, and motives. In addition, it considers that certain interpersonal and environmental contextual conditions further influence the decision, namely the organization's diversity climate, existing professional and industry norms, legal protections, and the relationship with and characteristics of the target of their disclosure (i.e., the confidant). Eventually, the individual's decision to reveal (i.e., disclose) or pass (i.e., conceal) results in individual and interpersonal costs and benefits, which will, in turn, influence future disclosure decisions. Although this model highlights the importance of interpersonal outcomes within the disclosure process, it does not explore specific constructs.

Next, we consider Chaudoir and Fisher's (2010) *disclosure processes model* (DPM). Distinct from prior models, the DPM aims to explain when and why disclosure might be beneficial and conceptualizes disclosure as a single process that involves decision-making and outcome processes. Within the decision-making process, an individual's decision to disclose will be influenced by either approach- (e.g., to pursue positive outcomes) or avoidance-focused goals (e.g., to prevent negative outcomes). These goals will then shape both the content of the disclosure, in terms of depth, breadth, duration, and emotional content, and the reaction of the confidant, which can be supportive or unsupportive. Within the outcome process, the model proposes three types of mediating processes to explain how the disclosure event impacts long-term outcomes: by alleviating the individual's stress due to the concealment of their condition, by allowing the individual to garner social support, and by impacting the social context and the way people interact with one another. Finally, the authors posit that the disclosure experience will influence individual outcomes (e.g., psychological, behavioral, and health effects), dyadic outcomes (e.g., liking, intimacy, and trust), and social contextual outcomes (e.g., cultural stigma and norms for disclosure) in the long term, shaping future disclosure experiences. In the context of our study, one of the drawbacks of the DPM is that it does not consider the use of specific strategies for concealing or disclosing a stigmatized identity but instead focuses on the content of the disclosure itself. Furthermore, unlike the model developed by Clair et al. (2005), the DPM was not explicitly developed for the workplace setting. However, this model provides valuable insights into how stigmatized individuals can influence the confidant's reactions through disclosure and distinctly explores outcomes at the dyadic level.

The third and final model we consider is Jones and King's (2014) *multilevel model of workplace concealable stigma management*, which conceptualizes IM as a phenomenon at a between-person and within-person level. The between-person level considers behavioral averages, tendencies, and accumulation, while the within-person level varies depending on specific situational characteristics. At the latter, each time an individual with a concealable stigma interacts with someone else at work, they make decisions regarding the management of their identity. Their disclosure behavior will be primarily predicted by the level of acceptance they anticipate from the confidant. Depending on this, they then must choose the extent of their disclosure, that is, how much information they will disclose and which strategies they will use to enact their decision. Afterward, they experience both individual outcomes, such as changes in their psychological and physical well-being, and social outcomes, such as changes in helping behavior from others. The model further proposes three boundary conditions that influence the outcomes of a disclosure decision: the confidant's reaction, the timing of disclosure, and the visibility of the stigma. Firstly, the degree to which a confidant's reaction is accepting or supportive will impact the well-being of the discloser and will influence future decisions to disclose. The reaction of the confidant is further influenced by the timing of the disclosure, with disclosures that happen later in the relationship generally resulting in more positive responses. Finally, the degree of visibility of the stigma will influence disclosure outcomes, with more evident stigmas resulting in decreased benefits from revealing and increased damage from concealing strategies.

Although these models focus on different antecedents and outcomes, they all underscore the importance of confidants' reactions to the disclosure process. Not only do their reactions have the power to affect outcomes at the individual and social level, but they can also influence an individual's future decisions to disclose. This notion becomes particularly relevant in the workplace context, where a leader's reactions have the potential to impact critical outcomes, such as compensation or promotion decisions. These models, however, do not explicitly explore immediate interpersonal responses to disclosure. Furthermore, they tend to consider broad categories of supportive and unsupportive reactions without addressing the specific emotional and cognitive elements that shape them, nor what form these supportive responses may take.

2.3.4. Concealable IM strategies

Disclosure can be understood as a continuum in which an individual may choose not to disclose their identity, disclose only partial information about it, or disclose it fully (Ragins,

2008). Depending on the desired extent of disclosure, individuals may then enact different behavioral strategies to manage and present their identity. Relevant to our work, a recent study performed by Follmer and Jones (2022) used in-depth interviews to organically derive the IM strategies that individuals with a mental illness (i.e., depression) utilized in the workplace context. Their study maps these strategies along the disclosure continuum into three major categories: *non-disclosure*, *partial disclosure*, and *full disclosure*. Although distinct, these categories are comparable to Jones and King's (2014) classification between *concealing*, *signaling*, and *revealing* strategies.

Non-disclosure strategies, similar to *concealing* strategies, involve hiding the stigmatized identity and posing as a non-stigmatized individual to prevent discovery (Clair et al., 2005). Follmer and Jones (2022) mapped three strategies in this category: *concealment*, *fabrication*, and *masking* (see also Clair et al. (2005) and Goffman (1963)). *Concealment* involves hiding information and behaviors that could expose the stigmatized identity. A *fabrication* strategy occurs when an individual goes beyond withholding information and deliberately provides false information to others to cover up. Finally, with a *masking* strategy, individuals "put on a mask" at work to prevent others from realizing their condition.

In the middle of the spectrum, *partial disclosure* strategies are those that straddle the line between disclosure and non-disclosure and involve selectively sharing some information about the identity or disclosing only to certain individuals. Strategies in this category include *signaling*, *limited disclosure,* and *selective disclosure*. Among *signaling* strategies, Follmer and Jones further identified passive and active signaling. The former occurs involuntarily when an individual cannot hide their stigmatized identity (e.g., when depressive symptoms become salient), while the latter involves actively dropping hints, using nonverbal cues, or giving clues to their condition (Clair et al., 2005). When using a *limited disclosure* strategy, individuals disclose some aspects of their social identity but do not share complete information. Finally, by using a *selective disclosure* strategy, individuals reveal their identity only to specifically chosen people.

On the other end of the spectrum, *full disclosure* strategies, similar to *revealing* strategies, involve making the stigmatized identity known to others or "coming out" (Clair et al., 2005). Two strategies identified in this category are *transparency* and *advocacy*. With a *transparency* strategy, individuals show a general openness to share information with others about their stigmatized identity when prompted. On the other hand, someone using an *advocacy* strategy goes beyond sharing information and seeks to educate others about their identity with the aim of promoting awareness and social change.

In this study, we aim to explore leaders' reactions to employees with mental illness. For this, as outlined in **Section 2.2.**, we will first assess their responses to an employee displaying warning signs of a mental health issue, which would be consistent with a *passive signaling* strategy (an example of partial disclosure). Afterward, we will analyze their responses when the employee actively uses either a non-disclosure or a full-disclosure strategy to cover the remaining sides of the spectrum.

On the non-disclosure end, we argue that if an individual is already displaying symptoms of a mental health issue, *concealment* or *signaling* strategies would no longer be a viable option. They must find a way to "justify" their symptoms or devise a believable excuse if they wish to hide their condition, which would be consistent with a *fabrication* strategy.

On the full disclosure end, we posit that an individual who has observable symptoms and has not actively talked about them at work does not fit an *advocacy* strategy. Such behavior would be better explained through a *transparency* strategy to the extent that they would share information about their condition if prompted.

Considering these arguments, we narrow down our previously stated research question (see **RQ1**) by considering the following sub-question:

> **RQ1b.** How do leaders respond to employees with mental health issues when they use a *fabrication* versus a *transparency* strategy?

2.4. The present study

This study aims to contribute to IM literature by addressing the oft-overlooked perspective of leaders. To achieve this, we used *inductive thematic analysis* to understand the processes that shape leaders' responses toward employees showing warning signs of mental health issues and how specific IM strategies used by employees can further influence leaders' perceptions. Thematic analysis is a widely adopted approach for analyzing individuals' experiences, perspectives, and views and was, therefore, deemed appropriate for the given research goals.

The rest of the thesis is structured as follows. In **Section 3**, we explain the methodology adopted in this study and describe the design and implementation of our research materials. In **Section 4**, we report our main findings. Finally, in **Section 5**, we summarize and discuss our results, their potential theoretical and practical implications, and the limitations of our study.

3. Method

The focus of this research is exploratory, as we are looking to develop an understanding of leaders' perspectives, how they make sense of, analyze, and evaluate employees with mental health issues and their IM strategies, and how this shapes their reactions toward them. For this purpose, we conducted in-depth semi-structured interviews with team leaders from different industries and explored their responses to three specific strategies, namely *passive signaling*, *fabrication*, and *transparency,* which were manipulated through written vignettes in a within-subjects design.

3.1. Sampling

To achieve our research goals, we used a purposive sampling technique, according to which we identified and selected participants based on their potential to provide rich and valuable insights into our research question (Etikan et al., 2016). Specifically, participants were required to meet the following criteria to be included in the study:

1. **Working in Germany.** Since stigmas are socially constructed, cultural context and norms must be taken into consideration (Evans-Lacko & Knapp, 2014; Ragins, 2008). Therefore, we limited our study to the German working context to produce comparable results.

2. **At least one year of leadership experience.** A minimum of leadership experience was deemed necessary for participants to be aware of the challenges of their role and be able to put themselves in the situations described in this study.

It should be noted that since our goal is to understand leaders' attitudes and perceptions, recruitment was not restricted to those with first-hand experience managing employees with mental health issues. Furthermore, participants from different industries, ages, and genders were encouraged to participate to ensure that multiple perspectives were accounted for.

To reach our target population, we created a recruitment flyer (see **Figure 1**), which included a vague description of the purpose of the thesis (i.e., without mentioning the focus on mental health issues and IM strategies), the abovementioned inclusion criteria, the procedure, and contact information. To increase engagement, it also included a QR code leading interested individuals to a survey in which they could share their email addresses to be contacted by the researcher. The flyer was distributed among personal and professional networks via email and social media platforms such as LinkedIn, WhatsApp, and Instagram.

This strategy yielded 19 potential candidates, who were then contacted via email and invited to a 30-minute online interview via Zoom. The email contained a reminder of the thesis topic and inclusion criteria, as well as a link to Calendly. This online scheduling software allowed candidates to schedule their interview appointments at their convenience. We used this setup to simplify the scheduling process and increase the engagement of potential candidates from the first email. In the end, 15 leaders showed interest and scheduled an interview.

3.2. Participants

The final sample consisted of 15 team leaders, in line with our expectations given the qualitative nature of our research (Charmaz, 2006), the restricted target group, and the limited time frame of the study. Most participants identified as male (66.67%, $N = 10$), with 4 (26.67%) identifying as female and 1 (6.67%) as diverse. Their age ranged from 30 to 60 years ($M = 40.71$, $SD = 9.24$). On average, participants had 7.67 years of leadership experience ($SD = 5.98$) and worked in various industries and roles. A detailed description of participants' demographics is presented in **Table 1**.

3.3. Materials

3.3.1. Vignettes

Vignettes are traditionally used in qualitative research to explore participants' thoughts, attitudes, and beliefs within a specific context (Barter & Renold, 1999). Furthermore, their hypothetical nature provides a non-threatening way of analyzing sensitive topics (Barter & Renold, 1999; Schoenberg & Ravdal, 2000), making them a valuable tool in stigma-related research.

The vignettes used in this study were developed by integrating critical elements from studies performed by Angermeyer et al. (1998) and Martin et al. (2015), and Dimoff and Kelloway (2019a) (see **Appendix A**). Given practical limitations and to avoid introducing gender as an additional variable, the vignettes only described a male employee, referred to as "Mr. Müller." Previous research has shown that men tend to be subjected to more mental illness stigma than women (Brown et al., 2017; Farina, 1981) and are less likely to be diagnosed with depression and anxiety disorders (Cochran & Rabinowitz, 2000; Purvanova & Muros, 2010). Therefore, we expect participants' potential stigma-related responses to be stronger if the hypothetical individual is a male. Furthermore, to minimize name-related bias, we opted for the surname Müller, the most common surname in Germany (Marynissen & Nübling, 2010).

In the first vignette, Mr. Müller displayed clear warning signs of an emerging mental health issue. Following Dimoff and Kelloway's (2019a) SOS checklist, the described signs were a combination of expressions of distress (e.g., "he looks tense and exhausted"), withdrawal (e.g., "has withdrawn from social activities"), reduced attendance (e.g., "he is often late for work"), and degradations in performance (e.g., "the quality of his work has decreased"). Although no specific diagnostic label was given, the symptomatology used aligned with DSM-5 criteria for a severe depressive disorder, with symptoms that markedly interfered with social and occupational functioning. Depression was chosen as a baseline to illustrate mental distress because of its high prevalence in the adult population (Jacobi et al., 2014, 2016) and its diagnostic overlap with other disorders, such as generalized anxiety disorder (Zbozinek et al., 2012).

The second and third vignettes were elaborated considering Follmer and Jones' (2022) findings on IM strategies used by individuals with depression. Both vignettes were almost identical in their formulation, with changes in key aspects to indicate the use of a specific strategy. In the second vignette, Mr. Müller disclosed a mental health issue using a *transparency* strategy, openly sharing information about his condition (e.g., "reveals that he has been struggling with a mental health issue"). We chose the common-use term "mental health issue" instead of the medical terms "mental disorder" or "mental illness" because we deem its usage more realistic in a workplace setting. In this scenario, Mr. Müller

Figure 1: Recruitment flyer

acknowledged a link between his condition and his diminished work performance and confessed feeling embarrassed about it, a common issue among individuals with depression (Dietrich et al., 2014). In the third vignette, Mr. Müller did not disclose his condition and used a *fabrication* strategy instead, explaining his behavior using other excuses (e.g., "tells you that he has been having relationship problems"). In this vignette, Mr. Müller tried to keep his condition separate from his work performance, brushing off possible concerns in that regard.

3.3.2. Interview protocol

As mentioned at the beginning of this section, we used semi-structured interviewing, a qualitative research approach that uses a predetermined set of questions as a guide but gives the interviewer the freedom to dive deeper into interviewees' responses through follow-up questions (McGrath et al., 2019). As such, it is particularly suited for understanding a participant's unique point of view, attitudes, and experiences surrounding a phenomenon expressed in their own words (Charmaz, 2006; McGrath et al., 2019). This format is characterized by its flexibility, which offers both the possibility to address specific research constructs and a chance for participants to share their own reflections, discuss their impressions, and tell their stories (Charmaz, 2006; Galletta, 2013). In this way, this method helps guide and advance understanding when little is known about an issue, helping uncover important concepts to guide future inquiries. Furthermore, it provides an appropriate format for discussing sensitive topics (Fylan, 2005), such as mental illness awareness and management.

Drawing on our literature review, we crafted an interview protocol aimed at exploring different aspects of leaders' reactions, including their emotional (i.e., their feelings) and cognitive (i.e., what they think) responses, as well as their behavioral intentions (i.e., how they intend to behave in each situation). This protocol was then tested during a pilot interview, which resulted in minor changes to some questions to improve clarity.

The final interview protocol was structured in five sections, which are illustrated in **Figure 2**.

1. **General background information.** Following the recommendations by Galletta (2013), the interview began with simple questions to build rapport and help make the interviewee comfortable (e.g., their current position, their years of leadership experience).

2. **Leader awareness.** In this stage, the interviewees were presented with "*Vignette I: Warning signs.*" First, they were asked about their feelings toward Mr. Müller. Participants were presented with a pictorial feeling thermometer to aid in this process, a tool commonly used to gauge feelings about a specific group (Lavrakas, 2008). The thermometer was structured on a 9-point scale ranging from 0° (*very unfavorable/negative feeling*) to 100° (*very favorable/positive feeling*). It should be noted that this thermometer was only used as a visual aid to help participants evaluate and voice their feelings and was not intended as a quantitative measure. Afterward, interviewees were asked about their expectations regarding Mr. Müller and his situation (i.e., what they thought should happen next).

3. **IM strategy I.** Here, the interviewees were randomly presented with either "*Vignette II: Transparency*" or "*Vignette III: Fabrication.*" We first used an open-ended instruction to assess their implicit attitudes: "Please tell me 1 or 2 words that you would use to describe Mr. Müller." Afterward, participants were asked about their feelings toward Mr. Müller and whether they had changed from the previous scenario, using once again the feeling thermometer as an aid. Finally, they were asked about their perceptions and strategies (e.g., how they would handle the situation, what were their main concerns).

Table 1: Participant demographics

ID	Age	Gender	Years of leadership experience	Current position	Industry	Company size	Experience with others' MH issues	
							Workplace	Private life
L_01	33	Male	7	CEO	Healthcare	11 - 50 employees	Yes	Yes
L_02	60	Male	20	Managing Director	Renewable energy	5 - 10 employees	Yes	Yes
L_03	35	Diverse	2	Head of Department	Semiconductor	More than 10.000 employees	Yes	Yes
L_04	34	Male	1	Team Lead	E-mobility software	51 - 250 employees	No	N/A
L_05	33	Male	4	Project Manager	Temporary architecture	51 - 250 employees	Yes	No
L_06	N/A	Female	8	Head of Department	Climate tech	11 - 50 employees	No	Yes
L_07	30	Female	3	Team Lead	E-mobility software	51 - 250 employees	Yes	Yes
L_08	53	Male	20	Director	Mining	251 - 500 employees	N/A	Yes
L_09	46	Male	5	Consultant	IT	1.001 - 5.000 employees	Yes	Yes
L_10	40	Male	2	Team Lead	Automotive	51 - 250 employees	No	Yes
L_11	46	Male	9	Group Leader	Space engineering	5.001 - 10.000 employees	Yes	Yes
L_12	38	Male	10	Team Lead	Healthcare	5.001 - 10.000 employees	Yes	Yes
L_13	38	Male	5	Director	Software development	51 - 250 employees	Yes	Yes
L_14	52	Female	13	Head of Department	Semiconductor	51 - 250 employees	Yes	N/A
L_15	32	Female	6	Head of Department	Fashion e-commerce	1.001 - 5.000 employees	Yes	Yes

Note. MH = Mental Health.

4. **IM strategy II.** In this stage, the interviewees were presented with the remaining vignette, "*Vignette III: Fabrication*" or "*Vignette II: Transparency*." The line of questioning was the same as in the previous stage.

5. **Final questions and sensitive information.** The interview finished with questions regarding organizational resources, interviewees' training needs, and personal experiences with mental health issues. Demographics such as age, gender, industry, and company size were collected using Zoom's poll feature.

Upon completion of the interview, participants were thanked for their participation and had the opportunity to share additional thoughts and insights. The complete interview protocol is detailed in **Appendix B**.

It should be noted that, given the semi-structured nature of the interviews, the order of the questions within each section of the protocol was not rigorously followed but rather used as a general guideline. Furthermore, participants would sometimes answer questions planned for a later moment, in which case the interview was adapted to allow for a more natural flow in the conversation.

3.4. Procedure

Before the interview, each participant was sent a reminder email with the interview date, time, Zoom meeting details, and a consent form in PDF format (see **Appendix C**), which detailed the interview procedure as well as data privacy and confidentiality conditions. Participants could then indicate their consent by sending a copy of the signed consent form or by sending an email expressly stating their consent (e.g., by replying, "I consent to the processing of my data for the purpose of this research").

Once participants had given their consent to the recording of the interview, they were invited to respond to the questions outlined in the interview protocol. The interviewing process took place between July and September 2023. All interviews were conducted in English and digitally recorded. Most interviews were conducted via Zoom (version 5.15.7), with two of them being conducted via Microsoft Teams due to technical difficulties on the participants' side. Overall, the interviews lasted between 26 and 48 minutes.

3.5. Data analysis

Each interview was digitally recorded via Zoom (version 5.15.7) or Microsoft Teams and transcribed verbatim prior to data analysis. An initial transcription was done using Trint transcription software (https://trint.com/), an AI-powered tool with automated speech recognition and natural language processing technology. Afterward, the resulting transcript was reviewed thoroughly and edited to accurately reflect the participants' exact wording. During this phase, a detailed transcription protocol following the guidelines proposed by McLellan et al. (2003) was developed to ensure the creation of standardized transcripts to facilitate data analysis (see **Appendix D**). This process resulted in approximately 204 pages of text. The finalized transcripts were analyzed and coded using MAXQDA Analytics Pro 2022 software (Release 22.8.0).

Data analysis was performed through *inductive thematic analysis*, which entails identifying, analyzing, coding, and reporting patterns within the data without trying to fit them into preconceived frameworks (Braun & Clarke, 2006). Following Braun and Clarke's (2006) guidelines, the analysis involved six phases. The first phase, *becoming familiar with the data*, was achieved by repeatedly listening to the interview recordings, performing a detailed transcription, and then reading and re-reading the finalized transcripts. At this stage, some meaningful experiences and ideas were noted down for future analysis without engaging in formal coding. In the second phase, we *generated initial codes*, systematically coding each transcript line-by-line. These initial codes were developed inductively and were meant to reflect participants' actual wording without engaging in interpretations. For example, when participants read about Mr. Müller's situation, some of them described their feelings using phrases such as "poor guy," "sorry for him," or "sad for him," all of which were coded separately. Furthermore, during this process, the answers pertaining to each vignette were color-coded and treated as separate units of analysis: "*Vignette I: Warning signs*" was light blue, "*Vignette II: Transparency*" was green, and "*Vignette III: Fabrication*" was orange. This approach resulted in over 350 initial codes. In the third phase, we started *searching for themes* in the coded data by grouping similar codes together. For example, the previously mentioned expressions "sorry for him" and "sad for him" were clustered together under the sub-theme "Sympathy." By the end of this stage, lists of candidate themes and sub-themes that better summarized the coded feelings, experiences, and understandings were developed for each of the three vignettes. In phase four, *reviewing themes*, the codes within each theme were reviewed to ensure conceptual similarity, and the different themes were compared to ensure their distinctiveness. At this stage, themes and sub-themes evolved iteratively, and patterns within and across vignettes started to emerge. In the fifth phase, *defining and naming the themes*, the themes found in the previous phase were further refined and organized to uncover the "story" behind the data. Finally, in phase six, we started *producing the report*, polishing our chosen themes and sub-themes, selecting quote examples and extracts, and linking the analysis to our guiding research question and sub-questions. For simplicity and to aid the narrative, the extracted quotes do not consider filler and repetitive words used by participants, nor the interviewer's crosstalk. The final themes and sub-themes derived for each vignette are detailed in **Appendix E**.

4. Results

4.1. Leaders' responses to warning signs of mental health issues

The diagram in **Figure 3** summarizes the general process leaders underwent when presented with an employee with

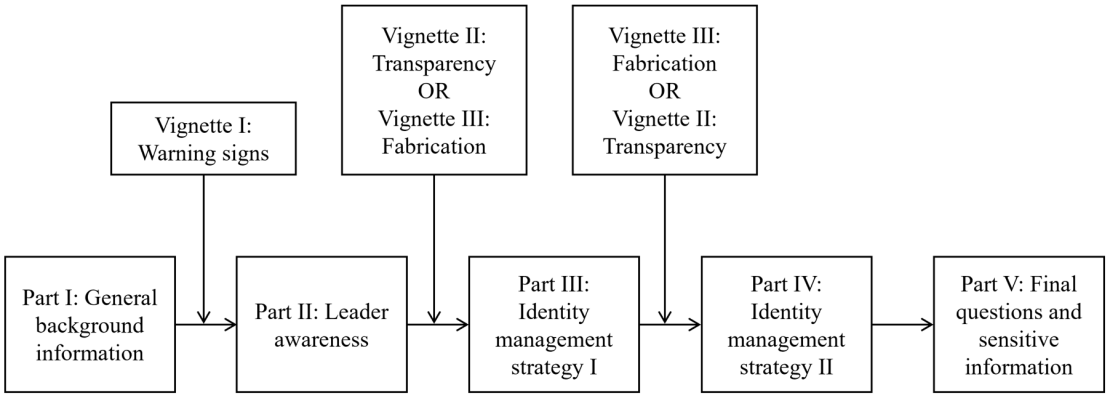

Figure 2: Study design

warning signs of a mental health issue. This process model proposes that managing a distressed employee involves emotional and cognitive reactions, which are closely linked and dynamically shape leaders' behavioral intentions. These reactions often happen simultaneously, so there is no clear distinction between a cause and an effect.

When reading the first vignette, all interviewed leaders recognized that there was something wrong with Mr. Müller and expressed a need for immediate action. As one interviewee pointed out, "Clearly something is going on. [...] Immediate reaction, I would say I... You have-, I have to talk to him. Ask him 'What's going on?'" (Leader_13). However, only two leaders explicitly recognized the signs described in the vignettes as indicators of a potential mental health issue, specifically depression. In the case of one leader, this early detection stemmed from his own experience dealing with burnout and depression and allowed him to empathize with Mr. Müller:

> I think that what I would feel it's empathy. Because I've been in that situation. I've been burned out. Or I've been with depression. So, I know what it feels. I know when someone is feeling down and I've been there. (Leader_01)

When elaborating on this instinctive thought of "I need to talk to him" or "I need to do something about this," both emotional and cognitive aspects emerged. On the emotional side, the interviewed leaders exhibited a range of sympathetic and empathetic responses toward Mr. Müller and his situation. These included expressions of concern, worry, and a desire to support him professionally and sometimes even personally:

> I feel sad for him, actually. I would like to find a way to help him somehow. (Leader_10)

> Well, I feel concerned. More on a personal level, I would say. So, yeah, I have the feeling that something is off. (Leader_11)

Furthermore, most leaders evaluated Mr. Müller favorably on the feeling thermometer (ratings of 50° and above), focusing first on understanding his situation rather than jumping to negative judgments. Only one leader perceived his behavior as someone who was "losing track and interest in his work" (Leader_09), resulting in a more unfavorable evaluation.

On the cognitive side, interviewees tended to reflect on their role as leaders and their dual responsibility of ensuring the employee's well-being and the team's performance. Leader 15 best explains this duality as follows:

> For me, always, I have two thoughts, right? And I guess that's due to my role. [...] And first thing is, like, you feel sorry for the person, and you want to personally help this person to feel better. But obviously, then you have a second thought that's more rational and is, "Okay, I will need to replace this person, or I need to see how I can make work happen if this person is not working." Right? So... You cannot be only in the personal level, because otherwise you're just a friend. And at the end of the day, you also need to make sure that the work is done and that the other teammates are not being affected by this case. (Leader_15)

Looking to fulfill these two responsibilities, interviewees set themselves two consecutive objectives to successfully manage the situation: (1) try to understand what is behind Mr. Müller's behavior (i.e., sensemaking), and (2) figure out how to help (i.e., problem-solving). In the words of two leaders:

> So, I would confront him, basically. Confronting sounds aggressive, but I would confront him with the situation. I would ask him, "Hey, look. You were really contributing a lot in the past, and the quality that you delivered was really good. And recently, I see that, you know, your behavior has changed, the quality of your output decreased, and you seem stressed. So... Is something wrong? And can I support you with this?" (Leader_04)

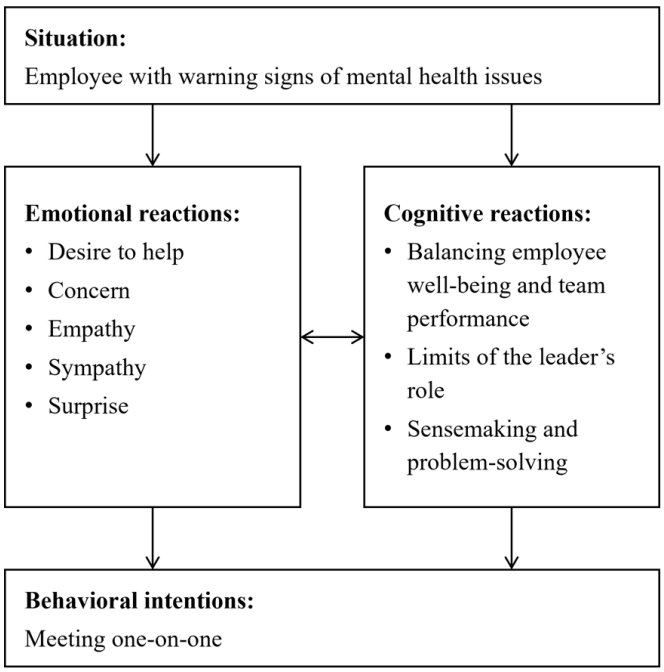

Figure 3: Leaders' responses to an employee displaying warning signs of a mental health issue

> I should try to understand what's the origin of this situation. So, if it's related to the work environment, if it's something that is out of the, let's say, sphere of the work. So, and yeah, I feel that I should try to understand what's going on and, if possible, to help. (Leader_11)

Emphasizing the importance of communication and understanding as a first step, leaders often pondered possible causes for Mr. Müller's change. For example, Leader 08 recounted:

> So, if a person's behavior changes like that, usually you're gonna find something in the private background, yeah? So, could be a family member that needs extra care. So, it could be a kid that's passed away. Could be a partner that's passed away. Could be financial problems. All of that. So, I would, first of all, be interested in what's happening with that person. And, of course, I would, um, talk to the person and say, "We should have a four-eye conversation. Is there anything you would like to tell me?" (Leader_08)

In this regard, Leader 04 further highlighted the importance of figuring out whether Mr. Müller was struggling due to a personal situation or something in the workplace, as there are limits to what a leader can help with:

> I think it's a thin line, right? You should not really... If it's something private, then you should-, I mean, it's difficult to confront people with something private, obviously. But maybe it's also within the company, right? And if it's within the company, then it's also my duty to find out. Maybe [...] he has problems with other colleagues, or something like that. (Leader_04)

This search for understanding to develop a concrete action plan, together with their underlying feelings of sympathy and concern, ultimately translated into the intention of arranging a one-on-one meeting with Mr. Müller. In describing this hypothetical meeting, leaders emphasized aspects such as asking directly, discussing openly, and explaining their position by "sticking to the facts." Moreover, some leaders noted the importance of trying to ensure a comfortable, non-threatening environment for the employee to encourage an open and honest dialogue:

> And I would approach him out of the office, for example. "Let's go have a coffee in the corner." I think when you take twenty minutes, half an hour, to do something like that is equally important than "keep on working" because it depends... Your whole team is depending on this person, so you're working for everyone. So, I would take some time - and I've done it actually - outside of the office, some like common space, not... Like at the same heights, in a more friendly way of speaking, you know? More like "relax." And ask him, "What is happening?" [...] And the idea is to... Both of us to feel comfortable, and nobody's watching, and it's like a safe space or something like that. So, I would-, I prefer that. (Leader_05)

4.2. Leaders' responses to employees' IM strategies

4.2.1. Commonalities in managing transparency and fabrication strategies

When analyzing interviewees' responses to Mr. Müller's IM strategies, a general pattern of management emerged, rooted in leaders' distinction between their own responsibilities (i.e., what they should do) and the employee's responsibilities (i.e., what they expected the employee to do). However, these two spheres of responsibility are not entirely separate: both sides have a shared responsibility in finding solutions to move forward. These findings are visually represented in **Figure** 4.

"What the leader should do"

The dual responsibility of protecting employees' well-being while ensuring the team's performance mentioned during the warning signs stage also underpinned leaders' cognitions and intended behaviors when reflecting on how to manage Mr. Müller's *transparency* and *fabrication* strategies, with differential focus on the well-being or performance sides depending on the specific situation. Here, leaders were concerned with finding a balance between providing support to Mr. Müller to aid in his recovery while maintaining productivity and achieving the team's goals. Leader 05 recounts this challenge as striking a balance between a "human" side and a "work" side:

> Like "work thing": what we can do from official information. And "human behavior" is like: "But you're not alone in this. So, we're gonna work it out. We're gonna see what happens." Something like that would be the message. Like in those two channels. [...] Because, well (chuckles), we're still working. And at the end of the day, the results are the results. (Leader_05)

On the well-being side of the equation, leaders were concerned with providing support by offering workplace accommodations, suggesting time off, encouraging the employee to seek professional help, and engaging the employee in an open discussion to find out what he needs. Moreover, some interviewees highlighted the importance of emotional support, particularly by "being there for them" and reassuring job security.

> So, I think if it's a... If it's something that I think is probably very serious, then I'd probably suggest that they, you know, maybe see a counselor or somebody who's professionally trained to take these things on. Obviously, what I can do as a boss is say, "Look," you know, I can reduce their workload so that they'd have more time to focus on their personal problem, or suggest that they take a, you know, bit of time off and this kind of thing... [...] And obviously, if they need professional therapy or counselor or something, to seek that out, and I would obviously be supportive of that and give them the time to do that. (Leader_02)

> And I would ask him, like, to tell me what's good for him at the moment. Like, if he knows that already or if he has someone he can talk to about it and figure it out. (Leader_07)

> But he doesn't need to worry. I'm not going to fire him or her because of this. Of course not. Especially if he was a good performer. So is all fine. But that he needs to, you know, take it easy. (Leader_15)

On the performance side, leaders reflected on how to manage the workload and balance the team's responsibilities to ensure that work would continue smoothly in the absence of a team member. Here, leaders were concerned with ensuring that Mr. Müller's tasks were covered while trying to minimize the impact on the team. In this regard, interviewees proposed taking up Mr. Müller's tasks themselves, distributing them among the team, or even hiring someone to temporarily cover for him.

> In the meantime, I would check the workload from the rest of the team. Maybe I could take some part of his responsibilities. Work out [...] a plan. [...] But there are for sure tasks that are not being done. So, we have to do something about that today (chuckles). Or yesterday, for sure. So, try to take his activities, that he is not doing. Then, help from the rest of the team, including me. I can take some tasks, etc. But the result? Results are the results, and... When you have to... Explain yourself at the end of the day. The numbers, and from experience, doesn't matter what happened in the middle, right? It's tough. It is tough. But you have to show... Results. (Leader_05)

When reflecting on the impact task redistribution could have on team dynamics, interviewees recounted another dual responsibility for leaders: balancing the needs of the affected employee and those of the other team members. On the employee's side, leaders highlighted the importance of respecting Mr. Müller's privacy and need for confidentiality. On the side of the team, leaders were concerned with managing communication with the team to protect team dynamics and prevent misunderstandings and negative perceptions. These negative perceptions could be directed toward Mr. Müller due to his decreased work performance and any "special treatment" he might receive, but also toward the leader due to a feeling of them "not doing anything about this." In the words of Leader 14:

> Very difficult if it's, like, a closed situation. Nobody knows about it. Nobody wants to talk

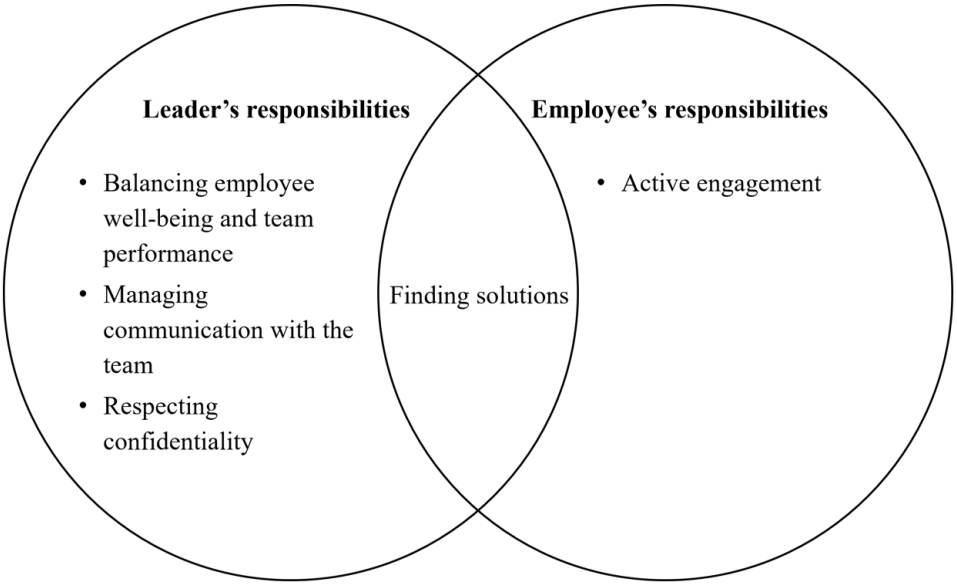

Figure 4: Leaders' distinction between spheres of responsibility

> about it. [...] The people will then see, "Okay, we achieved" or "We achieved something, we could cover for that person." But if they don't know what's behind, it will not give them a good feeling or a sense why is... Why is that done. It would be more negative. Not necessarily towards that person but also towards the boss and the company. "Why aren't they doing anything about it? This person is not working, is not performing, is showing up late, is distancing himself from social activities, and nobody does anything about it. The company doesn't care." Yeah? "They let me do more work, and they don't care." (Leader_14)

In managing this delicate balance between confidentiality for the sake of the affected employee and transparency for the sake of the team, interviewees proposed to encourage Mr. Müller to open up with the team, even if partially, citing that keeping the team "in the dark" could create a vicious cycle in which the team starts distancing from Mr. Müller, and this worsens his situation.

> Because I think it makes things easier, right? And I would try to explain him that if there is no knowledge about it, people tend to, you know, go for the wrong conclusions. And think that he's, I don't know, not interested or not motivated or... [...] But that would just be a suggestion, right? It's not... [...] It's not on me to decide, right? I would just suggest it. (Leader_04)

Finally, interviewees also recognized that there were boundaries to their responsibilities as leaders. First and foremost, the support they can provide to a struggling employee is limited to the workplace context. They can adjust working conditions, take over some tasks, and even offer time off to give the employee time to recover. However, they cannot and should not interfere in the personal sphere. In this regard, several interviewees highlighted that leaders are not trained mental health professionals and, as such, are not qualified to treat an employee's potential mental health issues. The only thing they can do is encourage employees to seek help and support them in a professional capacity.

"What the employee should do"

Just as leaders recognized their responsibilities in managing a struggling employee, they also acknowledged that the situation could not continue indefinitely, and voiced expectations of what Mr. Müller should do. Specifically, interviewees emphasized the importance of not staying passive in the face of challenges, expecting the employee to demonstrate active engagement and proactive involvement in seeking solutions. Furthermore, leaders noted that this perceived effort and willingness to overcome his personal situation would be crucial in shaping their subsequent understanding and support.

> I mean, you're having a problem. Okay, I get it. But what are you doing to get over it? I mean, staying in bed it's not a solution, or not-, getting to a point where you're not delivering, it's not a solution. You cannot be like that, in a momentum forever. You have to do something. (Leader_01)

> And then you understand, you try to support, you try to change the work schedule, and so on, but you still EXPECT something also from the team member. We try to give some flexibility or sup-

> port, but [...] I also expect something back. (Leader_14)

> I also feel like this in a personal way. That we can be like that, but eventually the person needs to take action. What I mean with this is, like, we can have this conversation. I can support you. I can advise you. I can tell you, okay, how we can come-, what can we do. But this is not something that could lend-, long for... Three months. So, this person needs to take action. Because, again, [...] my boss part. And my boss part is, "I need the job to be done." (Leader_15)

Finding solutions: A shared responsibility

Although leaders established having a responsibility to provide support for a struggling employee, they emphasized that finding solutions and moving forward was a shared responsibility. In this regard, interviewees sought to empower Mr. Müller to voice his needs and encourage him to make choices that could help him move forward, whether this involved taking time off, staying engaged at work, or seeking professional support.

> I mean, I can offer him any kind of options. So, if he prefers to keep doing the work he's doing because somehow it helps to keep his mind occupied, then we can do that. He prefers to be a little bit unloaded from work duties? We can do that as well. He'd prefer to take to take a period off? That's totally okay. So, we can tune the situation to what also he believes is the best for him. (Leader_11)

> Employees are so different and different personalities. And I think, like, each person knows best what would help. And also, I think it's always important to bring them into an active role because when I always offer something, then, I mean, he seems-, it seems that he's a more passive person. So that's why I also would ask HIM to say, "Okay, are you then committed to get better at that point? And what helps you there?" And I think when he suggests something, him, then he also is able to take more commitment for it. (Leader_06)

4.2.2. Differences in managing transparency and fabrication strategies

When comparing leaders' responses to *transparency* versus *fabrication* strategies, we uncovered three main differences: (1) in their feelings toward Mr. Müller, (2) in their focus on well-being versus performance, and (3) in their perception of Mr. Müller's control over his situation (i.e., controllability) and, subsequently, his expectations of recovery.

The importance of (perceived) transparency

When faced with a *transparency* strategy, interviewees tended to feel more favorably toward the struggling employee (i.e., indicated they would increase their rating on the feeling thermometer), voicing renewed feelings of sympathy, empathy, and support. When reflecting on why they felt more positively, leaders indicated their appreciation for Mr. Müller's openness and honesty in sharing his personal difficulties, with two leaders further characterizing him as "brave." Moreover, due to his acknowledgment of his mental health issues, leaders perceived him as someone who was willing to face his problems and wanted to move forward. One leader explained this as follows:

> Here's a German saying, maybe you can translate, "*Einsicht ist der erste Weg zu Verbesserung*." [...] So, if you acknowledge something's wrong, that is the first step for change. [...] And that, of course, would make my life and the person's life much better, because this is the first step on a way towards a change, right? Because when the person says, "Yes, of course, there is something wrong." Okay. Then you know, from there, you can change something. But if you deny that something's wrong, then of course it's not gonna-, you're gonna head down the same path as you have been doing the last couple of days or months. (Leader_08)

In contrast, when faced with a *fabrication* strategy, interviewees tended to feel more unfavorably toward Mr. Müller, rating him lower on the feeling thermometer compared to the *warning signs* and *transparency* scenarios. In this case, leaders generally perceived him as someone in denial or lacking self-awareness regarding how his personal situation affects his and the team's overall performance. Furthermore, interviewees noted that insofar as the person continued denying or refusing to acknowledge the problem, their ability to intervene and address the issue would be hindered, resulting in feelings of frustration and annoyance.

> He was blocking. [...] He blamed it on different sources and not in his self. That's or he's not aware that his performance is not good. And if someone is not aware of this issue, and I had this too, it's very difficult to talk with these people because they're living their own bubble. (Leader_09)

> From the scenario reading, I would assume it IS affecting work and I have an objective view on the things here. So, it's always hard, because always-, if you deal with people, it is always subjective. It can never be 100% objective. But given the fact that I am absolutely objective in this scenario, and if someone then would say, "Well, no, I don't have a problem" and forces that

> away, then of course I would have a more unfavorable feeling, saying, "Listen, you gotta do something and you can't ignore that there is a problem." (Leader_08)

Despite this comparatively more unfavorable evaluation, most leaders still showed sympathy and concern toward Mr. Müller and an overall positive evaluation on the feeling thermometer (ratings of 50° and above), with only three leaders evaluating him below 50°. However, interviewees pointed out that this evaluation hinged on Mr. Müller's reactions during and after the meeting.

> Depending on the outcome of the discussion. Because, of course, in the meeting, I would tell them, "Look, I understand your situation. I understand it's really tough." [...] "Your performance HAS changed significantly, and everybody is noticing it." And depending on... How he would react to that. Understanding when I give [...] him examples and so on. Or still rejecting. Yeah? So, if he would understand, my feelings would still be the same. If not, of course, they would go down. (Leader_14)

Finally, it should be noted that two leaders considered that Mr. Müller was being open and honest when using a *fabrication* strategy. In this case, they sympathized with his relationship problems and appreciated his perceived transparency, which resulted in an overall favorable evaluation. In the words of Leader 13:

> If he was good before... And he was transparent. There is no trouble. In my-, from my side. If he's trying to conceal something, to hide something, then there would be the drop there. (Leader_13)

Shifting the focus between well-being and performance

As mentioned previously, leaders' cognitions and intended behaviors were primarily rooted in keeping a balance between protecting employees' well-being and ensuring the team's performance, with differing emphasis on one side or the other depending on the IM strategy the employee used. When confronted with a *transparency* strategy, leaders' focus shifted toward the well-being part of the scale, striving to provide support and encourage the struggling employee. In this case, leaders focused on urging Mr. Müller to seek professional help and to prioritize their health over work. In addition to workplace accommodations and potential time off, leaders also mentioned enlisting HR's support, acting as a bridge to find suitable help, and monitoring the employee to provide further assistance as needed.

> So first of all, I was mentioning offer my support, but also to make sure that he takes the right steps on looking for a specialist [...] "Hey, I wanna help you. I don't wanna you to come to work if you feel mentally disabled, so I want you to stay home and look for a treatment so that you can get well again." (Leader_03)

> I think this is, like, also some issue that you as an employer or manager should really take serious. And actually I would, like, recommend him to also, like, maybe go to the doctor's and maybe to take some time off, so to be, I mean, sick. And then to just focus on his mental health and to say, "This is more important than your job is at the moment, and just take your time." And I wouldn't put any pressure on him. And I mean, of course, I can't really recommend, when it comes to the whole doctor things, but I would just say for myself, "It's totally okay when you take your time" and "Focus on your health now" and "Don't be embarrassed about it" and, yeah, that we find a solution there. And I would support him. (Leader_06)

Moreover, leaders sought to provide more emotional support, emphasizing that mental health is like physical health and "there is nothing to be embarrassed about." In this regard, two leaders stated that they would share their own experiences with mental health issues to make Mr. Müller more comfortable and to show him that he can overcome his situation:

> Well, of course, he's been very open and honest. And I would admit the same thing because I've had a burnout. Yeah. So, I know what mental problems can do with you. And, of course, in that very private conversation, I would also admit that I had have problems and that there is a way to solve it. That you have to go and seek for someone that's gonna help you on a professional way, get out of that situation. So, you can't handle that yourself. (Leader_08)

> I mean, first, I also have gone to therapy in my life. I find therapy amazing, so I actually recommend it to everybody. I love it (chuckles). And... I think it's very good. And, you know, you have time to just to talk to someone about your life. So, I would feel even more sorry and more connected to this person. And I will definitely recommend-. I will share my personal experience, as well, so that he doesn't need to feel embarrassed. And I would highlight that mental health is like the physical health. (Leader_15)

In contrast, when faced with a *fabrication* strategy, leaders' focus shifted toward the performance side of the scale, looking to align perspectives and ensure a prompt return to previous performance. Here, interviewees were first concerned with communicating openly to clarify the problem

and ensure that both parties had a shared understanding of the situation. During this process, leaders highlighted the importance of appreciating Mr. Müller's previous contributions and talking in an objective, non-accusatory manner, with concrete facts to back their claims.

> I think, in this case, it's really important to show, but I mean in a really appreciative way. To show HOW it's actually affecting his work and not in a personal way, but I'm just naming examples where I would have wished for other reactions, actions. So, like giving feedback to specific work performance, topics, and situations. And showing him like this, "Okay, see, it IS somehow affecting your work performance." "That's not only the reason why I'm asking and why I want to talk about it, but it shows, like, that we have to deal with that and that we have to find solutions that work for both of us." (Leader_07)

After getting on the same page about the situation, interviewees sought to set clear expectations for future performance, emphasizing that the situation cannot go on for an extended period. To aid in this process, leaders stated that they would, for example, encourage Mr. Müller to take time off to address his personal issues, rest, and return to work with a clear mind.

> So, I would say, "Okay, when you are not able to work at all, then you have to think about, taking some time off or, yeah (chuckles), deal with your things that you have on a private side and then you have to come back to work and be on the same level that you had before." (Leader_06)

> Yeah, come up to a certain agreement that this should not go… For far long. And if he also needs some time to rest and take time for himself, I'd also check if he could take some day off, vacation, so that he can work through his problems. I'd offer some options. (Leader_03)

> […] and if he has a relationship problem, you have to take some days free and come back with a clear mind. (Leader_12)

Perceived controllability and expectations of recovery

Another difference that emerged in the management of IM strategies was Mr. Müller's perceived control over his situation and, subsequently, the expectations that leaders had of a potential recovery. When faced with a *transparency* strategy, leaders highlighted that having a mental health issue was not the employee's "fault" and that it was something out of his control:

> This is not on you; this is not on me. We have something to do. […] But it's not... Whose fault is this? I cannot feel negative about something that I know he cannot control. (Leader_05)

> […] it's something you never ask for. To be impacted by some problem like this. […] I mean, it's simply something that is impacting you like any other kind of problem-, sickness. I mean. And so, you have just to be lucky of finding the right therapy to get out of this. To get out of this problem. (Leader_11)

Furthermore, interviewees were concerned with the possibility that the workplace or the working conditions caused the employee's mental health issues:

> And with the mental health, for example, we don't know where it came from, right? It can also be a company issue. It could've been that he has too many tasks, too many, I don't know, tight deadlines, pressure from other colleagues, something like that. (Leader_04)

> And I also hope that he's not mentally sick because of the work (chuckles). (Leader_03)

Conversely, when dealing with a *fabrication* strategy, leaders expressed the belief that while personal challenges may affect an individual's well-being, it is ultimately their own responsibility to manage and resolve these issues without letting them interfere with their work performance. Here, interviewees highlighted the importance of maintaining clear boundaries between personal and professional lives and expected Mr. Müller to be able to make this separation in the future.

> I can understand his situation, but it's still unprofessional. Because your private stuff has not to interfere to your job. Of course, when someone died in your family, this is absolutely understandable. But if you have relationship problems, then I would say fix it and get back to work because this pays your salary. (Leader_09)

> I had also a relationship problem in the past. And (sighs) it's a problem, but it's a problem you can keep without infecting your work. […] In the first case, the health issue was the problem. In this case, Mr. Müller is, for me, the problem. (Leader_12)

These opposing views regarding the employee's control over his condition further influenced leaders' expectations of a return to normalcy. In the case of *transparency*, leaders perceived mental health issues as more complex, noting that they could manifest in various forms and had the potential to be more severe and long-lasting, unlike the relationship problems described in the *fabrication* vignette, which could be resolved more quickly. Moreover, interviewees were concerned with the possibility of mental health issues worsening over time without proper intervention.

> [...] a relationship problem, you know, it can be triggered for a while, and then it can be managed, or the relationship resolves itself. But a mental health issue can be a much longer term thing. (Leader_02)

> Because in the first case *[referring to fabrication vignette]*, it's a personal thing and-, which can be a start for a mental health disease or a depression, but it's just on the beginning, and I think that at that moment, things can develop for better or for worse. And it's just happening there, you know? Which in the second case *[referring to transparency vignette]*, is already-, already became a problem. So, there the person doesn't-, not only need a week at home, maybe having a vacation to... To have a free mindset, but now this is one step ahead. (Leader_03)

> So, the period he is probably not at 100% would be much longer. If-, there's a serious probability that it will never be better. It might... There's a serious probability that it will even get worse. (Leader_13)

> I'm not sure at this moment if we can go on with him in the future. Psychology problems are not easy to cure. (Leader_12)

4.3. Company support

When asked about the availability of company resources and guidance in cases such as the ones described in the vignettes, six leaders stated that their company did not offer such resources, and three acknowledged that they were unsure what resources were available, if any. On the other hand, five leaders indicated that their companies did offer resources to help them in matters of mental health, either through dedicated mental health platforms or through a specific person responsible for such matters.

Regardless of whether specific resources were available, six leaders stated they would likely ask their HR or P&O teams for support in managing the situation, and four indicated that they would also turn to their supervisors for help.

4.4. Leaders' training needs

In closing, interviewees were also invited to share their training needs regarding the management of mental health issues in the workplace and their preferred learning methods. On the side of leaders' training needs, we identified six main topics of interest, which are detailed in **Table 2**, together with interviewees' specific learning objectives.

Regarding leaders' preferred learning methods, all interviewees emphasized the importance of using interactive, hands-on, experiential learning approaches beyond traditional lectures or theoretical presentations. In this line, leaders expressed the need for an engaging workshop or training focused primarily on real-life applications. More specifically, interviewees highlighted three learning methods:

1. **Role-playing.** By engaging in role-playing scenarios (either with a professional actor/actress, another participant, or a coach), leaders sought to have the opportunity to try out what they learn in a low-stakes environment, giving them a space to practice, adjust, and improve their skills.

2. **Use of real-life cases.** By using real cases and experiences, leaders expected to be able to understand the practical application of the theoretical input. With this method, interviewees wanted the opportunity to engage in practical problem-solving and to better understand how a mental health issue could develop, how to detect it in time, and lessons learned from others' past experiences.

3. **Groupwork.** In this regard, interviewees emphasized the value of having a small, close group of colleagues with whom to work together to solve problems, discuss case studies, give feedback, and exchange opinions and experiences.

Finally, leaders also mentioned needing a handout with concrete guidelines and recommendations. Examples mentioned in this regard included a checklist with the warning signs that leaders should look out for in their employees, a guideline with the critical steps in managing situations of mental ill-health in the workplace, a guide on how to talk about this topic with a struggling employee, and a list with "Dos and Don'ts" with clear instructions to avoid making critical mistakes.

5. Discussion

By using vignettes and semi-structured interviewing, this study aimed to explore leaders' responses to employees with mental health issues depending on their IM strategies. Through an inductive approach, we identified the emotional and cognitive processes that shaped 15 leaders' intentions to behave in three scenarios: when an employee is displaying warning signs of mental health issues, when the employee discloses a mental health issue (a *transparency* strategy), and when the employee covers up their mental health issue by using a personal problem as an excuse (a *fabrication* strategy).

In the first scenario, our results showed that leaders tended to sympathize with the employee, acknowledging that something was wrong and that there was an urgent need for intervention. Although all leaders expressed a desire to understand and help their employee, only two leaders were able to explicitly identify the described signs as symptoms of a mental health condition (i.e., depression). This finding is troubling, as this limited awareness hinders leaders' ability to provide appropriate resources to mentally strained employees in a timely manner (e.g., encouraging them to seek professional help, connecting them to relevant company programs, etc.). Furthermore, this implies that if

Table 2: Leaders' training needs

Topic	Learning objectives
Background on mental health	What is mental health
	Types of mental health conditions
	Prevalence of mental health conditions
	Causes and symptoms of mental health conditions
Prevention	Healthy leadership styles
	How to avoid burnout
	How to design and ensure a healthy workplace
	How to promote healthy behavior in the team
Awareness and sign recognition	How to identify the signs of a potential mental health issue
	How to distinguish warning signs from lack of motivation or a "bad day"
	How to anticipate if someone is more at risk of developing a mental health issue
Managing the situation	How to react depending on the type of mental health condition
	How to broach the subject with the employee
	How to communicate with the employee in an appropriate manner
	How to manage these situations, potential approaches and solutions
	Ways in which the leader (and the company) can provide support
	How to accompany the employee in the process
	How to manage the communication with the team
	Things to avoid or that are a "no go"
Reintegration	How to "onboard" the employee again (when they have been out for a long time)
Training the team	How to train others so that they know how to react

employees themselves do not acknowledge that they have a mental health issue, either because emotional and cognitive impairments preclude them from doing so (Dimoff & Kelloway, 2019b) or because of a conscious decision not to disclose, they may not gain access to these critical resources at all.

In the second and third scenarios, we identified common and distinct elements in leaders' management of employees' IM strategies. Among the commonalities, leaders were concerned with maintaining two balances: one between the employee's well-being and the team's performance, and another between the employee's confidentiality and the communication with the team. In the first, leaders strived to provide support for the struggling employee while ensuring that the team's goals were met. In the second, leaders were concerned with respecting the employee's privacy while determining how to communicate with the team to minimize misunderstandings and adverse effects on team dynamics. These challenges have also been reported in previous research on managers' experiences in situations of employee mental ill-health (Ladegaard et al., 2017; Martin et al., 2018) and highlight the need to provide training and support for leaders to strike the right balance among these different sources of cross-pressure.

Another common point in the management of IM strategies was leaders' expectation of the employee's active engagement and accountability for their situation. In this regard, although leaders were generally understanding and willing to provide support, such support was framed on the expectation of the employee actively trying to resolve their situation and, eventually, returning to their previous performance. This finding is consistent with previous research showing that individuals with a stigmatizing condition (e.g., depression) who are actively coping and managing their symptoms are blamed less and are more likely to receive social support, regardless of whether they were perceived to be responsible for their condition in the first place (Key & Vaughn, 2019; Schwarzer & Weiner, 1991).

On the other side, we uncovered three main differences in leaders' management of *transparency* versus *fabrication* strategies. First, leaders felt more favorably when they perceived that the employee was being honest and transparent. In contrast, their feelings were more unfavorable when they perceived that the employee was concealing something or was in denial. Second, leaders adjusted their focus on well-being versus performance depending on the situation. In the case of *transparency*, their efforts were focused on ensuring the employee's well-being and providing adequate support. In the case of *fabrication*, the focus shifted toward aligning perspectives and trying to get the employee's performance back to normal. Finally, leaders perceived that the employee had more control over his situation when using a *fabrication* strategy, which further influenced expectations of a quicker recovery.

These findings provide evidence that *transparency* strategies are more likely to lead to supportive leader responses, eliciting more favorable feelings and helping behaviors and allowing struggling employees access to relevant resources, such as employee assistance programs. Conversely, *concealing* strategies such as *fabrication* were shown to be more likely to elicit negative feelings, limiting the extent of the support provided and, in some cases, even leading to un-

supportive responses (e.g., judgmental behavior). One possible explanation for these results derives from the visibility of symptoms. Following Jones & King's (2014) disclosure model, given that leaders were already aware that something was wrong with the employee after the first vignette (indicating a high degree of visibility), an attempt to conceal could communicate distrust in the leader and lead to more negative interpersonal outcomes. Furthermore, such behavior might be perceived as inauthentic, which may damage the relationship and increase social distance (Lynch & Rodell, 2018).

However, although a *transparency* strategy elicited more positive responses, leaders perceived that an acknowledged mental health issue represented a more severe, complex, and challenging situation, with lower expectations of recovery and a higher probability of worsening. These perceptions have the potential to negatively affect the individual's professional outcomes, such as performance evaluations, salary, or future promotion decisions. These results support the existence of a *disclosure dilemma* (Griffith & Hebl, 2002; K. P. Jones & King, 2014) that individuals with mental health issues must negotiate when deciding whether to disclose their condition. On the one hand, they could garner social support and access much-needed resources. On the other hand, they could also face workplace inequities due to underlying assumptions about their capabilities (Colella & Santuzzi, 2022; Kalfa et al., 2021). These findings highlight the need for workplace interventions to reduce stigma and challenge common misunderstandings surrounding mental health conditions, such as the perception that those with a mental illness are less competent or that working is unhealthy for them (Colella & Santuzzi, 2022).

5.1. Theoretical contributions

From a theoretical perspective, this study expands on existing disclosure and IM models and frameworks by exploring the cognitive and emotional mechanisms that shape leaders' supportive or unsupportive responses toward stigmatized employees. Specifically, our findings suggest that the discloser's perceived honesty and active coping efforts (i.e., *offset controllability* (Key & Vaughn, 2019)) could be critical in determining positive outcomes via the confidant's reaction. However, these dimensions were not explicitly explored in the reviewed disclosure models. Future research could further analyze these constructs as potential moderators between IM and the confidant's reaction, similar to the *timing* attribute in the model developed by K. P. Jones and King (2014).

Another contribution from this study relates to the previously discussed *disclosure dilemma*. More specifically, even if the confidant's reaction is supportive and has a positive influence on the discloser's well-being and interpersonal outcomes (as described in the models by Chaudoir and Fisher (2010) and K. P. Jones and King (2014)), individual professional outcomes could still be negatively impacted. This is consistent with Kalfa et al.'s (2021) concept of *care-based structural stigma*: Even a well-intentioned approach, intent on supporting and protecting the employee, might inadvertently restrict the employee's opportunities and agency in their work. This finding underscores the complexity of the stigma surrounding mental illnesses, showing that supportive responses can be a double-edged sword and challenging the notion that specific IM strategies could be labeled as "good" or "bad."

5.2. Practical implications

The findings from this study also provide practical insights for HR practitioners, management education, and employees. First, our results highlight leaders' need for clearly defined and accessible organizational policies, guidelines, and resources to support them in managing an employee with a mental health issue. In this regard, organizations and HR practitioners can provide support in at least four ways. Firstly, by implementing and investing in mental health-specific resources, such as employee assistance programs and mental health platforms. Secondly, by providing mental health training to leaders so that they have the knowledge and tools to manage their responsibilities and different sources of cross-pressure. Thirdly, by accompanying leaders during the process of managing an employee with a mental health issue, ensuring that the leader also has access to support as needed. Lastly, by continuously promoting the resources available within the company to all employees.

Second, in this study, we uncovered leaders' self-identified learning needs and preferred learning methods regarding mental health management. In this process, we identified six learning topics from which leaders could benefit: background on mental health, prevention, awareness and sign recognition, management of the situation, reintegration, and team training. Notably, and in alignment with leaders' self-evaluation, leaders' responses to the first vignette in this study further highlight the need for awareness training so that leaders can recognize warning signs of mental health issues even if the affected employee is unaware or unwilling to disclose. Moreover, our findings on IM strategies also underscore the importance of stigma reduction training to avoid, for example, possible instances of *care-based structural stigma*. Put together, these topics can serve as a basis for developing and implementing appropriate mental health education initiatives and training programs, which could contribute to creating healthier work environments in which leaders and their teams can thrive.

Finally, our findings may help employees currently struggling with a mental illness to choose a strategy that is more likely to increase supportive responses from others and avoid strategies that could be harmful. Specifically, we found that demonstrating transparency and active coping mechanisms can help garner social support and elicit more favorable feelings. However, it is essential to note that these results are not meant to solely place the responsibility for supportive responses on the employee's shoulders. Both leaders and organizations have a responsibility to provide support and work on ways to reduce discrimination against those diagnosed with a mental illness.

5.3. Limitations and future research

Although this study contributes to theory and practice, it also has several limitations that should be noted. First, even though vignettes are helpful for exploring individuals' attitudes and beliefs in a specific context, they are not as realistic as a workplace setting. Even if they are carefully developed, they cannot possibly include all aspects of the experience of an employee with a mental health issue. Moreover, the lack of para- and non-verbal context in the described interactions might have made it difficult for participants to connect with the hypothetical employee. To address these issues, future research should consider methods that can capture the nuanced dynamics between discloser and confidant, such as experimental field studies with trained confederates. This method has been used in other areas of stigma research (e.g., religion (King & Ahmad, 2010)) and has the potential to provide unique and rich insights.

A second limitation comes from exploring responses to mental illnesses in general rather than a specific diagnostic. This generalization can be problematic, as different mental disorders might be stigmatized for different reasons. For example, an individual with schizophrenia may be perceived as dangerous, while an individual with depression may not face that stigma (Krendl & Freeman, 2019; Link et al., 1999). Furthermore, by using the general term "mental health issues," the interpretation is left to the interviewee, which could minimize or exacerbate underlying stigma processes. Therefore, further research is needed to analyze responses to specific mental disorders and whether they differ from the ones found in this study.

Third, due to practical limitations, our study did not consider the intersectionality of mental illness with other identities, such as gender, sexual orientation, or race. However, extant research suggests that stigmatization may change and even be compounded by this intersection (Colella & Santuzzi, 2022). For example, regarding race, previous research suggests that certain minority groups, such as Latinas/os and African Americans, hold higher levels of stigma toward mental illness (DuPont-Reyes et al., 2020). Concerning sexual orientation, a study by Holley et al. (2016) found that LGB individuals experienced a "double stigma" in mental health treatment programs. Given that individuals have multiple social identities, future research should consider using an intersectional approach to better understand the complexities underlying the management of mental illness.

A fourth limitation derives from our focus on only two types of active IM strategies (*transparency* and *fabrication*). However, these strategies, which were qualitatively derived from the lived experiences of individuals with depression (Follmer & Jones, 2022), may not be the most commonly used in the work context. In this regard, future research should consider exploring other strategies from stigma management literature, such as *claiming* positive aspects or *downplaying* negative aspects (Lyons et al., 2018), to understand how they may influence supportive confidant responses toward individuals with mental illnesses and whether these findings align with the ones from our study.

Fifth, our study might be limited due to interviewees' social desirability biases. Social desirability refers to a desire to present oneself in a socially acceptable way, which might not reflect reality (Bergen & Labonté, 2020). In this regard, leaders might have displayed more empathetic, understanding, and supportive responses than they would have in a real-life situation. To limit this bias, we used several of the techniques recommended by Bergen and Labonté (2020) for qualitative research, such as using indirect questioning (e.g., "What do you think should happen next?"), providing assurances of confidentiality and anonymity, and probing for more information by asking follow-up questions. However, considering that our study was focused on interviewees' intentions to behave and did not analyze actual behavior, the influence of social desirability cannot be completely ruled out. Therefore, future research in leaders' reactions should consider analyzing the discloser's perspective or using independent observers to gather more objective results.

A sixth limitation comes from using a qualitative research approach. This type of research is used to achieve an in-depth understanding of the perceptions and experiences of individuals, which often limits the sample size that can be analyzed (Charmaz, 2006). In this regard, our small sample size limits the external validity of our study. Furthermore, most of the interviewed leaders identified as male, reducing our sample's diversity. To overcome these limitations, future research should consider approaches that allow reaching a more extensive and diverse sample that more closely represents the general working population, such as scenario-based online surveys with open-ended questions.

Finally, it should be noted that the researcher's own biases may have affected how the information was collected and interpreted. To minimize this bias in the interviewing stage, the interview protocol was carefully revised and adjusted so as not to prime participants toward a desired answer. Furthermore, during the interviews, the interviewer would reformulate some of the interviewees' responses in her own words to verify that she had adequately interpreted their answers. This process of asking participants for clarification and confirmation aided in creating memos for the data analysis stage. During data analysis, we tried to limit potential biases by first analyzing the transcribed interviews line by line and coding them with the participant's own words rather than what the researcher thought they meant. However, due to the inexperience of the researcher, the possibility of biases cannot be discarded entirely.

5.4. Conclusion

The high prevalence of mental illnesses and their significant social and economic impact in the workplace highlight the need for organizations to provide adequate policies and resources to support employee well-being. In this regard, given that leaders are in a position to act as bridges between such resources and their teams, it is critical to understand how they react to and manage employees with mental health issues. Through our study, we uncovered different emotional and cognitive elements that shape leaders' re-

sponses to employees' IM strategies. Our findings provide evidence for when specific IM strategies lead to supportive responses. Specifically, a strategy that demonstrates transparency and active coping will be more likely to lead to positive interpersonal outcomes and a higher level of social support. However, unintended stigma can turn this support into a double-edged sword and lead to negative professional outcomes for individuals. Finally, through our work, we also identified leaders' training needs regarding the management of mental health in the workplace. These learning objectives and our findings on leaders' preferred learning methods could provide a foundation for HR practitioners and management education to develop and implement trainings and initiatives that successfully support and prepare leaders to prevent, identify, and deal with these complex situations.

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