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Managing boundaries: exploring the experiences of line-managers who provide mental health support in the workplace

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ABSTRACT

The increase in mental ill-health amongst the working population presents a serious challenge for organisations. Line-managers are an important provider of support to staff with psychological distress (PD), their experiences however, are under-researched. In response, we interviewed 15 line-managers from the private, public, and voluntary sector about their support provision to subordinates with PD. Drawing upon workplace social support and boundary management theory we explored line-manager confidence, boundaries of the manager/subordinate relationship, and how they navigate the competing demands of their role. We found that organisational psychosocial climate and context are key factors: a stressful or demanding working environment, and/or unsupportive colleagues can undermine the capacity of line-managers to provide social support. Theoretical contributions include focusing on the provider, rather than recipient, of social support and integrating social support and boundary management theory. Practical recommendations include removing the onus on line-managers to provide support and advocating shared organisational responsibility for support from multiple sources, underpinned by a wider remit of policies and procedures. This paper includes line-manager narratives around employee mental ill-health including reference to suicide, that some readers may find distressing.

KEYWORDS

Workplace social support; boundary management; workplace mental ill-health; suicide ideation

Introduction

Globally, it is estimated that fifteen percent of the working-age population have a mental health condition, with the most common disorders being depression and anxiety (WHO, 2022). Prior to the COVID-19 pandemic, the WHO (2019) warned of the growing incidence of mental

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disorders as a global 'burden' with 'significant impacts on health and major social, human rights and economic consequences'. In the UK, workplace mental ill-health was increasing across all major occupation groups (ONS, 2018) and this upward trajectory has continued [Health and Safety Executive (HSE), 2023]. Post-pandemic, of the 1.8 million UK workers with a work-related illness in 2022/23 almost half were due to stress, anxiety, or depression, accounting for 17.1 million lost working days (HSE, 2023). In the workplace, psychological distress (PD) (a range of psychological states such as stress, anxiety, and depression) results in sickness absence, work disability and exit (Aknin et al., 2022; Viertiö et al., 2021). Some symptoms of psychological states may be perceived as part of everyday life, but higher levels indicate impaired mental health (MH), disrupted daily living, and require clinical diagnosis and treatment (Aknin et al., 2022; Viertiö et al., 2021). From an organisational perspective, therefore, maintaining employee mental wellbeing presents a profound challenge.

A UK government commissioned report called *Thriving at Work* identifies public sector employers, the human resource (HR) management profession and line-managers as the frontline for addressing MH at work (Stevenson & Farmer, 2017). Line-managers[1] especially it is argued, play a key role in organisational strategies to promote mental health and wellbeing (Shift, 2007; Stevenson & Farmer, 2017). Line-managers provide support to staff by spotting and responding to signs of PD, facilitating support/adjustment pathways, return to work planning (if employees take sickness absence), and support and monitoring on their return (e.g. Shift, 2007; Bramwell et al., 2016). They also deal with multiple organisational demands requiring them to enact distinct roles, such as staff recruitment, training and development, work scheduling, performance management, customer service and budgetary control (Evans, 2017). A recent report by Chartered Management Institute (CMI, 2023) highlighted that 82% of managers are promoted to the role with no formal training. It is perhaps not surprising that these 'accidental managers' find it difficult to deal with the multiple work and home issues of their staff with sensitivity (CMI, 2023). Thus, line-managers face several potentially conflicting demands, often with little training and possible reluctance for the role that may present challenges, which this paper seeks to explore. Drawing upon workplace social support and boundary management theory we explore the experiences of line-managers in this neglected area of their role.

Our research makes three key theoretical contributions. First, while social support is a widely applied and important research construct, research on support providers is limited (Bavik et al., 2020; Jolly et al., 2021). We respond to the call from Jolly et al. (2021, p. 244) for research on the 'implications for support providers' by drawing on in-depth

accounts from line-managers who support subordinates with PD. In doing so we explore how line managers enact HR policy and work with HR to achieve good people management (Op De Beeck et al., 2016) and how it impacts upon line-manager willingness and capacity. We thereby also contribute to the knowledge base on the manager–employee dyad, specifically the interpersonal dynamics that operate when line-managers are both providers and gatekeepers for social support (Fletcher, 2019). Second, we integrate social support and boundary management theory to explore the challenges and opportunities for line-managers when providing support, and how they navigate the competing demands of their role. Third, we question the role of line-managers at the forefront of supporting subordinates with PD (e.g Hastuti & Timming, 2021; Kellner et al., 2019). We suggest organisational strategies to facilitate shared responsibility towards workplace mental health to strengthen and widen the support provision given to staff with PD.

Workplace social support

Workplace social support has been defined and conceptualised in different ways, across disciplines (Bavik et al., 2020; Jolly et al., 2021). In a review of the literature Jolly et al., (2021) found that 44% of published social support research had 'no clear theoretical' lens, while three frameworks dominated: the job demands-resources (JD-R) model (Bakker & Demerouti, 2007); the conservation of resources (COR) theory (Hobfoll, 1989) and social exchange theory (SET) (Blau, 1964). The JD-R model proposes that every occupation has inherent job demands, such as high workload and role ambiguity that may lead to employee strain, while job resources such as social support may lead to employee engagement (Bakker & Demerouti, 2007). For the provider however, social support may itself be a job demand: Martin et al. (2018) found supporting subordinates with mental ill-health can be emotionally demanding for line-managers.

From a COR perspective, line-managers are an important support resource because they can influence job demands and reduce stress and burnout (Halbesleben, 2006). Resources available to the line-manager are also important, as if they lack resources or have resource depletion, it can negatively impact the support they give and may lead to abusive supervision (Byrne et al., 2014). SET views social support as a reciprocal exchange relationship which develops over time between the provider and recipient and generates feelings of obligations for the recipient to 'respond in kind' (Cropanzano et al., 2017, p. 27). The organisation is a principal factor within social exchange relationships, as line-managers are more likely to be supportive to their subordinates if they are themselves supported by the organisation (Cropanzano et al., 2017).

Each framework provides important conceptual insights into workplace social support, however, while line-managers are perceived as a key source of support, research into their role as support provider has been neglected (Bacharach et al.,2000; Bavik et al., 2020; Jolly et al., 2021). Although research suggests that providing social support has both positive and negative implications for the provider, whether the net outcome is beneficial or harmful remains unclear (Jolly et al., 2021). We have, therefore, adopted a wider perspective of social support that goes beyond a single theory to explore the perceptions and experiences of line-managers who provide psychological or material resources (Jolly et al., 2021) to subordinates. We draw upon House's (1981) conceptualisation of social support, as line-managers may need to provide different types of support, namely, emotional support (e.g empathy or esteem), instrumental support (e.g workplace modification) and/or informational support (e.g signposting to employee assistance programmes) when supporting subordinates with PD.

Supporting others can deplete a line-manager's personal resources if they have several demands, negatively affecting wellbeing (e.g Bolino et al., 2015; Liao et al., 2021). Providing emotional social support at the same time as task-related support, moreover, may have negative implications for line-managers' wellbeing, especially if they have limited managerial experience (Lanaj & Jennings, 2020; Liao et al., 2021). A report by the CIPD. (2018) reinforces the well-established notion of the squeezed middle management, with 35% of middle managers reporting they had too much work to do, and 28% reporting work had a negative effect on their MH. Thus, line-managers may be motivated to protect and preserve resources (Halbesleben et al., 2014). They may adopt, intentionally or unintentionally, a management style that discourages the sharing of emotions by workers (Hadley, 2014) to avoid dealing with negative emotions.

Supporting staff disclosing mental ill-health

While it is increasingly acceptable to talk about stress-related illness in organisational environments (Fineman, 2000), such disclosures are often 'feared' by line-managers (Mind, 2016) because they may feel unsure how to respond (Martin et al., 2018). Supporting subordinates with PD can, therefore, be a sensitive area for both disclosers and those being disclosed to. In some cases, employee MH disclosures can facilitate access to support or work accommodations (Hastuti & Timming, 2021; Mind, 2016), in others they can lead to stigma, discrimination at work, loss of support or even dismissal (Westerman et al., 2017). A conceptual knowledge of PD may not be sufficient, as line-managers also require interpersonal skills to respond to a disclosure appropriately, be empathetic,

respect the privacy of the individual, implement workplace adjustments, and manage the impact upon colleagues (Martin & Fisher, 2014).

In organisations where there is a shared perception of values, policies and procedures that exemplify management commitment to worker psychological health and wellbeing (Law et al., 2011; Dollard et al., 2012; Dollard et al., 2017) the psychosocial safety climate (PSC) is likely to be high. Mainly driven by senior management, the PSC reflects support, commitment, participation, and consultation for 'psychological health and work stress prevention' (Dollard et al. 2012, p. 385). In organisations with low PSC the psychosocial hazard of high job demands, and low resources may leave line-managers little room for manoeuvre when supporting the psychological wellbeing of subordinates. Senior leaders, moreover, influence the behaviour and practices adopted by junior managers towards subordinates (Cropanzano et al., 2017) and ultimately how a manager responds to the mental ill-health of colleagues (Kalfa et al., 2021; Martin & Fisher, 2014). If negative behaviours are tolerated by the organisation, line-managers may engage in workplace mistreatment of subordinates such as social undermining or ostracism (Follmer & Follmer, 2021), rather than social support. Workplace mistreatment can have profound consequences, especially for employees with mood disorders who are not undergoing treatment, increasing their risk of suicide ideation (Follmer & Follmer, 2021). The *Thriving at Work* report asserts that although employers 'want to do the right thing' their line-managers do not have the skills or confidence to provide MH support at work (Stevenson & Farmer, 2017, p. 30) thereby perhaps, assigning inadequate weight to organisational failings. The consequence for the aforementioned 'squeezed middle managers' can be classic role and boundary ambiguity.

Managing boundaries while providing support

Each role a line-manager performs may demand a separate identity that requires a distinctive 'persona' involving explicit objectives, values, and interaction approaches for that role (Ashforth et al., 2000). Over time, some 'personas' may conflict. Boundary theory concerns the different organisational roles that individuals enact, and the transitions people make between these roles psychologically and physically. It reveals the strategies that people adopt to create or manage the boundaries between their various roles (Ashforth et al., 2000). Line-managers, for instance, supporting subordinates may want to determine boundaries to ensure that they maintain a balance between seeming detached and indifferent, at one extreme, and becoming too emotionally involved, at the other (Bacharach et al.,2000). As workplace friendships develop, some behaviours, such as socializing with colleagues or discussing personal matters unrelated to

work, can blur boundaries between work and professional life (Rothbard et al., 2022). The consequences for line-managers, however, remain understudied and, likewise, it is unclear how transitioning between roles may impact upon the wellbeing of responders (Anglin et al., 2022).

Line-managers may experience role conflict when supporting staff with PD because they may have competing demands from other parties, such as their own manager, co-workers, and the HR function (Anglin et al., 2022). In providing support to subordinates with PD line-managers may experience 'cross-pressures'. They can be expected, for example, to be empathetic and accommodating towards their charge, whilst also ensuring that co-workers taking on extra workload are supported and strategic and productivity demands are met (Bramwell et al., 2016; Ladegaard et al., 2019). A further consideration is that subordinates may be unaware of, or unwilling to acknowledge, their MH problems and line-managers may have to deal with associated tensions such as tardiness, absenteeism, disruptive behaviour and low productivity (Bramwell et al., 2016; Gignac et al., 2021). This may leave their line-manager trying to reconcile the conflicting roles of disciplinarian and support provider (Gignac et al., 2021). If line-managers lack clarity as to what is expected of them, or what to prioritise, they can experience role ambiguity (Evans, 2017) which may reduce their ability to support staff with PD. At the same time, line-managers need to respect confidentiality, and tensions are likely to arise, especially in small work groups when co-workers witness the PD of their colleague (Gignac et al., 2021). Co-worker support, moreover, may decline over time especially if behaviours are episodic or symptoms are invisible or if empathy fatigue sets in Suter et al. (2023; Gignac et al., 2021). As a result of these various pressures, line-managers can experience internal dissonance when balancing organisational demands with personal feelings of discomfort, guilt and wanting to do the 'right thing' for their staff (Bramwell et al., 2016).

Line-managers are frequently portrayed as playing the primary role in supporting employees with PD (e.g. Kellner et al., 2019; Stevenson & Farmer, 2017) their experiences, however, have been rarely examined (Martin et al., 2015; Quinane et al., 2021). Little is known about the challenges line-managers face in supporting people experiencing PD before diagnosis and sanctioned absence (Martin et al., 2018) or how providing that support to staff impacts upon them (Bacharach et al.,2000; Jolly et al., 2021). Thus, this paper aims to answer the following research questions: 1: What are the experiences of line-managers who provide social support (emotional, instrument, informational) to staff with PD? 2: How do line-managers navigate the competing demands of their role when providing social support?

Methodology

Participant recruitment

This qualitative study adopts an interpretivist approach (Schwandt, 1998) to explore the experiences of line-managers who support employees with PD. Following University research ethics approval, we sought volunteers through our professional contacts and networks. For example, the study research flyer was posted on LinkedIn and Twitter social networking websites of the study team and Research Institute; network members were asked to share and further disseminate details of the study onwards *via* their individual networks; details of the study were presented during a guest talk at an external research event organised by the Research Institute, which was subsequently posted on Twitter; the Advisory, Conciliation and Arbitration Service (Acas) circulated study flyers at their open access events; a research colleague distributed the study details *via* their Research Institute electronic newsletter. Responding individuals were provided with a participant information sheet detailing the nature and aims of the research alongside notice of how participant anonymity would be ensured. Three participants were known to the research team members who interviewed them, what Garton and Copland (2010) refer to as 'acquaintance interviews'. The three acquaintances discussed experiences that were separate/unfamiliar to the research team, but nonetheless, we were particularly careful with anonymity. We compared their transcripts with the other participants to see if the interviews differed in detail, and we believe that familiarity did not affect their responses (Roiha & Iikkanen, 2022). All participants were invited to complete a brief pre-interview 'face sheet' that provides the information outlined in Table 1.

The inclusion criteria were that participants had line-managed subordinates with perceived mental ill-health, either through employee self-diagnosis/formal diagnosis, or their own observation of behaviours. Participant narratives provided information-rich data on a range of PD behaviours from low/moderate symptoms of psychological states to levels which indicated impaired MH. We deliberately avoided defining 'mental illness', because defining it can be sensitive, coupled with the potential for stigma and discrimination in the workplace context (e.g. Hastuti & Timming, 2021), thereby allowing participants to focus on their own interpretation of the notion. Follmer and Jones (2018) point out that 'mental illness' includes over 200 classified disorders (citing the American Psychiatric Associations Diagnostic and Statistical Manual of Mental Disorders) covering a wide range of severity. As the line-managers in this study noted employees may not want to admit to having a MH condition or symptoms, or even discuss their MH. Thus, an important aspect of the study is that many PD symptoms displayed by staff were never diagnosed,

Table 1. Participant characteristics.

Participant	Gender	Age range	Public or Private Sector	Size of organisation	Received training in managing workplace MH
Adam	Male	26-35	private	200 – 500	Yes
Amy	Female	46–55	private	200 – 500	not sure
Daniel	Male	36–45	public	500+	No
Eleanor	Female	36–45	voluntary	200 – 500	Yes
Ellen	Female	46–55	private	500+	No
Hannah	Female	36–45	voluntary	<20	Yes
Isabelle	Female	26–35	private	50–200	Yes
Jane	Female	26–35	private	20–50	No
Jason	Male	66+	private	20–50	No
Joe	Male	36–45	private	500+	Yes
Julie	Female	26–35	private	200 – 500	Yes
Liam	Male	26–35	public	90–100	No
Maria	Female	16–25	private	500+	No
Melanie	Female	26–35	voluntary	20–50	No
Vicky	Female	36–45	public	500+	not sure

or confirmed, as a specific MH condition. This can complicate matters because, as Sainsbury et al. (2008) suggest, staff without a diagnosis are likely, nevertheless, to be experiencing genuine pressure and stress, which often seemed to be the case in situations described by participants. Participants interpreted the symptoms and behaviours of employees in terms of a range of MH conditions including stress, paranoia, bereavement, anxiety, depression, addiction, post-traumatic stress disorder and psychosis. The most common conditions identified by participants were anxiety and depression. Three interviewees dealt with the repercussions of suicide. Six of the participants reported receiving training around managing MH in the workplace, while two could not recall attending training.

In keeping with Quinane et al. (2021) we sought a heterogeneous sample with diverse experiences rather than concentrating on a particular organisational size or industry. Table 1 shows the participant characteristics. Participants worked across a range of employment sectors including legal services, financial services, retail and sales, hospitality, leisure, education, and emergency services. Five participants held HR development/advisor/director roles. Three had chief executive/director roles in small/medium companies (less than 100 employees). Three worked in the voluntary sector representing a social enterprise, a MH charity, and a faith organisation/charity. Five participants had personal experience of PD, and three had experience of mental ill-health due to witnessing it in family/friends. Subscribing to Malterud et al. (2016) concept of 'information power' we consider the sample size to be appropriate for meeting the aims of the study.

Data collection

In-depth interviews were conducted either face-to-face, *via* telephone or MS Teams and were 42–85 min in length. The interviews followed a topic

guide, which explored their recollection of the first and most recent occasions when they supported someone experiencing mental ill-health, addressing their confidence in recognising and dealing with those situations. All names used to identify participants in this paper are pseudonyms.

Data analysis

Consistent with our epistemological position, we understood the participants' accounts as being socially constructed, in that respondents have ascribed meaning and meaningfulness to their experiences of managing staff with PD. The data were organised and analysed using template analysis, a systematic approach to data analysis (King & Brooks, 2017) that categorises and codes qualitative data according to themes. By themes we refer to 'the recurrent and distinctive features of participants' accounts…that characterize perceptions and/or experiences, seen by the researcher as relevant to the research question' (King, 2012, p. 4). It is a flexible approach which emphasises hierarchical coding but does not advocate a particular sequence of themes, subthemes, or codes, allowing the method to be adapted to the needs of the research (King & Brooks, 2017). Themes relating to key research areas can be defined *a priori*, as well as *posteriori* codes developed from the empirical data. First, following familiarisation of the transcripts, initial themes were identified *a priori* from the interview questions by the first and third author to form a provisional template that was applied to a sub-set of the transcripts. Initial themes, around line manager confidence, understanding of mental health conditions, challenges, and impact of providing support were tentative, as template analysis is an iterative process and modifications were made to the template as the coding and interpretation developed. The primary focus of the research was line-manager support to subordinates, and we were initially guided by social support theory. Recurring through the participant accounts, however, were tensions between work and personal factors, and through discussion and reflective analysis of the data by all the authors, we made the decision to also integrate boundary management theory into the template. As part of the reflective process, we considered our own positionality as members of a research team who have professional expertise in workplace health, experience as recipients and providers of support within our work roles and exposure to PD in different contexts. We discussed the influences of these experiences as they relate to our reactions to the data, and how we attached meaning to the findings, allowing us to reflect upon these areas of influence that shaped our coding and the interconnectivity between

themes. Data were categorised into 'meaningful clusters' (King, 2012) of themes and sub-themes around line-manager provision of support to colleagues with PD, presented in Table 2, which were organized into separate word-processing documents to facilitate analysis. The final iteration of the template was applied to all transcripts by the first author. As King and Brooks (2017) point out, themes are not 'objective facts' that are independent of the researcher. Theme identification requires the researcher to make choices about what to include and how to interpret the data. Thus, although we found social support and boundary management theory facilitated our interpretation of the data, our account is not presented as definitive.

Findings

This section presents our findings relating to the experiences of line-managers who support subordinates with PD, and how they navigate the competing demands of their role. The line-manager perspective is explored in terms of five overarching themes developed from our analysis: confidence in dealing with the PD of staff; boundaries of the manager/subordinate relationship; balancing the interests of an individual and the organisation; the impact of providing support; and support for line-managers.

Confidence handling psychological distress among staff

While all participants expressed a desire to support those they line-managed, the level of confidence to deal with PD varied across the sample. Typically line-managers with personal experience of PD or having witnessed it in family and friends were more confident and felt comfortable asking if employees 'were OK' if they had concerns about their welfare. General conversations, however, could lead to impromptu discussions around subordinates' personal lives. Participants expressed their surprise at some disclosures from staff feeling lonely or unhappy and felt personal pressure in terms of how best to respond. While participants recognised that PD could come from both work and personal situations, they did not always feel comfortable 'delving' into subordinate's lives:

> …too deeply into the whys and wherefores, so I just let him talk to the level that he wanted to without me feeling like I was prying too much (Ellen)

Staff disclosures of potentially more serious PD could also be revealed with no forewarning. One participant described how a subordinate approached her unexpectedly:

Table 2. Template: Providing support to subordinates with psychological distress Themes and subthemes.

1. Confidence in dealing with the PD of staff*A*bility to recognise behaviours as psychological distress
   a. Able to ask the 'right questions'/have conversations
   b. Own personal/life experiences
   c. Navigating professional boundariesDefining boundaries within manager and subordinate relationship
4. Occupational versus personal boundaries
   a. Misinformation from subordinates
   b. Managers not informed of mental ill-health
   c. Managers providing poor/inappropriate advice
   d. Balancing the interests of an individual and the organisationCapability of individual with PD
   e. Pressures to meet team deliverables and performance
6. Dealing with interplay of physical and mental health
   a. Dealing with disclosure/reluctance to disclose PD
   b. Confidentiality of person with mental ill-health
   c. Impact of providing support
   d. Emotional
   e. Line-managers preserving own mental health
6. Sharing same challenging working environment
   a. Experiencing own PD
      i. Workload
      ii. Line-managers taking on extra work
      iii. Coworkers taking on extra work
   d. Line-manager support
      i. Internal
      iii. Manager training
4. Support from HR/Peers
   a. MH first aiders
      i. External
      ii. EAP/Industry helplines
      iii. [Mental health] Charities e.g MIND

> …saying I'm feeling all this stress, all this pressure, money, children, work - all of these things. And then in the next breath she had said, yeah I felt really low before, and I felt suicidal, and then you're thinking, Ok, whoa, whoa this is a completely different ballgame (Jane).

In high trauma roles such as emergency services, staff are exposed to distressing and stressful situations and high workloads. Whether diagnosis is absent or present, line-managers have to differentiate between mental ill-health and general low wellbeing, to judge what level of intervention/support is appropriate. Line-managers may have to make assessments of subordinates' behaviour which they may, or may not be, competent to make. This circumstance is illustrated by Vicky, recalling a previous career in an emergency service, who compared the behaviour of someone in her team diagnosed with PTSD and those of the rest of the team, and concluded, rightly or wrongly, their:

> …wellbeing was challenged. I had tears in the office after people were dealing with things, but I wouldn't say that these people were suffering from MH issues. I think they were just distressed and overworked and struggled to process that.

Defining the boundaries of the manager/subordinate relationship

Our findings highlight the interplay between work and home domains and participants placed importance on the maintenance of appropriate boundaries when managing staff. There was, however, a recognition that this was often hard to do because work, and those they work with, play such a large part of an individual's life. As one participant summed it up 'boundaries are really difficult' because:

> …as a line-manager, you're a big part of that person's life and you have a massive impact, [due to] the power you hold. (Vicky)

Managers were privy to the personal details of many of their employees, and often built-up personal relationships with their staff. There was a concern, however, about crossing a line from being a 'supportive' manager to adopting a role, more akin to a 'counsellor', especially when having simultaneously to act in a command capacity. As one participant noted some employees are:

> … a kind of friend […] but then at what point is it where you actually have to say, no, as a manager this is what I need to do or this is what we need you to do, when it might be something they don't want? (Hannah)

Line-managers may be drawn into the personal lives of subordinates with PD, making it harder to establish appropriate occupational and personal boundaries. As one participant highlighted not everyone can turn to friends and family so the onus of support can fall to a line-manager, which may lead to them becoming 'more involved' than they would want yet, in the following case, still feeling inadequate:

> I was being his best friend, his dad, his manager, and his MH first aider and that's where it gets really, really, a grey area. Because what I actually should be doing according to the MH stuff, is signposting him. […]…how do you just signpost someone when they're breaking down in front of you? (Joe)

Being drawn into the personal domain of a subordinate can lead potentially to an ethical tension between a line-manager helping subordinates and overstepping a boundary by giving advice they were not qualified to give. One HR manager recognised this scenario, and noted that while line-managers should be empowered to ask if staff are 'alright' it was not appropriate to 'advise on things like medication' or ask: 'Are you seeing a counsellor? Oh no, you want to try CBT. Have you tried CBT?' (Melanie)

Balancing the interests of the individual and the organisation

Participants noted the challenge when a subordinate's MH affected their behaviour to the extent that disciplinary action was deemed necessary.

Providing support to staff may require sustained effort over time, which can lead to areas of the business and other employees being neglected. Liam described how he supported a member of staff with depression for 'too long' over an 18-month period as he perceived him as a friend. Providing sustained support had impacted upon Liam's business because the company had lost contracts and services were not maintained:

> …it took a while to pull emotion away from it. I had to look at it from a business point of view. People picking up workload, people who were managing a team of 20 weren't getting managed, weren't getting their one-to-ones or the time and attention they needed (Liam).

Line-managers reported supporting some staff through PD for several months in addition to their regular duties. In a team context, not only would the line-manager be focused on supporting an individual experiencing PD, but co-workers could also be drawn in to provide support as well, distracting from the core business of 'what we're here to do' (Isabelle). Co-workers were often willing to take on extra work to help, especially if they could see their colleague struggling. Over time, however, feelings could change if, for example, people were perceived (accurately or not) to be taking advantage of goodwill. Where a MH condition is not formally established, moreover, co-workers may judge behaviour and absence negatively, which can lead to bullying behaviours. For example, Joe recalled how a team leader set up a Facebook page which highlighted each period of sickness absence one staff member with PD had taken. The page was shared and 'liked' by the rest of the team because they perceived the individual's lack of performance in terms of making their lives difficult rather than someone needing support: 'we've got more work to do now, [they're] taking the piss' (Joe). Thus, other supervisory staff may not only add to the psychological stress of subordinates through bullying behaviours, but also undermine support given by a line-manager.

Participants noted the importance of an open, non-judgmental attitude towards mental ill-health. As one line-manager pointed out employee support could often depend upon chance and 'getting the right manager at the right time' otherwise 'they're just going to be destroyed' (Joe). In such circumstances support may be required from elsewhere in the organisation. One participant who was a senior HR professional described a situation where they intervened between a senior line-manager and an employee with PD. They had the authority and confidence, because the organisation was supportive of psychological health, to be able to assure the employee that they would be line-managed by someone else, and to say to the senior manager:

> 'Whatever you're doing…' That manager was pressing the buttons, and not the right buttons for that member of staff. 'So, you need to back off'. (Amy)

Impact upon line-managers and co-workers

Participants highlighted the emotional and workload implications of supporting subordinates through PD alongside their other job roles. While supporting staff was seen as the right thing to do participants were mindful of their other role demands, as one noted:

> you don't have that much time to spend with the people that you're managing so if you end up getting somebody with some problems, it's almost like oh, god, I haven't got time for this (Ellen).

This can have negative repercussions for both the individual and the organisation if people are unsupported and ultimately go off sick.

Colleagues noticed when individuals were showing out of character behaviours but did not always know how to respond. Amy recalled a subordinate who had severe 'mood swings' and 'anger management issues' that impacted upon the rest of the team: 'because they were treading on eggshells'. Maria recalled a subordinate whose behaviours due to mental ill-health, had an impact upon the rest of the staff, even after leaving her organisation, which had to be managed as 'the colleagues were quite scared of [the individual] approaching the [workplace] again'.

The most severe impact was unsurprisingly, in incidences of colleague suicide, which had a devastating effect upon the line-manager and their team. Two of our participants drew on their experiences of managing staff in the emergency services high-pressure environment and both revealed that they struggled later with their own well-being. Daniel explained how he had managed two staff who had taken their own lives and three others who had attempted suicide. Attending the scene where a colleague had taken their own life significantly affected his own MH: 'I broke down. I lost all ability to do anything that I needed to do in order to function' (Daniel). Vicky described a situation whereby a member of staff who had taken their own life was replaced by an individual with their own MH difficulties. Despite describing the situation as 'terrifying', because she was struggling with her own MH, she still wanted to support and protect her team:

> …it made me really aware of how much we were all struggling and that […] I didn't want to end up either very ill and off sick or, like [my colleague], taking my own life.

Such experiences raise the question of what support is available to the line managers.

Support for line-managers

Participants managed a range of behaviours from subordinates that, while challenging, were not necessarily accompanied by a medical

mental ill-health diagnosis. Participants would often turn to a peer, senior manager, mentor, or the internet for guidance. Such advisory support appeared to be sought ad hoc and informally, rather than being embedded in organisational procedures. The HR department, nevertheless, was identified as an important source of support by many of our participants. The level and quality of support provided to participants, however, varied inevitably because the availability of advice and support depended on individual role holders (peers, managers, HR or whoever) rather than organizational systems. Daniel described how the attitudes towards social support can transform with a change in personnel:

> …in years gone by, if I was asked [by a manager], 'Morning, Daniel - how are things?' I would automatically have to reel off performance details - what our sickness levels were, all the key metrics. I did that for the first few times and then the new manager that had come in, sat down, and went, 'No, no, mate - how are you?' and that completely threw me.

Around half of the participants had not had, or could not recall having, training on how to manage MH at work. Where it did exist, it did not necessarily prepare line-managers to cope with staff with severe MH conditions. It may be detrimental if those attending are perceived by colleagues to be the default support system for subordinates with PD. Joe, who had received MH first aid training, thought that although it was a 'good initiative' the responsibility the training can place on a first aider could be a 'burden' without wider organisational support—in this instance, in another case of colleague suicide:

> the feeling I had after that was like, that isn't my job. As a human being, of course I was upset but I was the only person at the company supporting [them]. From a professional point of view, I think that was really unfair on me. (Joe)

Discussion

Our research responds to calls in the literature for research into the implications for support providers (Jolly et al., 2021). Specifically, we explore the experiences of line-managers who provide support to subordinates with PD. Figure 1 outlines our conceptual framing depicting how social support, boundary management, psychosocial safety climate (PSC) and context interact together to influence line-manager MH support provision. This works to extend our knowledge, thereby, of the challenges and complexities around MH support and their implications for human resource management, especially so given the need to better understand the complexities that operate as line managers work to enact HR in practice (Op de Beeck et al., 2016). As line-managers are an important source of support for staff (e.g. Bavik et al., 2020; Jolly

et al., 2021) exploring the implications of their role as support provider at the same time as navigating other competing demands advances our knowledge of social support theory. The outer circle of our model illustrates the themes developed from our analysis and highlights PSC and context as key factors that influence support provision. Line-managers recognised that the interplay between work and home domains often made it difficult to manage boundaries (e.g. Ashforth et al., 2000) when staff disclosed personal mental-health information. Support provision, moreover, does not exist in a vacuum: a stressful or demanding working environment can diminish the ability of line-managers to provide support to staff, and potentially affect their own wellbeing. Line-manager support can be undermined by colleagues or the organisational environment. Thus, another contribution is to question the key role of line-managers in providing social support for subordinates with PD, instead advocating for shared organisational responsibility.

From a COR theory perspective, social support is perceived as broadly positive (Jolly et al., 2021). Our analysis, however, indicates that providing MH support to subordinates over an extended period or when the condition seems severe may negatively affect line-managers' own wellbeing, and the wellbeing of colleagues and the organisation. Providing MH support may deplete resources as some line-managers in this study reported emotional and workload implications. Line-managers often felt ill-equipped to deal with commonplace PD conditions and yet were sometimes called upon to deal with severe MH disorders. Recent research by Lebenbaum et al. (2021) found that workplace social support from co-workers and supervisors decreased as an employee's MH severity

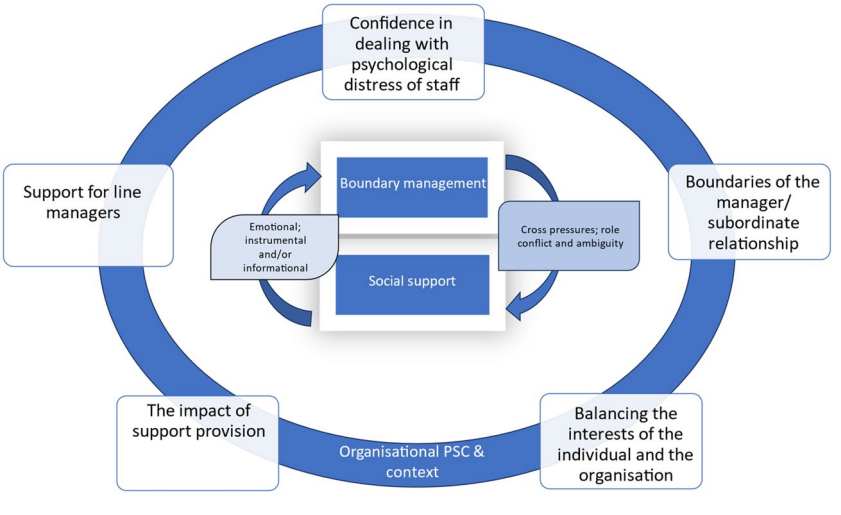

Figure 1. Summary of the conceptual framing and contributions of the study.

increased. From a provider perspective, our findings suggest that the decline in social support can occur because line-managers are unable to support others if they are affected by the same stressful work environment or lack confidence and the skill set to provide support. Our findings highlight, moreover, the additional managerial pressure and responsibility associated with supporting staff with more severe MH conditions such as suicide ideation. Support for line-managers varied and was dependent on individual circumstances and the availability of advice and support from peers, managers, and HR, rather than being embedded in organisational systems. Emotional demands play a key role in the development of job strain, (Bakker & Demerouti, 2007), thus our findings highlight the importance of line-managers themselves being supported to help them cope with the demands of being a support provider.

Participants in this study encountered a range of challenging behaviours that were often undiagnosed as symptomatic of a MH condition. This often led to a focus on addressing an individual's behaviour (and co-worker reactions) to the detriment of supporting and perhaps developing an understanding of their mental wellbeing. Hastuti and Timming (2021) noted that individuals are often reluctant to disclose a MH condition to line-managers and co-workers because of the stigma and discrimination associated with mental ill-health. The hidden nature of many psychological conditions, moreover, can lead to sufferers being viewed as 'malingerers' (Gignac et al., 2021). Our analysis illustrates how easily social networks can be used to undermine or ostracise an employee if their condition is not understood. It also shows that line-manager behaviour (recall the Facebook page was initiated by a team leader) can also be detrimental, having a negative impact upon the MH of individuals (Peltokorpi & Ramaswami, 2021).

Our findings provide some support for Byrne et al. (2014) who suggest that when the resources of leaders are depleted, in this case through taking on the workload of a psychologically distressed staff member during frequent sickness absence, it can lead to abusive supervision. Our findings, however, also highlight the importance of the wider organisational PSC. Cyberbullying may reflect pressures within workgroups, and senior leaders' lack of commitment to protect employee psychological wellbeing (Law et al., 2011). Thus, as a consequence an individual line-manager may find it difficult to stop workplace mistreatment (such as *via* social media), and even have their support undermined, if senior management allow bullying and harassment to go unchallenged (as in the Facebook page example). The implications for a targeted employee are serious because workplace mistreatment is a harmful job demand for all employees, but especially those with untreated mood disorders, and is

associated with increased suicide ideation over time (Follmer & Follmer, 2021). An important wider implication is that such behaviour reinforces the overall organisational PSC, and the lack of employee psychological protection. This is likely to reinforce stigma and deter other employees who witnessed the mistreatment to disclose their own PD. Social networks are likely to play an increasingly important part of workplace social support, for good or ill, and we therefore echo Jolly et al. (2021) call for more research to be undertaken in this area.

Our findings indicate the importance of organisational context. This supports previous research by Kellner et al. (2019) who found that the MH and emotional intelligence of a frontline manager could be a barrier to them providing support to staff in high-trauma workplaces. However, our analysis focuses upon the support provider and highlights how sharing the same stressful work environments can diminish line-manager capacity to support others. The prominence of suicide and suicide ideation in our data (three line-managers had direct experience) was unexpected but perhaps should not have come as a surprise. Globally, suicide is a leading cause of death in OECD countries, with the rate of reported deaths in 2021 ranging from 1.8 in Peru up to 24.3 per 100,000 in Korea (OECD, 2024). In the UK there were 12.9 suicide deaths per 100,000 (OECD, 2024). Two of our cases came from the emergency services where the UK MH charity Mind (n.d) has found employees have poorer mental wellbeing in comparison with the general population and are more likely to identify work issues as the key cause. The extreme end of the vicarious consequences of mental illness revealed in our analysis is undoubtedly the most demanding upon line-managers and a huge challenge for organisations. The provision of line-manager MH training may be welcomed but if colleagues see such training as justification for passing responsibility for support to just a few individuals, it can, as one of our respondents pointed out, place an unfair responsibility on the support provider.

Research on the return-to-work process (e.g Bramwell et al., 2016; Ladegaard et al., 2019) identifies the notion of 'cross-pressures' as line-managers support staff at the same time as juggling organisational demands. Our data shows the presence of such 'cross-pressures' in day-to-day management. Providing empathy and support to an employee alongside other organisational demands and priorities can be a significant resource drain for line-managers, and encroachment into the personal domain can also be problematic. For example, our findings illustrate a tension between a line-manager helping subordinates and overstepping a boundary by giving advice on medication or treatment they were not qualified to give. A lack of understanding around MH conditions and receiving only partial or perhaps misleading accounts from subordinates may lead to line-managers

giving flawed or unqualified advice (Garvin & Margolis, 2015). Such advice could potentially have profound consequences for an individual with PD. One case from our sample, moreover, shows that transitioning from friend to manager and back can be challenging when dealing with, say, changes in performance expectations, and we echo Anglin's (2022) call for further research into the impact of the role change on a support provider's wellbeing.

Implications for HRM

Recent research suggests that line-managers should not be solely responsible for supporting mental wellbeing at work, advocating a 'shared responsibility' approach (e.g. Kalfa et al., 2021; Lecours et al., 2022; St-Hilaire et al., 2019). Line-managers, however, remain at the forefront of supporting subordinates with PD (e.g. Hastuti & Timming, 2021; Kellner et al., 2019). Our research suggests that supporting subordinates with PD can negatively affect line-manager wellbeing, especially when they share the same high-pressure work context. We suggest, therefore, the concept of 'shared responsibility' is even more important, and a greater understanding of how line-managers enact HR practice when supporting staff is needed (Op de Beeck et al., 2016). Guest and Woodrow (2012) note it is 'unrealistic' to put the onus on HR managers (or indeed line-managers) to implement 'ethical human resource management' but we nevertheless argue that HRM has a key role in establishing a broader conceptualization of workplace social support.

As with the wider health and safety best practice we suggest that the protection of worker psychological health needs to be prioritised and led by senior management (HSE, n.d), jointly implemented by HR professionals and line-management (Op de Beeck et al., 2016), involving all staff levels and stakeholders, such as the trade unions (Dollard et al., 2017). Introducing clear and written policies around, for example, equality and diversity, bullying and harassment, and social media work-life boundaries can help mitigate against unacceptable employee behaviour. This in turn can support line-managers by reducing abusive behaviour that may undermine individual support. Senior managers, moreover, need to take swift and decisive action when psychological health is affected, for example, commitment to a zero tolerance to work mistreatment could have prevented the Facebook page bullying example. A PSC of shared responsibility coupled with formal policies can help to connect organisational policy and practice. Organisational context, moreover, is important, and HRM can play a key role in identifying industry-specific psychosocial hazards (social and emotional demands) and introduce job resources (such as work flexibility, and supportive policies) in mitigation. For example, for emergency services staff incorporating relevant resources

to alleviate job related demands such as irregular hours, time pressures, and their working environment (Crowe et al., 2020) along with wider social support can alleviate work issues associated with poor mental health.

Given that some organisations may not know what to do with employees following disclosure of mental health conditions (Quinane et al., 2021) and that a third of managers lack formal management training (CMI, 2023) we suggest that attention is paid to the development of management at all levels. We also advocate for wider employee MH training as having a chain of support at all levels within the organisation to remove the onus on line-managers. A supportive PSC where staff can talk openly about their problems is also likely to encourage employees to disclose conditions (whether diagnosed or not) and help to reduce stigma in terms of employee mental ill-health (e.g. Follmer & Jones, 2018; Hastuti & Timming, 2021). Practitioners could utilise case studies and examples of real-life challenges, along with formal training programmes to highlight the importance of PSC and how to promote it, including, for example, enhancing supportive leadership skills. More work is needed to address specific challenges. For example, the way in which managers from all levels form judgments about MH conditions; and how the PSC shapes their experience of supporting subordinate PD. Organisations would benefit from exploring this through, for example, the lens of psychological safety (Edmondson, 1999) to extrapolate how values and behaviours drive positive action surrounding health for all employees at all levels.

Study limitations and directions for future research

The study sample was limited to fifteen line-managers recruited through our social media and professional networks. Our sample included three 'acquaintance interviews' which does have implications for participant anonymity (Garton & Copland, 2010) and we were, therefore, particularly careful in minimizing personal contextual information. The fact that the three shared experiences unfamiliar/separate to the research team helped to maintain anonymity. Our acquaintance may have facilitated their recruitment and potentially individuals could feel obligated to participate in the research, and we therefore emphasised participation was voluntary. In the participant recruitment literature, we acknowledged the sensitivity of the topic area, emphasising confidentiality of personal and organisational details, and anonymity of information. The participants were self-selecting, appeared sympathetic towards, and willing to support, staff with PD and discussed a range of PD behaviours (from mild to severe) they have perceived in staff they have managed, and this should

be taken into consideration when reflecting upon the results. While our findings are not generalisable, they are transferable to similar work contexts where line-managers provide support for PD in others. This study shows that providing social support to subordinates can have both costs and benefits for the provider, and further research exploring the implications for line-managers supporting staff with PD is needed. Such research may wish to explore how age, training and/or managerial experience, motivation to provide support, confidence in mental health/ill-health influences the experiences of the provider and the perceptions of the recipient. Whether confidence influences how boundaries are managed also merits further research. Diary accounts could be utilized to gain a perspective and insight into how situations develop over time. Further research exploring the line-manager experience of supporting colleagues with severe mental illness versus more fleeting PD behaviours would help our understanding of how an organisation can create a more inclusive environment to support mental ill-health within the workplace.

Conclusion

This paper integrated workplace social support and boundary management theory to explore how managers deal with organisational demands alongside providing social support to subordinates with PD. We highlight the importance of the organisational context and PSC, and how sharing the same high-pressure environment as those they manage can reduce the capacity of line-managers to provide support to employees. For HRM, this study has practical implications for how mental ill-health is supported in the workplace as line-managers cannot provide support in a vacuum and need to be supported themselves. Moreover, putting the onus on line-managers to recognise symptoms of mental ill-health, and provide support, is not proactive especially given the lack of understanding senior leaders often have of employee MH (Quinane et al., 2021). We therefore advocate shared organisational responsibility highlighting the importance of HR (along with senior leaders) in building a supportive PSC, not only in promoting MH awareness in the workplace, but also strengthening and widening the support provision given to staff with PD. This would help to reduce pressure upon line-managers to be the forefront of support, especially when working in the same high-pressure environments.

Note

1. We acknowledge that while there are key differences between leaders, managers and supervisors we use the term line-manager to refer to anybody with direct responsibility for a subordinate (regardless of where they reside in a hierarchy).

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Data availability statement

The datasets generated and analysed during this study are not publicly available due to the terms of the ethics approval granted by Manchester Metropolitan University. Review reference 2019-10564-6267

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