

The impact of career guidance on well-being outcomes

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Declaration of authorship

This thesis contains no material that has been submitted previously, in whole or in part, for the award of any other degree or qualification to this or any other university. Except where otherwise indicated, this thesis is my own work.

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Abbreviations

ALMPs	Active Labour Market Programmes
BPS	British Psychological Society
CBT	Cognitive-Behavioural Therapy
CMHT	Community Mental Health Team
CMP	Condition Management Programme
CPN	Community Psychiatric Nurse
DALYs	Disability Adjusted Life Years
DCSF	Department for Children, Schools and Families
DDA	Disability Discrimination Act
DEA	Disability Employment Adviser (JobCentre Plus)
DfES	Department for Education and Skills
DH	Department of Health
DLA	Disability Living Allowance
DOTS	Law & Watts (1977) model of career education
DSM IV	Diagnostic & Statistical Manual of Mental Disorders (4 th ed)
DWP	Department for Work and Pensions
ERC	Employment Rehabilitation Centre
ESA	Employment and Support Allowance
EU	European Union
FE	Further Education
GDP	Gross Domestic Product
GHQ	General Health Questionnaire
GP	General Practitioner
HADS	Hospital Anxiety and Depression Scale
HE	Higher Education
HEI	Higher Education Institution
HSE	Health and Safety Executive
IAG	Information, Advice and Guidance
IAPT	Improving Access to Psychological Therapies
IB	Incapacity Benefit
IBPA	Incapacity Benefit Personal Adviser
ICG	Institute of Career Guidance
ILO	International Labour Organisation
IPA	Interpretative Phenomenological Analysis
IS	Income Support
JCP	JobCentre Plus
JSA	Job Seekers Allowance

LEA	Local Education Authority
MPRC	Michigan Prevention Research Centre
NEETs	Young people not in education, employment or training
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NICEC	National Institute for Careers and Educational Counselling
ND(DP)	New Deal for Disabled People
NMHDU	National Mental Health Development Unit
NVQ	National Vocational Qualification
OCD	Obsessive Compulsive Disorder
ODPM	Office of the Deputy Prime Minister
OECD	Organisation for Economic Co-operation and Development
OH	Occupational Health
ONS	Office for National Statistics
OT	Occupational Therapy
PCT	Primary Care Trust
P-E	Person-Environment (fit)
PSA16	Public Service Agreement (employment outcomes)
PSHE	Personal, Social and Health Education
PtW	Pathways to Work
PWB	Psychological Well-Being
QoL	Quality of Life
RCI	Reliable Change Index
RCP	Royal College of Psychiatrists
SAMH	Scottish Association for Mental Health
SDA	Severe Disablement Allowance
SDS	Skills Development Scotland
SIMD	Scottish Index of Multiple Deprivation
SWB	Subjective Well-Being
SWEMWBS	Warwick-Edinburgh Mental Well-Being Scale (short form)
VR	Vocational Rehabilitation
VRA	Vocational Rehabilitation Association
WCA	Work Capability Assessment
WEMWBS	Warwick-Edinburgh Mental Well-Being Scale
WFHRA	Work-Focused Health-Related Assessment
WFI	Work-Focused Interview
WHO	World Health Organization
YOP	Youth Opportunity Scheme

A note on terminology

Following the line taken in the *Realising Ambitions* report (Perkins, Farmer, & Litchfield, 2009) the term 'mental health condition' is used in preference to 'illness' or 'problem' to avoid the implication that meeting the criteria for clinical diagnosis is necessarily associated with incapacity to work or develop a career. Similarly 'common mental health condition' is used to refer to the experience of a very large number of people with anxiety or depression that might normally be supported through primary health care, and who might access mainstream employment related services. Other terms will be used occasionally, so as to avoid repetition, to add nuance, or to be consistent with the source literature.

The term 'well-being' will be used primarily to refer to mental well-being, whilst also recognising there is some overlap between physical and mental health. This is a contested term, and a brief discussion of the debate is provided in chapter 1, although these issues are too complex to explore in full within the scope of this thesis.

The terms 'career guidance' and 'guidance' are used loosely and interchangeably in this document, much as they are commonly used in the career guidance profession. This is done with recognition that there is considerable overlap between the activities undertaken by services that might label themselves as career guidance providers, and other services that might locate themselves outside the guidance profession. The latter might include services commissioned or provided by the Department of Work and Pensions; vocational rehabilitation services; or other kinds of labour market intermediary. Relevant evidence is sourced from these diverse environments.

Abstract

The thesis explores the interrelationship between career guidance, mental health, and well-being: an area neglected by the career guidance community in the UK. This topic is explored against a background of growing interest in the connections between work, worklessness and health. As a result of the global economic downturn the need to identify effective interventions to ameliorate the effects of unemployment is now pressing.

Multiple theoretical perspectives were applied to generate possible causal mechanisms by which career guidance interventions might impact on mental health. The empirical literature was explored for evidence linking career guidance to well-being. It emerges there is a shortage of evidence that directly addresses the issue, but a plethora of evidence is available if the search is widened to include the relations between well-being and work (or substitute activities such as education or volunteering), variables related to well-being, and also to include other vocational interventions, such as training and rehabilitation.

New data were generated using a mixed-method approach, underpinned by a critical realist philosophy. The sample population was unemployed adults recovering from mental health conditions, the service users of a specialist employment support agency in Scotland. This group throws the themes of the thesis into sharp focus, as they are on the cusp between work and worklessness, health and illness.

Quantitative evidence from pre, post and follow up measures suggested that participants' well-being improved in the period during which they were engaged with the service. Levels of anxiety and depression followed the same pattern of improvement. Causality cannot be determined as there was no control group and attrition was high.

Qualitative data from research interviews generated confirmatory evidence that well-being had improved while engaged with the service. Participants clearly

attributed causality to the guidance service. Partial deterioration when interventions were completed was also evident.

Three key themes emerge from the analysis:

1. Career guidance may have a direct impact on well-being via mechanisms analogous to therapeutic counselling.
2. Career guidance may impact indirectly on well-being by promoting engagement in work or learning.
3. If these effects can scale up to a population level, then the potential exists for career guidance to be a social intervention with public health implications.

Chapter 1: Introduction

1.1 Overview

This study sets out to explore the potential for career guidance to contribute to the promotion of well-being and the prevention or amelioration of mental health conditions. The study of career guidance is multi-disciplinary, with occupational psychology as a major element, a characteristic that this thesis reflects. The argument draws on other perspectives and sub-disciplines in psychology notably health, positive, counselling and community psychology. This is bolstered by use of other health and social science disciplines including perspectives from sociology, labour market economics, psychiatry, public health and policy studies.

The introduction begins by providing background on the issue of mental health, well-being and employment. This sets out to establish the importance of the topic of study, and the growing interest from academics and Government in this domain of enquiry. The topic is then placed in the wider context of guidance impact research and the search for an underpinning empirical evidence base for the profession. A case is made for the consideration of well-being as an outcome of guidance. The concept of well-being is then introduced, with an acknowledgement of the debate surrounding its definition. Finally, the nature of this study is outlined by making explicit the underpinning research philosophy, the research question, the purpose and structure of the thesis.

1.2 Background

1.2.1 Epidemiological evidence of the incidence of mental health conditions

Mental health is an issue of global importance. Attempts have been made, notably by the World Health Organisation (WHO), to assess its impact. They suggest that one person in four will develop a mental health related condition in their lifetime, and that these disorders account for 13% of the total Disability Adjusted Life Years (DALYs)¹ lost due to diseases across the planet (WHO, 2004c). Similar concerns are raised at European level: Jané-Llopis & Anderson (2005) suggests that psychiatric conditions account for a quarter of all European ill-health and premature death; with depression coming second only to heart disease as the leading cause of disability.

In the UK, a picture emerges of common mental health conditions being very widespread, with far reaching consequences. Citing evidence from the King's Fund report and the 2000 Psychiatric Morbidity Survey, The Foresight Mental Capital and Wellbeing Project (2008) reports there are 828,000 people with moderate to severe depression in England. Singleton *et al.* (2000) present statistical evidence of the prevalence of mental health conditions among people of working age (16-64). This is converted in table 1 below to percentages for ease of comparison:

Table 1: Incidence of mental health conditions, adapted from Singleton et al. (2000)

Condition	% incidence
Psychotic illness	0.4 %
Neuroses (depression & anxiety related conditions)	17.3%
Drug dependence	4.2%
Alcohol dependence	8.1%

¹ Also known as Quality Adjusted Life Years (QALYs).

Drawing on this evidence and other sources, the Foresight Mental Capital and Wellbeing Project (2008) suggests that over 16% of people have common mental health conditions at any one time; half of these go undiagnosed. Cases identified by a General Practitioner (GP) are often inadequately treated. The Social Exclusion Unit (2004) cites evidence to suggest that depression, anxiety and phobias can affect one in six people at any one time, and GPs spend up to a third of their time on mental health issues. Scotland fares badly on measures of health and well-being in comparison to the rest of the UK (Bell & Blanchflower, 2004), notably depression and life satisfaction.

Even allowing for the possibility that some groups may have a stake in exaggerating the level of need in the community, it is difficult to escape the conclusion that mental health conditions are widespread in society. Diverse authoritative international sources point to a high level for incidence. Evidence that is not based on estimates from mental health professional interest groups, but from patient behaviour (such as rates of self-referral to GPs, and suicide) all suggest a substantial issue facing society.

1.2.2 The nature of mental health conditions

The nature of specific diagnoses has been thoroughly described elsewhere, most notably in the influential diagnostic manual *DSM IV* (American Psychiatric Association, 2000).² A more accessible outline aimed at career advisers is provided by Advice Resources (2009a). In broad brush terms, mental health conditions can be characterised in the following ways:

- In most cases they are of unknown aetiology: there is no single pathogen or causal factor that can be isolated. They appear to be multi-causal in nature. Both genetic and developmental factors are pertinent.

² Work on the updating the diagnostic categories for the forthcoming DSM V is currently underway and generating controversy.

- They typically fluctuate in an unpredictable way. They are intangible, and often can only be known if a person overcomes barriers to the disclosure of their own experience of distress.
- They affect a person's ability to navigate the social rather than the physical world. People with mental health conditions may be seen as dangerous or incompetent as a result of stereotyping (Perkins, Farmer and Litchfield, 2009).
- They can emerge at any time of life. However, they tend to early onset compared to other major groups of disabling illness. Therefore they are potentially of longer duration and have a very substantial impact on the health of the population (Dept of Health, 2009). It means they are more likely to affect people of working age than most health conditions which appear post-retirement (SAMH, 2011).
- Co-morbidity and multi-morbidity is prevalent, notably with cardio-vascular and muscular-skeletal conditions, and substance use (Cooper, 2011; McGee and Ashby, 2010; McGurk *et al.*, 2009; Mental Health Foundation, 2006). Mental health conditions, particularly depression, are more common in people with physical health problems (Barnett *et al.*, 2012).
- They are associated with suicidal ideation, with self harm and parasuicide, and via suicide are potentially fatal, with unemployed young men particularly at risk of mortality (Social Exclusion Unit, 2004).

An important distinction needs to be drawn between common mental health conditions that are normally treated by GPs in primary care settings, and relatively rare but severe and/or enduring conditions, such as schizophrenia, which are normally treated by specialist mental health professionals in secondary health care services. Up to 90% of mental health conditions are treated in primary care, (Social Exclusion Unit, 2004; Sainsbury Centre for Mental Health, 2007b; Black 2008). Anxiety and depression represent the great

majority of these consultations, and the bulk of the burden of mental ill health on the community.

The diagnosis of mental illness is a contested area (e.g. Benthall, 2006; Maddux, 2002). It can be convincingly argued that there is no clear boundary between those with and those without a condition. It may be thought of as a continuum between positive mental health and illness (Huppert, 2004). The same symptoms that define mental illness can be found in the general (non-clinical) population. This is true not just of the universal and mundane experience of anxiety, but also of the more colourful and less common psychotic symptoms such as hallucinations, which are sometimes interpreted as religious or artistic experiences (e.g. David and Leudar, 2001). Diagnosis is often defined by a relatively arbitrary cut off point based on the number, intensity or frequency of symptoms. The presence of symptoms may not in itself be enough to trigger diagnosis; the resulting level of concern and inconvenience caused to others may also be a factor.

Some have argued that the medicalisation of psychological distress has become widespread due to the vested interests of the psychiatric profession, or the pharmaceutical industry. Anti-depressants represent one of the largest categories among drug sales (Horowitz and Wakefield, 2007), so corporate influence on diagnosis cannot be dismissed. Sociological critiques of the medico-legal structures for conceptualising and managing 'madness' are well developed (e.g. Pilgrim & Rogers, 2005) and stress the way in which deviance is socially constructed for purposes of social control. The work of psychiatrist Szasz (1974) represents a landmark contribution to this argument.

Taken together, these issues suggest that for the purposes of this research, people with mental health conditions need not be considered as a distinct population.

1.2.3 The economic cost to society of unemployment associated with psychiatric illness

There is international recognition of the economic importance of the burden of psychiatric disease on society (WHO, 2004c). This global perspective is echoed at the UK level. Health conditions in the working population in general, and the economic impact of mental health conditions in particular are a concern for Government:

“Life expectancy and numbers in employment are higher than ever before, yet around 175 million working days were lost to illness in 2006...The economic costs of sickness absence and worklessness associated with working age ill-health are over £ 100 billion a year...” (Black, 2008: 9 & 16).

“The social and financial costs of mental health problems are immense. The burden on individuals, families and communities as a whole includes the psychological distress, the impact on physical health, the social consequences of mental health problems, and the financial and economic costs. Recent estimates put the full cost at around £ 77 billion, mostly due to lost productivity.” (Department of Health, 2009: 8)

Friedli & Parsonage 2007, provide a balanced discussion of the health economics surrounding mental health. Whilst making it clear that economic quantification is only one way of thinking about issues in mental health, they identify costs as falling into three broad categories:

- the cost of health and social care provided by the state and by families
- the loss to the economy resulting from inability to work
- a monetary estimate of the human cost resulting from reduced quality of life.

They estimate the overall costs to the UK of nearly £ 115 billion in 2006/7 (equivalent to 8.6% of national income). Estimates vary depending on the methodology used, but there is consistent evidence that mental health conditions present a substantial economic burden to society, and that the greater part of the costs are associated with the consequences for workplace participation (Greenberg, Stiglin, Finkelstein & Berndt 1993; Curran *et al.*,

2007). McGee & Ashby (2010) speculate that the costs from 'presenteeism', i.e. underperformance from unwell attendees at work, may be greater than those resulting from absenteeism, but such claims lack evidential basis.

These estimates underpin an argument for improved workplace management of conditions. Sainsbury Centre for Mental Health (2009a) suggests there are possible savings of £8 billion per annum if mental health at work was managed more effectively. Historically the evidence for a link between happiness and productivity in workers has been equivocal (Cropanza & Wright, 2001). More recently, research suggests that promoting well-being at work may be consistent with encouraging sustainable improvements to productivity (e.g. Harter, Schmidt & Keyes, 2002). Price Waterhouse Coopers (2008) reviewed published evidence and good practice case studies, and found that although employers have been slow to take up the idea that they had a role in promoting wellness in the work force, there was evidence that doing so produced benefits to both intermediate and bottom line (profit) outcomes. There is correlational evidence showing an association between job satisfaction and productivity (Diener *et al.*, 2009). Job satisfaction is positively associated with productivity, and other desirable outcomes such as low staff turnover (Judge & Klinger, 2008). However, there may be some wishful thinking here: Shackleton (2012) suggests this evidence base is not strong enough to be used to make recommendations to business or Government. Irrespective of the links to productivity, the workplace remains a focus for state funded health promotion, as exemplified by the Scottish Centre for Healthy Working Lives (2012).

1.2.4 Economic inactivity among benefit claimants as a focus of concern for Government

With factors such as prolonged education delaying entry to the labour market, and increased longevity extending the retirement years, the proportion of the population in work has decreased (e.g. McQuaid, 2007; McQuaid, Brown & Newlands, 2008). The far-reaching fiscal consequences of this changing dependency ratio have forced Governments to take steps to reduce the number

of people of working age who are economically inactive. Since the 1990s the scale of incapacity related benefit claims has been a source of concern in the UK (Black, 2008), and those not working for reason of mental illness has become proportionately the largest group among claimants. Drawing on Labour Force Survey data and other sources, the Foresight Mental Capital and Wellbeing Project (2008) suggests that people with mental health conditions experience a disproportionately low rate of employment, 21%, as compared to 47% for all people with disabilities and 74% for the UK working age population.

In recent years positive psychologists have highlighted concerns about the scale of the burden of mental health conditions, and the apparent failure of economic growth to result in increased happiness. Economists have been influenced by these arguments, notably Richard Layard. He has argued that the mental illness 'epidemic' is the biggest social problem facing the nation. The promotion of happiness represents an important goal for government policy: both alleviating the burden of distress on individuals and reducing the economic burden on society of inactivity (Layard, 2004; 2005a & b; 2006).

1.2.5 Growing interest in well-being in wider social policy

Layard's contribution is one manifestation of a wider movement towards consideration of well-being in policy discourse (e.g. Donovan & Halpern, 2002; Marks & Shah, 2005). A discussion paper from the Young Foundation argues that:

“...psychological needs are a crucial and still relatively neglected lens for social policy...It is no longer the case that exclusive priority and attention to material need can be justified. Nor is it the case that methodological or practical barriers to understanding and measuring psychological needs should act as an impediment.” (Watts & Vale, 2008: 1-2)

It could be argued that well-being has become a politically malleable phrase in policy discourse (e.g. Field 2009b). This critique may be fair in relation to the developments described above, but is harder to sustain when confronted with

the more substantive scientific contributions on the topic (e.g. Foresight Mental Capital and Wellbeing Project, 2008; Marmot, 2010).

Health promotion is becoming an increasing focus in education, another policy domain of interest to the career guidance profession. In relation to the school sector, one author comments:

“...there has been an explosion of interest, policy debate, policy making, academic research and programme development around the concept of emotional well-being...” (McLaughlin, 2008: 353).

This is evident both in the literature relating to well-being in schools (e.g. Noddings, 2003; Spratt *et al.*, 2006), and also in Government policy initiatives (e.g. DfES 2001; HM Government, 2004; Scottish Executive, 2005a). However, the reality of implementation lags far behind the rhetoric (Finney, 2006).

Added impetus to the focus on well-being in social policy comes from a growing epidemiological evidence base linking physical and mental health outcomes to social causation. The observation that there are socio-economic gradients in health outcomes is underpinned by robust international evidence showing associations between income, occupational status, educational status and a variety of health outcomes including the prevalence of symptoms, morbidity, and mortality (Marmot, 2010)³.

Wilkinson & Pickett (2010) take the argument a stage further by suggesting there is a relationship between the degree of inequality and health outcomes at a societal level. Relative rather than absolute levels of deprivation are important for them; the steeper the inequality gradient, the worse the health outcomes at the societal level.⁴ This has wide implications for public health policy.

³ Barnett *et al.* (2012) provide a recent illustration. They found a strong tendency for mental health disorders to co-exist with other health conditions, and that association showed a social gradient. Adults living in the most deprived areas had a prevalence of multimorbidity the same as people 10-15 years older than them in the most affluent areas.

⁴ Wilkinson & Pickett's book *The Spirit Level* has attracted intense criticism. The critique is primarily from a neo liberal political stance, as their position implies an interventionist policy agenda. Discussion of these critiques and their rebuttal can be found at the Equality Trust (2010).

1.3 Career guidance impact research

1.3.1 The need for the guidance profession to develop an evidence base

Bernes, Bardick & Orr (2007) suggest that the career guidance literature is rich in theory but often assumes that this will somehow translate into effective practice, without testing the efficacy of its recommendations. Evidence-based practice in the field has been described as the 'holy grail' of career guidance (e.g. Hughes, 2011): desirable but out of reach. Whilst there are some early landmark sources such as Oliver (1979), Fretz (1981) and Oliver and Spokane (1988), in general most of the relevant literature pre-dating the 1990s represents isolated studies of theories or interventions, without a shared sense of an evaluative culture or authoritative surveys of the impact literature.

This is in contrast to the extensive research in occupational psychology on the effectiveness of employee recruitment and selection procedures (summarised by Smith & Robertson, 2001). The comparison with therapeutic counselling psychology is similarly unfavourable where there is a well established outcome research effort. This is most evident in relation to cognitive behavioural therapy (CBT) where quantitative studies demonstrating impact have been instrumental in its recognition as treatment of choice for some mental health conditions, and as a mechanism for reactivating unemployed workers (NICE, 2004; Centre For Economic Performance, 2006). Whilst career counselling might seem to be a more obvious choice for a response to unemployment than a therapy such as CBT, it has not enjoyed a favourable profile with policy makers. Its lack of a persuasive evidence base is, at least in part, to blame for this.

Whilst some argue that recent years have seen a decline in the number of guidance impact evaluation studies, particularly those that adopt strong research designs (Magnusson & Roest, 2004), this is perhaps an over-pessimistic viewpoint. There have been notable contributions including the work of John Killeen (e.g. Killeen, 2004), and Susan Whiston (e.g. Whiston,

Sexton, & Lasoff, 1998). Recent important contributions in the UK include Bimrose, Barnes, & Hughes (2008) use of longitudinal qualitative research studies, and Hughes & Gration's (2009a) literature review. This study represents an attempt to complement this literature by drawing attention to a neglected category of outcomes: those related to health and well-being.

1.3.2 The neglect of health outcomes by the career guidance profession

In the mainstream career guidance literature there is a dearth of material that directly addresses positive health and mental well-being. Most relevant texts contain no direct reference to health or well-being, irrespective of whether their focus is career theory or guidance practice (e.g. Arthur & Rousseau, 1996; Gothard *et al.* 2001; Hall, 1986; Herriot, 1992; Jayasinghe, 2001; Kidd, 2006; Nathan & Hill, 1992; Peiperl *et al.*, 2000; Savickas & Spokane, 1999; Schein, 1978). Reference to mental illness is also largely absent from the literature. There are isolated examples of writings on career related stress (e.g. Latack, 1989; Baruch, 2009)⁵. This powerfully indicates that career theorists, researchers and practitioners have not incorporated mental well-being into their conceptual models.

It might appear that most authors do not see a connection between guidance and well-being. However this is not universally true. Passing references to well-being can be found in the mainstream careers literature, and sometimes in unexpected places. Curiously, even where they are emphatically stated, these ideas are not developed (e.g. Barham and Hawthorn, 2009; Gati, Saka & Krausz, 2001; Kline, 1975; Savickas & Walsh, 1996; Swanson & Fouad, 1999; Whiston & Rahardja, 2008). Osipow & Fitzgerald (1996) also has a relevant chapter, but only a few pages address mental health directly and there is no material on the implications of mental health and well-being for guidance

⁵ These examples are perhaps more typical of references to career in the stress literature, than vice versa. However, as Blustein (2008) points out, occupational health psychology can provide a useful perspective to inform career counselling.

practice. In general, these sources express a belief in a guidance and well-being relationship, rather than make a serious attempt to explore the nature of this connection, or its implications.

There are two strands in the North American literature which represent important exceptions to the generalizations made in the critique above. The first is a long running debate concerning the relationship between career counselling and therapeutic counselling. Some authors involved in this debate argue that career interventions have mental health implications, notably Herr:

“If one considers work and mental health to be linked, and career counselling to be an effective process in helping people choose work wisely and improve their adjustment to it, then, logic would argue for career counselling to be a useful process in the service of improved mental health.” (Herr, 1989:13)

Herr (1994) subsequently suggested that there is a trend in career theory towards a growing awareness of the link between mental health, well-being and career experiences. Zunker (2008) represents perhaps the best developed case for a close relationship between counselling for career and for mental health issues:

“Increasing awareness of the connection between mental health conditions and career choice and maintenance is a refreshing development. The whole-person approach of helpers who offer career counselling include significant emotional and cognitive influences that have an effect on how each person approaches the initial choice process. Mood disorders, which usually include anxiety, depression and emotional instability, are logical concerns of helpers who are assisting clients in the decision process. Negative cognitions can seriously alter an individual’s ability to make an optimal career decision. Self-referent beliefs and assumptions that are demeaning can influence feelings of being inadequate, incompetent, and inefficient. Negative cognitions can lead to indecision and/or negative overgeneralisations about the world of work and one’s future goals...” (Zunker, 2008: 81).

The other strand in the career literature that takes these issues seriously is a more recent one, drawing on influences from positive psychology. This is best exemplified by a special edition of the *Journal of Career Assessment* (edited by Walsh, 2008), which directly addresses well-being and guidance. Here we can find cogent arguments for taking a well-being focus, and an argument that vocational psychology already contains within it a valuable health-related body of knowledge:

“Although a scant literature has specifically addressed the relevance of SWB [subjective well-being] for career theory and practice, particularly within an assessment context, a vast vocational psychology literature has dealt with highly related constructs of work values, work adjustment, and job satisfaction.” (Hartung & Taber, 2008:76).

Material in the British literature directly linking health, mental health or well-being to career guidance is extremely rare. Peck’s (2004) history of guidance in the UK contains no reference to health or well-being. Exceptions to the rule include DfES (2003), which is an example of practice in the Connexions service addressing the needs of people with mental health conditions. Advice Resources (2009a & b) provide background information and guidelines for guidance practitioners on working with clients with mental health conditions. Research on relevant practice includes Harvey (1998), Butterworth & Dean (2000), Chambers (2010) and Barker *et al.* (2005). Kidd (1998; 2004), makes a convincing case that emotion is neglected as an explicit focus in the study of careers, although it is implicit in much of the literature.⁶ Kidd’s wide ranging articles provide no clear way forward on the implications of such a focus for researchers or practitioners. However, some of her more recent work does focus in on aspects of well-being (e.g. Kidd 2006b; 2007; 2008; see section 3.5.1).

⁶ In this respect Kidd’s work is influenced by writers who have considered emotion in work organisations e.g. Fineman, Hochschild, and her colleague Briner. She adopts a technically correct but narrow definition of emotion as a transient state.

It seems that, with the notable exception of two threads in the literature, the career and well-being link has not been systematically explored. This thesis is, in part, a response to isolated calls for a focus on the well-being outcomes of career guidance, not just in practice, but also in research:

“Hence, we encourage researchers to include measures of psychological distress and life satisfaction in outcome studies. Although our experiences tend to support the view that vocational counselling can affect the psychological, physical and financial well-being of individuals, additional systematic research is needed to verify our perspective.” (Whiston & Rahardja, 2008: 457).

1.3.3 Developing an argument linking guidance and well-being

There are two channels whereby career guidance could impact on mental health and well-being. Firstly, career guidance may have a direct impact. It can be conceptualised as a form of counselling. Counselling interventions are intended to reduce distress and improve well-being and do so by a ‘talking cure’. Career guidance is not normally thought of as directly addressing symptoms; but there are reasons to suppose it could have similar effects to therapeutic counselling. This line of reasoning draws on the arguments of Herr (1989) and Zunker (2008), amongst others.

Secondly, career guidance may impact on well-being indirectly by facilitating access to healthy activities. In spite of concerns about stress in the workplace, there is a substantial body of evidence that employment is on balance good for well-being, and that unemployment is a significant risk factor for mental health problems (e.g. Warr, 1987; Murphy & Athanasou, 1999; Fryer, 2000). Similar but smaller evidence bases exist for participation in education, voluntary work, leisure activities and religious group membership. By promoting participation in work and learning, career guidance may increase access to social group membership which has health promoting benefits for the individual, in addition to economic benefits to society. For the purposes of this mechanism, career guidance need not be conceptualised as counselling, indeed any intervention

intended to promote participation would be pertinent. Furthermore, if there are health gains from engaging in work or learning, it seems likely that supporting service users to select opportunities well matched to their abilities, interests, personality and circumstances will tend to maximise those gains. This notion is explored in chapter 2, where person-environment fit theory is considered.

The direct and indirect channels of impact emerge as key themes in this thesis and are explored in depth in the discussion, together with a discussion of their implications for public health, which emerges as a third key theme.

To posit such causal linkages can be justified by drawing on two recent authoritative scientific contributions, which point to the potential contribution of guidance to health. The Marmot Review (2009) argues for strong government policy that combats inequality in general, but also (amongst many recommendations) suggests objectives that could imply the strengthening of career guidance structures is needed:

“Increase access and use of quality lifelong learning opportunities across the social gradient, by:

- providing easily accessible support for 16-25 year olds on life skills, training and employment opportunities
- providing work-based learning, including apprenticeships, for young people and those changing jobs/careers
- increasing availability of non-vocational lifelong learning across the life course.” (Marmot, 2010:18).

Implicit in Marmot Review, it is explicit here in this call for:

“Well designed work placement, support and intervention programmes to help those with mental health problems. Better access to work for those with mental health problems is known to offer both clinical and economic benefits; such schemes offer good value for money...The strategic economic role of career guidance needs to be reconsidered and emphasised. This is because the nature of career is changing for a large proportion of the population, and because the provision of learning for adults is becoming more demand-led and

complex...As careers, career expectations and opportunities change in the future, it will be important to develop new markers of career success and different criteria that reflect the diversity of the workforce and the changing aspirations of individuals". (Foresight Mental Capital and Wellbeing Project, 2008:20/23).

These two sources are independent of the guidance profession (although the Foresight Project received a contribution from Kidd, 2008). Leading health sources seem to find the idea of causal link between career interventions and health outcomes to be sufficiently plausible to suggest policy action.

Unfortunately, the application of the occupational psychology to develop interventions to support the jobless is under-developed (Stansfield, 2001); the same is true of career guidance (Patton, 1996): so an empirical base is lacking for these prescriptions.

1.3.4 The construct of well-being

Concepts such as happiness and well-being are ancient in origin and have been explored by a variety of philosophers, notably from the epicurean, utilitarian and existential traditions. A full discussion of the roots of these ideas and alternative ways of conceptualising happiness is provided by Haybron (2008) and is beyond the scope of this study, as the concepts available in the psychological literature are adequate.⁷ Whilst the following outlines the most influential and most relevant conceptions of happiness and well-being in contemporary psychology, it should be noted that within the discipline fundamental conceptual debates continue (e.g. Griffin, 2007; Brulde, 2007). A foundation for many contributions is that the WHO conception of health is explicitly more than the absence of illness, as it encompasses notions of positive experience of complete well-being (WHO, 1948).

Initially, the psychology of well-being focused on happiness in the sense of pleasure and the experience of positive emotion, which is referred to as

⁷ The sociological literature in this field is quite limited according to Veenhoven (2008).

hedonia. This focus is evident in Kahnmann, Diener & Schwarz (1999), an influential text, and one where the authors distinguish their focus on emotion from the earlier behaviourist movement and the cognitive revolution in psychology. The terms happiness and well-being are often used interchangeably in this literature.

Subsequently, this approach was seen as narrow, so a broader conception was adopted. The construct of subjective well-being (SWB) which underpins a great deal of empirical happiness research comprises two elements:

- life satisfaction, and
- the balance of positive and negative affect.

Many studies of well-being adopt this model, which was advocated by Diener (1984). The construct of life satisfaction adds an intellectual or cognitive element into the original narrow conception of hedonia as emotion. It is an important variable, strongly linked to career satisfaction (Erdogan *et al.*, 2012).

Whilst this view is influential in positive psychology, it is not shared by all. For example, Chekola (2007) suggests that the concept of happiness as currently employed neglects the important issues of autonomy and rationality, arguing these are desirable end states in their own right. The relevance to career is clear as the implementation of a life plan requires both autonomy and rationality. Haybron (2007) questions the identification of life satisfaction with well-being and happiness, and suggests that it cannot be understood without consideration of norms and values: an ethical dimension is needed. This concern is echoed by Griffin (2007). Similarly, Brulde (2007) questions equating happiness with 'the good life', whilst neglecting the 'life well lived': the former implies pleasure seeking, but the latter represents the pursuit of something more meaningful.

Concerns such as these have led to the use of a concept with its roots in ancient philosophy. This is the distinction between hedonia and eudaimonia, attributed to Aristotle in his *Nicomachean Ethics* (Deci & Ryan, 2008; Haybron,

2008; Ryff & Singer, 2008). Eudaimonia represents a more subtle concept than hedonia, and encompasses ideas such as engaging purposeful activity, fulfilling one's true nature or potential, and effective functioning.

From this perspective well-being cannot simply be reduced to the experience of hedonia, which may occasionally be inappropriate or maladaptive (as in the case of recreational use of Class A drugs). A strong case can be made for the importance of eudaimonia for well-being in general (Deci & Ryan, 2008) and its inclusion in the study of careers would seem to be more pertinent than the consideration of hedonia in isolation: work may provide engaging activity and opportunities for personal growth more often than experience of pleasure.

“A further claim is that eudaimonic living is associated with a wide array of wellness outcomes. Those outcomes include hedonic happiness as typically assessed, but it also produces a fuller, more stable and enduring type of happiness than that obtained when one's goals are more directly hedonistic. Among these enduring positive outcomes are a sense of meaning, subjective vitality, higher quality relationships, and better physical health indicators, especially with respect to symptoms related to stress...That is eudaimonic living fosters well-being because it provides satisfaction of people's most fundamental psychological needs.” (Ryan, Huta & Deci, 2008:163).

Eudaimonic behaviour is seen as prosocial and beneficial to society: evidence suggests that increased well-being is associated with a range of social 'goods'. The work of Keyes (2006) helps to flesh out this idea. He suggests there are thirteen dimensions of well-being, but accepts that the distinction between hedonia and eudaimonia represents an effective meta-theory, well supported by research.⁸ These dimensions describe his notion of a mentally flourishing person, several elements of which seem pertinent to careers:

⁸ An approach similar to Keyes' work is presented by Day & Rottinghaus (2008) who collate theories to produce a list of characteristics of the healthy personality: positive view of the future, sense of control, self knowledge, activity, self-regulation, flexibility, wholeness, connection with others, happiness, and wisdom.

Hedonic well-being:	Life satisfaction Positive affect
Eudaimonic well-being: Incorporating both psychological well-being and social well-being	Contribution to society Social integration Social growth and potential Acceptance of others Social interest and coherence Self acceptance Environmental mastery Positive relations with others Personal growth Autonomy Purpose in life

The well-being construct can be very broad, encompassing all positive aspects of health. For example, a perspective emerging in some recent sources associates health and well-being with functional capacity, resilience, adaptability or coping with adversity. Sen (1993) provides a philosophical underpinning of this position by describing his notion of capability. As an approach that stresses personal agency, respect for individual choice, and the use of assets in pursuit of valued goals, Sen's position has much in common with the values of the career guidance profession. Boardman (2010a) identifies advantages of the capability approach to mental health, including its potential to focus attention on individual choice of actions and goals, and equality and human rights. This may be the reason the discourse of capability is adopted in the Marmot Review (2010). As Kajanoja (2002) points out, ideas such as capability relate well-being to freedom and human rights. A libertarian perspective might suggest that well-being should be self-defined by the individual, and that we should be free to choose to reject notions of happiness. This latter position is grounded in political philosophy, but does render measurement problematic.

Huber *et al.* (2011) reject the WHO's founding idea of equating health with a complete state of well-being as unrealistic in a world where chronic illness and

disability are normal elements of the ageing process, and suggest that it simply justifies an unhelpful endless expansion of medical and pharmaceutical industries. They prefer a notion of health that involves the ability to adapt and self-manage. In terms of mental health, they equate this with Antonovsky's (1984) 'sense of coherence' concept. This influential idea involves notions of self-managing and making sense of the environment so as to cope and adapt to psychologically stressful situations.

Quality of life (QOL) is a construct closely related to well-being, but can encompass not just psychological factors, but also physical health and functioning, social health, environmental factors and local community resources (Bowling, 2005; Power *et al.*, 2002). Again this approach has political implications, and it demonstrates that ideas of well-being can expand with apparently few limits on their scope.

There seems to be a multitude of approaches. Forgeard *et al.* (2011) provide an up to date overview of approaches to both conceptualising and measuring well-being. They take the view that although there is a growing consensus that it is important to consider and measure well-being for the purposes of public policy, the issue of how to define it remains unresolved. They suggest that:

“Wellbeing is best understood as a multifaceted phenomenon that can be assessed by measuring a wide array of subjective and objective constructs.”
(Forgeard *et al.*, 2011:79).

The approach to operationalising well-being adopted in this study is outlined later, in the methodology (chapter 5).

1.4 The nature of the thesis

1.4.1 The philosophical position adopted in this study

Ponterotto (2005) argues it is important for counselling researchers to make explicit their research paradigm, particularly in qualitative studies where there are competing world views underpinning approaches to analysis. Similarly in the domain of work psychology, it has been suggested as essential that:

“...the researcher makes explicit, and critically reflects upon, the epistemological assumptions that underlie their own work.”

(Johnson & Cassell, 2001:125).

This section attempts to apply their advice in this study. Johnson & Casell (2001) go on to demonstrate that work psychology has been locked into a traditional positivist, quantitative paradigm and has fallen behind other sub-disciplines in psychology by failing to reflect on epistemological assumptions and to adopt new approaches. Similarly, McMahon & Watson (2007) explore the implications of the shift towards postmodernism for career research.

The philosophical position adopted in this study is that of critical realism, a broad movement in the social sciences originating primarily in the work of Bhasker (1997; 1998). This relatively new, but complex and highly developed philosophy of science has been made more accessible by Collier (1994) and Sayer (2000). It has been applied to a variety of specific social sciences, including management (Ackroyd and Fleetwood, 2000; Easton, 2010), human geography (Yeung, 1997), and economics (Downward, Finch & Ramsay, 2002). A number of key features of this can be made explicit. It rejects the extremes of relativism and positivism, transcending this dichotomy. Nonetheless it adopts an epistemology that is relativist and interpretivist, recognising that knowledge of reality is always partial and local. This is consistent with elements of postmodernism, in that earlier naïve notions of scientific progress are rejected, the sociological determinants of knowledge are recognised, and multiple co-

existing explanations are possible (López & Potter, 2001; Lynch, 2001). However it rejects a 'strong' version of postmodern interpretivism, by taking a pragmatic approach: it is useful to treat objects of study as if they are real. This holds true even of social phenomena which may not be as enduring as natural objects, or exist entirely independently of an agent's conception of their actions (Outhwaite, 1987). Not all explanations may be equivalent in their ability to describe reality, and reality can be understood as complex and stratified, with different depths of explanation possible.

A realist ontology is the fundamental characteristic of critical realism, but it is not incompatible with a relativist epistemology (Bhaskar, 2002). Whilst new paradigm approaches may agree that knowledge is constructed and always from a specific perspective, they disagree about the ontological implications, i.e. on the nature of the observed reality (Johnson & Cassell, 2001). In Bhaskar's terms, radical new paradigm approaches are guilty of an 'epistemic fallacy': blurring epistemology and ontology, whilst privileging the former over the latter. The approach adopted here accepts that knowledge is partial and socially determined, but rejects the view that the only reality is a constructed one. The 'model of man' adopted is that of an evolved biological entity capable of complex social interactions and meaning making. The realist ontology of critical realism means it is consistent with biological causation. This is of value to social scientists engaging with health related research (Pilgrim & Rogers, 2005; Williams, 1999), even though the realities they seek to describe relate to social experience. Critical realist approaches to causation involve seeking and understanding causal mechanisms (Sayer, 2000), a key concern of this study.

The critical realist approach to social ontology reconciles structure and agency and derives from that of Marx: society exists prior to the lives of agents, but they then reproduce or transform it (Pilgrim & Rogers, 2005). This is consistent with the approach explicitly adopted by Bambra (2011) in her view of worklessness and health through the lens of political economy.

This does not represent an anti-positivist paradigm, but is perhaps closer to a post-positivist approach, as described by Szymanski & Parker (2001) and

Hanley-Maxwell, Al Hano & Skivington (2007), representing a reconciliation of the strengths of logical positivism with its critiques and alternative perspectives generated by contemporary paradigms. The rhetorical structure adopted in the reporting of the study is therefore a traditional one, so the use of the first person voice to emphasise the perspective of the researcher has been rejected. As López & Potter (2001) suggest, critical realist writing strives for clarity and rejects the complex linguistic artifice of postmodernism.

The axiological position adopted here recognises the central role of the researcher's values and preconceptions and the need to make these explicit. Essentially these are:

- A belief in the potential of the career guidance interventions to make an impact on individuals and on wider social outcomes.
- A sense that the scale of the distress associated with mental health conditions is not fully recognised and that there is a pressing compassionate need to respond to this problem.
- A view of common mental health conditions such as (mild to moderate) anxiety and depression as representing evolved adaptive responses to unfavourable environments. This represents both a stance on the nature of common mental health conditions, but also a desire for an evidence based approach to seeking non-medical, non-stigmatised responses. Through this lens, career guidance is a normalizing intervention.
- A belief that public mental health measures, and the promotion of positive well-being, are likely to be more powerful than remedial therapy in alleviating mental distress at the population level.

These positions are consistent with the broadly defined emancipatory axiological position of critical realism, and its realist ontology. The use of a mixed methods design in this study is also consistent with the critical realist position. Multi-methods researchers can adopt a variety of pure or hybrid

paradigmatic positions, and many ground their approach in the phenomenon of interest rather than in philosophy (Greene & Cararcelli, 2003). Nonetheless, it does raise issues about the relations of research philosophy to methods which are best resolved by an integrative paradigm (Teddlie & Tashakkori, 2003). Critical realism offers such a paradigm.

The choice of Interpretative Phenomenological Analysis (IPA) as the approach to handling qualitative data goes some way to reconciling these issues, as IPA is frequently combined with quantitative approaches in mixed methods studies adopting a realist ontology. Both the quantitative and the qualitative data generated in this study address self-report of participants' subjective experiences, so their combination is epistemologically consistent. A phenomenological approach is advocated by Wertz (2005) for research in counselling psychology, and is appropriate to this study because it gives primacy to the service users' perspective, and a treatment of such perspectives as 'real'.

Bernes, Bardick & Orr (2007) and Arthur (2008) argue for research into career guidance that adopts an inter-disciplinary approach, links theory with practice, and uses mixed-methods, longitudinal designs. This study represents an attempt to implement this ambitious prescription.

To summarise the research philosophy adopted here is rooted in critical realism. It adopts a realist ontology, an interpretivist postmodern epistemology, and an emancipatory axiology. This is inter-disciplinary, multi-method research, adopting a traditional reporting style.

1.4.2 The purpose of the thesis

This thesis seeks to address the relative absence of well-being in the career guidance professional literature, and to connect guidance research with the growth of health related enquiry in other fields of employment research.

It addresses an ambitious goal: to open up a new line of enquiry for guidance outcome research, that could ultimately inform guidance policy. Its main audience is the career guidance professional community. The message is for researchers, trainers, practitioners, and professional leaders who seek to influence policy.

The empirical research presented here represents an exemplar of the contexts in which relevant evidence may be found. The broad conceptual arguments put forward in this study would require exploration in a variety of contexts, so this study begins a line of enquiry, rather than completes it.

1.4.3 The research question

The research question for the study is stated here:

To what extent does career guidance have an impact on the well-being of clients?

This has been broken down into four sub-questions:

1. Is there a sound rationale for suggesting that career guidance may enhance subjective well-being?
2. To what extent do service users report experiencing changes in their subjective well-being, during and after guidance interventions?
3. To what extent do service users attribute changes to the effects of guidance interventions?
4. Can potential causal mechanisms linking guidance interventions and well-being outcomes be identified?

Although not a rigid division, elements of this thesis can be approximately mapped onto the sub-questions they seek to address as follows:

- | | |
|-----------------------|--|
| 1 Rationale: | Chapter 2: Theoretical perspectives |
| 2 Reporting changes: | Chapter 3: Empirical evidence
Chapter 6: Quantitative evidence
Chapter 7: Qualitative evidence (supplementary) |
| 3 Causal attribution: | Chapter 7: Qualitative evidence |
| 4 Causal mechanisms: | Chapter 2: Theoretical perspectives
Chapter 7: Qualitative evidence |

1.4.4 The structure of the thesis

The remaining chapters of the thesis are structured in the following way:

Chapter 2 begins the literature review by exploring the relationship between career guidance and well-being. This takes a postmodern approach to theory: a range of perspectives are considered, and then applied to generate possible causal mechanisms by which interventions could have an impact.

Chapter 3 continues the review of the literature by exploring the empirical evidence. The detrimental effects of unemployment on mental well-being are contrasted with the relative benefits of work, education, volunteering and leisure activities. The relationship between career development and well-being is explored. The focus then turns to evidence for direct therapeutic effects of career guidance on well-being and related variables.

Chapter 4 provides a brief overview of the social policy context including welfare benefits, labour activation measures, and vocational rehabilitation provision for unemployed adults with mental health conditions. This includes a critique of recent UK Government policy.

Chapter 5 outlines the methodology for both the qualitative and quantitative elements of the study. Some rationale for the choice of methods is provided, and ethical considerations are outlined. A critique of the methodology is provided to inform later interpretation.

Chapter 6 reports the findings from the quantitative data generated in the study.

Chapter 7 reports the findings from the qualitative data, together with some interpretation in the light of the published literature.

Chapter 8 provides an in-depth discussion of the findings, integrating them with a synthesis of the relevant literature. Three key emerging themes are identified.

Chapter 9 presents the conclusions. The state of current knowledge is summarised, followed by an outline of the specific contribution of this study. Implications for career guidance policy makers, service providers, practitioners, theorists and researchers are offered.

Chapter 2: Theoretical perspectives

2.1 Overview

This chapter will explore the relevance of theories of career choice and development to issues of mental well-being. No attempt will be made to provide an exhaustive account and critique of these theories as this has been adequately addressed in a variety of textbooks (including: Arthur, Hall & Lawrence 1989; Athanasou & van Esbroeck, 2008; Kidd, 2006; Osipow & Fitzgerald, 1996; Savickas & Walsh, 1996; Sharf 2006; Swanson & Fouad 1999; Walsh & Osipow, 1995; Zunker 1990, 2005). It will be argued that each theoretical perspective has the potential to suggest different causal mechanisms whereby career guidance interventions could impact on well-being.

It is clearly important to outline the theoretical underpinning of research:

“One observation that can be made from a reading of the representative research into the efficacy of career interventions is that results are often presented as if there is agreement regarding the ‘true aims’ of career planning. Theoretical assumptions are rarely made explicit, even though there may be a variety of perspectives about what constitutes ‘effective’ career planning.”
(Magnusson & Roest, 2004:10-11).

However, theory is used here in a very specific, generative way. Theoretical perspectives are treated as a creative resource. Each perspective is adopted, used to identify possible linkages between careers and well-being, and then discarded in turn. Each perspective has strengths and weaknesses; none offer a complete account of career phenomena. The identification of possible causal mechanisms by which guidance could impact on well-being is the key outcome of this process. This could be described as a postmodern approach. But, consistent with the research philosophy, the ontological reality of career and well-being experiences is assumed to remain unchanged, even though it may appear differently when viewed from different theoretical perspectives.

In order to structure this material, career theories will be grouped together into families using the following categories: person-environment fit; psychodynamic; developmental; counselling; structural; and postmodern constructivist. There is no perfect way of grouping this material, but this approach is adequate. Where appropriate the discussion will expand beyond career theory to identify important links with health and well-being, as the career literature fails to systematically address this issue.

Established career theory will be augmented by use of theory derived from three other approaches, less commonly considered in the study of careers. These are social capital; positive psychology; and the psychology of unemployment. These will be used to generate further potential mechanisms by which guidance could impact on mental health.

Some concepts cut across categories of theory, so the chapter ends by integrating the material: potential causal mechanisms are grouped thematically, rather than by source theory.

2.2 Perspectives from vocational choice and career development theory

2.2.1 Person-environment fit theories

This represents the oldest theoretical tradition in career guidance, originating in the work of Parsons (1908), and closely associated with individual difference psychology and the application of psychometric technologies. It is the most criticized and yet the most resilient perspective that continues to influence current practice. The idea that a person will enjoy greater well-being if matched wisely to their work may be a century old:

“An occupation is the only thing which balances the distinctive capacity of an individual with his social service. To find out what one is fitted to do and to secure an opportunity to do it is the key to happiness.” (Dewey, 1916: 308).

Influential contemporary sources share this intuitive view. Waddell & Burton (2006) state that the right type of work is good for health, because it improves self-esteem, quality of life and well-being.

Person-environment (P-E) fit conceptions are not unique to the career guidance literature and are widely used in other aspects of work psychology, notably the occupational stress literature (e.g. French, Caplan & Van Harrison, 1982; Kristof, 1996; Walsh, 2003). Mismatch between level of task demand, and levels of personal coping resource (or perception of demand and ability to cope) are seen as a key source of psychological distress from this viewpoint. This means P-E fit theory is of interest to us, not just because of its unique position in the history of vocational choice theory, but also because it provides one key framework for explaining the origins of psycho-social stress at work, and gives pointers to its management. It provides a logical reason why effective vocational guidance to promote good occupational choice should result in improved levels of workplace well-being. Yang, Che & Spector (2008) suggest

the P-E perspective is prominent in organizational stress research because it offers superior explanatory power as a result of the dynamic interaction it posits between people and the environment.

There seems to be no clear consensus within the P-E tradition as to which individual difference variables are most useful in matching people to occupations. Variables suggested include:

- Intelligence: a mismatch between task demands and cognitive abilities (specific or general) could lead to stress via mental overload or boredom and under-stimulation.
- Values: a poor fit between work activities and personal values could lead to cognitive dissonance. Indeed Osipow & Fitzgerald (1996) suggest career choice could be seen as process of dissonance reduction.
- Personality: Furnham (1992) explores how personality could influence vocational choice, motivation, productivity, absenteeism, accident proneness and vulnerability to stress.
- Work centrality: Robertson & Smith (2001) suggest that the extent to which work is important to an individual may be a neglected but important variable in matching people to jobs.

However no potential targets for assessment in the P-E fit approach to career guidance have equalled the dominant position of occupational interests (Savickas & Spokane, 1999). Silva (2006) is the most authoritative source on the psychology of interests. The essence of his position is that interest can be seen as a distinctive yet transient emotional state, which over time can become integrated into an individual's personality as an enduring trait. He is able to demonstrate that interest has all the characteristics of major evolved emotions, including distinctive facial expressions. Silvia distinguishes interest from happiness, and treats them as distinct and separate emotions, whilst accepting a connection, and seeing affective interest as a kind of well-being in itself.

Dik and Hanson (2008) accept Silva's approach and provide the most thorough discussion linking interests, careers and well-being. They suggest interests

motivate people to approach new objects, situations and activities. This is a necessary precursor to developing knowledge and competence and achieving goals. Transient affective interest is in itself a kind of (hedonic) well-being, but by promoting repeated encounters it facilitates the development of lasting attachment and patterns of behaviour. Thus it can lead on to more enduring and eudaimonic forms of well-being arising from interests as a stable disposition. For example, work can be experienced as meaningful, and a source of personal growth.

Dik & Hansen (2008) also cite studies that suggest that interest leads on to a variety of positive outcomes including (unsurprisingly) academic attainment, and (less obviously) reduction in degenerative central nervous system diseases in the elderly.

“Part of living the good life, in our view, means living the interested life. A posture of curiosity and inquisitiveness, both synonyms for emotional interest, is both pleasant by itself and also leads one to experience a richer more active life with a broad range of experiences and a broad range of competencies. Emotional interest also is theoretically, part of the mechanism through which vocational interests develop. Dispositional interests in work and leisure have been conceptualized as playing critical roles in providing direction for activities pursued within these life domains. Although the construct of interests is one of several factors that account for variability in well-being, research evidence has demonstrated that following one’s interests often sets the conditions in which satisfying, meaningful work can be pursued; pleasant, engaging leisure pastimes can be explored; and relationships built on shared interests can be strengthened.” (Dik & Hansen, 2008, 95).

Three problems with the P-E fit conception can be identified. Two are well established critiques in the career theory literature; the last arises from attempts to link P-E fit to well-being. Firstly, P-E fit approaches have often been criticized for being static, i.e. neglecting change over time in the individual and the environment, and simplistic. Swanson (1996), in a robust defence of P-E theory, argues that modern conceptions in this tradition have successfully

responded to criticisms of early occupational matching models and that they can provide a more holistic, sophisticated approach.

Secondly, P-E fit, like all psychological theory, is very vulnerable to sociological critiques pointing to the power of socio-economic structural factors in determining careers (e.g. Roberts, 1977). P-E fit could be taken to imply that a satisfactory role could be achieved for everyone given effective vocational choice followed up by adjustments made in post. This may ignore the possibility that some jobs or work environments contain more psycho-social hazards, and fewer benefits than others. Individuals or sub-groups in society may be powerless, limited by health problems, poverty, lacking skills or qualifications, burdened by dependants, or facing discrimination. In these circumstances seeking well-being through occupational interests is not a realistic proposition, but an unattainable luxury.

Thirdly, the belief that happiness and well-being could be promoted by effective assessment of individual traits and matching them to suitable work environments is turned on its head by the consideration of subjective well-being SWB as an individual difference variable in its own right. The direction of causality could be reversed. The possibility of strong traits in this area makes it possible to argue that constructs such as life satisfaction and positive affect are manifestations of persistent characteristics of the individual, drastically limiting the potential for guidance to have an impact. It is clear that there are individual differences in vulnerability to stress. Specifically, 'Type A' personalities are more prone to agitation, stress and associated cardiac disease (Cox, 1981). Those scoring high on the 'Big Five' personality trait of anxiety/neuroticism, and to a lesser extent those scoring low on extraversion, are known to report higher levels of psychological distress (e.g. Holland & Gottfredson, 1994; Furnham & Cheng, 1999). Similar evidence emerges with positive focused measures: Lounsbury *et al.* (2003) found that career satisfaction was influenced by personality traits, particularly neuroticism, optimism, and work drive. Bozionelos (2004) found agreeable personalities display greater intrinsic subjective career success. Most people report that they are happy, and individuals may tend towards their own 'set point' for happiness (Gottfredson & Duffy, 2008).

2.2.2 Psychodynamic theories

Psychodynamic approaches could be considered to be needs based motivational theories, or they could equally well be thought of as a branch of developmental theory, or a school of counselling. Here they are treated as a separate category because of their preoccupation with psychopathology. The notion of a mentally healthy personality being associated with the capacity to work is a well established theme in the psychodynamic perspective, and is often traced back to Freud's *Civilisation and its Discontents*:

"No other technique for the conduct of life attaches the individual so firmly to reality as laying emphasis on work for his work at least gives him a secure place in a portion of reality, in the human community." (Freud, 1930: 80)

The work of authors such as Roe, Bordin and Brill (as summarized by Osipow & Fitzgerald, 1996; Sharf, 1997; and Kidd, 2006) in applying psychodynamic thinking to career development includes emphasis on:

- early childhood experience and parental bonding as a potential source of emotional disturbance, and an important influence on career choice
- irrational career choice as an ego defence strategy
- unconscious factors including libidinal or aggressive impulses as influences on career choice
- achievement competition with the same sex parent as a potential source of distress.

Sonnenberg (1997) suggests that recent psychodynamic views of the role of work encompass its function as an outlet for aggression and competitiveness; a location for social support to be accessed by those with dependent personalities; a 'reparative' activity offering opportunities to contain guilt by 'putting things right'; a locus for psychological development and working through early relationship issues with colleagues; as an expression for healthy

narcissistic needs; and as a source of identification with power. Sonnenberg argues that changes in the 1990s workplace, such as reduced employment security and demands for autonomous flexible employees, have increased anxiety in employees. He argues that there is a role for career counsellors in offering 'containment' of this anxiety. This could mean refraining from advice giving, or rushing to find concrete solutions for the client. Instead seeking to provide a safe space for the expression of anxiety, and helping clients to realize the task is to learn to tolerate uncertainty. This view is consistent with other psychoanalytic writings on work, such as De Board (1978) and Hirschorn (1990) which place anxiety, and defences against it, as central concepts.

Psycho-analytic explanations have the merit that they explicitly address emotion, an issue of direct relevance to common mental health conditions. However these explanations are not influential in modern guidance. Whilst idiosyncratic linkages between childhood obsessions and adult career choice are postulated, these approaches seem to have little to offer in explaining anxiety associated with mass experiences like unemployment. Here the psychoanalytic sources fall back on an analogy between redundancy and mourning or loss, as described by Kübler-Ross (1969).

Although lacking empirical evidence, psychodynamic approaches can enrich other perspectives, such as a developmental viewpoint on careers. Erikson's (1959) model of psycho-social development identifies challenges at each stage of the lifespan; distress arises from a failure in these tasks. This has been an influential model, and one that underpins the next family of theories to consider.

2.2.3 Developmental Theory

Donald Super's influential work has at its heart a fusion of lifespan development psychology, with ideas of self-concept and roles (Swanson & Fouad, 1999; Kidd, 2006). Super attempted to explain how the challenges of the life cycle relate to the implementation of a self-concept, and have implications for

vocational behaviour. By introducing the idea of multiple life-career roles for adults, Super opened the door to consideration of pressure from the demands of these roles or conflict between them. However mental stress was not an important focus in his work. There is no coherent account linking developmental career theory with well-being, but it is possible to detect some areas of connection or overlap.

The notion of social adjustment is to be found in the developmental literature, and is akin to health concepts such as functional ability. It could be conceived in terms of successful fulfilment of social roles. However it is problematic because there are cultural, ethnic, class, and historical differences in what constitutes the proper fulfilment of an appropriate role function e.g. gendered housework/spousal roles. Linda Gottfredson (1981) refines Super's developmental perspective on careers by describing how self-concept in young people is progressively constrained by perceptions of gender and status. Tsousides & Jome (2008) suggest Gottfredson's theory neglects the negative consequences of career compromises:

“...little attention has been given to the psychological effects of career compromise. Given the vital role of work in physical and mental health, exploring such potential effects further is crucial. The emotional effects of compromising career aspiration may be intense and pervasive.” (Tsousides & Jome, 2008: 186).

As Gottfredson emphasises the importance of gender in self-concept development, it is a small step from her theory to suggest that to implement a self-concept that is at odds with one's gender identity is potentially stressful. Osipow & Fitzgerald (1996) describe early studies, pre-dating gender equality legislation and contemporary sensibilities, suggesting that gender atypical interest profiles are a manifestation of psychopathology. More recently, Bimrose (2004) demonstrated that women choosing traditionally masculine careers experience social pressure and harassment, sometimes making their role unsustainable. Thus any psychological distress experienced by those choosing non-traditional roles is more likely to be a consequence of pressures

in the social environment, rather than illness driving the choice. Few modern authors (with the exception of Lowman, 1997) link occupational choice to patterns of pathology.

While developmental career theory may not contain clear linkages to health, the issue takes on a different perspective if more generic life-span approaches to psychology are considered. Factors in childhood and young adulthood may have a profound effect on health and well-being later in life; logically this must include education and work related factors (Foresight Mental Capital and Wellbeing Project, 2008). Adverse life events seem to be particularly important in the aetiology of mental health difficulties. Lists of life events are used as an assessment tool in stress research and counselling (e.g. Holmes & Rahe, 1967; Cooper, Cooper & Eaker, 1988).

Crucial here is the notion of 'kindling': the idea that early experience of life stress (in adolescence or young adulthood) may bring about permanent neuro-biological changes in the brain.⁹ The onset of depression renders the individual more vulnerable to further episodes by lowering the threshold of stress that can be tolerated. Monroe & Harkness (2005) evaluate the kindling idea, and find that it has a lot of promise as an explanation for the development of depression and points to early intervention as the place to combat the condition.

If life events can shape the development of mental health conditions, and this includes experiences in education and work, then it follows that there is some potential for career guidance interventions to impact on health by helping to:

- prevent or limit the duration of potentially negative experiences such as youth unemployment
- challenge the negative evaluation of career related life events
- normalize the experience of developmental life challenges
- promote optimistic constructions of long term opportunities.

⁹ The term 'biological embedding' is also used to describe this phenomenon, but is perhaps a broader concept, encompassing childhood.

There are sources that suggest that the vocational rehabilitation of workers with health conditions, a practice dominated by P-E concepts, could be enriched by insights from life-career development theories (e.g. Buys, Hensby & Rennie, 2003; Shahnasarian, 2001; Young *et al.*, 2005).

A more basic point is that thinking underpinning career education often implies a developmental perspective. For example the influential 'DOTS' framework (Law & Watts, 1977), although simplistic and subject to some recent criticism (e.g. McCash, 2006), identifies possible broad targets for career learning. Learning experiences that shape self and opportunity awareness in a positive constructive light, and equip people for decision making and transitions in an empowering way would logically tend to promote well-being.

Sharf (2006) points out that career development is very complex. We should therefore expect the linkages to well-being to be complex. Whilst ideas of maturation, roles, self-concept, gender may cut across other theoretical traditions, life-span thinking about careers and well-being may give insights that other approaches do not offer. However, developmental conceptions remain predominantly individualistic in outlook, even where they consider social roles, a feature which limits the scope of the explanation they can offer. They are also preoccupied with descriptive stage models which tend to encourage retrospective rather than prospective thinking about career biography. These models can be insufficiently flexible to account for the gendered and culturally specific nature of career development, a problem that recent theorists have been keen to avoid.

2.2.4 Counselling theories

Whilst many of the theories in this chapter could reasonably be subsumed under a broadly defined umbrella of counselling psychology, this section has been reserved for those approaches to guidance practice that derive directly from mainstream counselling. Most influential in guidance practice have been person-centred approaches originating in the work of Carl Rogers (e.g. 1951),

goal-directed approaches, notably Egan's model (2002), other broad based or brief integrative helping approaches (e.g. Culley & Bond, 2011; Nelson-Jones, 1984 & 2009), and derivative approaches which apply these concepts to guidance (e.g. Ali & Graham 1996; Kidd, 2006).

It is impossible to consider the impact of guidance on well-being variables without raising this issue of the relationship between career counselling and therapeutic counselling. This is an issue that has attracted considerable interest (e.g. Subich, 1993; Imbibo, 1994; Burlew, 1996; Richardson, 1996; Westergaard, 2012). Rounds and Tinsley suggest:

“Career intervention is simply a form of psychological intervention designed to affect vocationally related feelings, attitudes, cognitions, and behaviors. Thus it is a form of *psychotherapy* and should be viewed as a method of behavior change and tied to psychotherapy theory...career interventions can be practiced and evaluated within the context of more general behavior theories that provide models of behavior change...a conceptual shift in which career interventions are understood as psychological interventions (and career counselling as psychotherapy) would foster advances in the understanding of vocational behavior change processes.” (Rounds & Tinsley, 1984:138-139).

The issue of the relationship between career and therapeutic counselling emerges as a key theme of this thesis, and is explored in depth in the discussion (chapter 9). Here we are concerned with causal mechanisms. If career guidance is considered as a type of counselling, then it is a small step to extrapolate from this to suggest that it may produce therapeutic outcomes as well as vocational ones. There are number of reasons why career interventions may have this effect:

- Service users have the opportunity to share problems, receive attention in a supportive non-judgemental way.
- There is a possibility that client-helper relationships are more important than specific therapeutic schools or techniques (e.g. Barkham, 1996).
- Unlike other forms of counselling, career guidance interventions may be 'normalising'. This is in contrast to therapeutic settings where service users

are implicitly defined as sick or inadequate, and thus stigmatised by virtue of their use of the service (Hayward & Bright, 1997).

- Career guidance is predominantly future focused: goals may be motivational and their identification may inject hope, as possible better lives are envisaged, validated by the advisers' approval.
- Where it does incorporate retrospective elements, career guidance frequently involves elements of skill, experience and strengths identification. These activities can positively impact on self-esteem and self concept, and may help to reframe the meaning placed on previous life events.

Much of career counselling theory was imported to guidance practice from therapeutic counselling so the rationale for its impact on well-being would be identical to the original conception. To argue that therapeutic techniques have no impact on well-being when deployed in careers counselling, would mean it is necessary to invoke special reasons why therapeutic ingredients are deactivated by the guidance setting. Only three reasons might present themselves:

Firstly, it could be argued that guidance practitioners do not have the necessary skills. It is true that in the UK the level of counselling skills developed in trainee guidance practitioners in general are more basic than the level required of therapeutic counsellors. However this observation does not constitute a persuasive theoretical argument as training regimes can be modified. To argue that guidance is not at present therapeutic is not the same as arguing that it cannot be so.

Secondly, it could be argued that using counselling skills is not the same as doing counselling. This argument is largely one of semantics, and is not convincing even on its own terms: Culley & Bond (2011) describe characteristics that distinguish between counselling and the supportive use of counselling skills: career guidance interactions more closely resemble the list they offer for counselling.

Thirdly, if assuaging symptoms of distress or boosting well-being is not the focus of the intervention then it could be argued they should not be anticipated as outcomes. However, multiple outcomes of interventions are very likely. Hanisch (1999) draws a useful distinction between symptom focused and problem focused coping strategies; career counselling would promote the latter. A purely symptom focused intervention may bring some consequences that are counterproductive. It labels the individual as dysfunctional and abnormal: by virtue of their participation in therapeutic counselling they must have something wrong with them. Some mental health conditions, such as depression, may be aggravated by rumination (Gilbert, 2007), so an inward looking focus may be less potent than an outward looking pragmatic problem solving focus. This thought is captured here from a sociological perspective:

“Unpleasant emotions are not in themselves problems to be solved. They are signs that problems remain unsolved...Emotional well-being comes from facing and solving problems.” (Mirosky & Ross, 2003: 275).

Research on therapeutic counselling has tried to isolate and assess the effectiveness of specific techniques or components advocated by rival schools of thought. This avenue has proved unproductive with the evidence most often pointing to no meaningful differences between approaches (e.g. Ahn & Wampold, 2001). This has led to attempts to identify those factors, common to the diverse approaches to helping, which bring about positive change. One focus of interest is that service users have the opportunity to share problems and receive attention in a supportive environment. Thus client–helper relationships may be an important common factor cutting across specific therapeutic schools or techniques. It makes sense to extend the same logic to helping relationships in a career guidance context, as done by Meara & Patton (1994), and Blustein & Spengler (1995). There are reasons to believe this will be promising:

“One of the reasons for identifying common factors in career counselling is that these factors may prove to be particularly potent. In psychotherapy research, a number of compelling reviews (e.g. Asay & Lambert, 1999; Wampold, 2001) have indicated that common factors such as the therapeutic alliance, rather

than specific factors account for the majority of variance in effectiveness. Walsh (2003) raised the issue of whether common factors might also explain significant variance in career counselling outcomes. A difficulty with this line of inquiry is the lack of research related to which factors are common within career counselling.” (Whiston *et al.*, 2005: 170).

One implication of the common factors argument is that it does throw the focus onto counsellor attributes, including the levels of skills and training they bring to bear on developing helping relationships. It is likely to be an appropriate starting point for seeking causal mechanisms for the therapeutic effects of guidance.

2.2.5 Structural theories

Sociological explanations of career development have often focused on broad structural factors that determine vocational outcomes. Two main threads can be discerned in this literature. Firstly, an extensive feminist literature focusing on issues of inequality affecting women, and a similar body of work describing ethnic minority experience. A second strand, stronger in the British than the American literature, is a focus on social class, poverty, and the consequences of local labour markets. A particular focus here is the transition from school to adult life. Landmark contributions include Willis (1977), and the work of Roberts (e.g. 1977 & 1997).

Although it has not yet influenced the careers literature, there is now a persuasive literature linking health outcomes to macro socio-economic structures. Friedli argues that mental health is central to understanding social disadvantage:

‘...levels of mental distress among communities need to be understood less in terms of individual pathology and more as a response to relative deprivation and social injustice, which erode the emotional, spiritual and intellectual resources essential to psychological well-being.’ (Friedli, 2009).

This is not an isolated viewpoint; other sources support the view that social factors such as poverty and inequality are the key to understanding mental health conditions (e.g. Mirosky & Ross, 2003; Murali and Oyebode, 2004; Rogers & Pilgrim, 2003). There is robust evidence of social inequality being related to incidence of common mental health conditions (Candy *et al.*, 2007). The view that labour market structures are a key determinant of health is accepted at an international level:

“...pathways linking labour market situations to health outcomes can be identified both at the macro level and for every individual employment condition. At the macro level, we have found that there is a strong association between labour market inequality and unfavourable population health outcomes...high levels of unemployment in both societies and neighbourhoods are correlated with poor health and increased mortality.” (WHO, 2007:17).

Exactly how social factors ‘get under the skin’ to cause health problems is not fully understood, although some physiological causal mechanisms have been proposed (e.g. Sapolsky, 2005; Wardle & Steptoe, 2005). Important channels that have been implicated are the detrimental effects of long term exposure to stress hormones (including suppression of the immune system), and increased risky health behaviours (Bambra, 2011).

Structural determinants of mental health conditions are highlighted by sociological approaches. Pilgrim & Rogers (2005) point to resonance between a view of madness as ‘other’ and the over-representation of black and minority ethnic groups. This cannot be explained solely by prejudice in diagnosis; differences in use of services, access to informal support, trauma associated with refugee status, and post-migration adjustment issues may also be factors (Boardman *et al.*, 2010).

For Pilgrim & Rogers (2005), mental health services are in themselves a part of the social structure. Key background issues include the long term shift from asylum based services to community based ones which has left some ambiguities, and the interdependence between psychiatric and legal systems of control. In recent years there have been moves towards service users and

other stakeholders acting as a political lobby group and having a voice in shaping services. However inequalities remain: they use the term 'inverse care law' to observe that the least needy get the most help from health services

More generally there are socio-economic gradients in both mental and physical health, with poor outcomes associated with low income, and low social class, educational or occupational status; (Marmot, 2010; Pilgrim & Rogers, 2005) ; outcomes are worst in the most unequal societies (Wilkinson & Pickett, 2010). There is robust international evidence to support these claims. The Marmot Review (2010) looked at health inequalities in England. This is an authoritative review of evidence that links socio-economic disadvantage with poor health outcomes. It demonstrates that there are clear gradients in the relationship between deprivation and life expectancy. Similar gradients exist for deprivation and incidence of psychiatric symptoms. This phenomenon is even found within hierarchical organisations, as demonstrated by the Whitehall II study of the British Civil Service (e.g. Stansfeld *et al.* 1999; Ferrie *et al.*, 2002), a large scale, prospective longitudinal study. This shows an association between poor physical health outcomes and junior status, and links psychiatric symptomatology to specific job characteristics, such as reduced levels of control experienced at the bottom of the status hierarchy.

The implications seem to be that the effects of social structure on career and health outcomes go hand in hand: they are intertwined as work is deeply connected to health. The literature on structural approaches to careers has not acknowledged these linkages. Furthermore it has a tendency to identify macro level concerns and suggest social goals for career guidance, rather than offering prescriptions for career guidance practice (although attempts to consider the professional implications of ethnicity and gender issues include Swanson & Fouad, 1999; and Bimrose, 2001 & 2004). However, this perspective provides an opportunity to acknowledge the importance and relevance of diversity issues, which are not otherwise a major focus in this study.

2.2.6 Social cognitive theories

These approaches originate in the work of Bandura (1997; 2001), and represent a direct application of his theories of self-efficacy to vocational behaviour (Betz & Hackett, 2006). They have been fertile ground for career researchers and designers of assessment tools (Gainor, 2006; Betz, 2007). The work of Betz & Hackett in the early 1980s led to the development of social cognitive career theory by Lent, Brown & Hackett (1994). Bandura influenced other approaches, such as Krumboltz's (1996) learning theory of career counselling. The concept of self-efficacy is linked not just to careers, but also to health and well-being (e.g. Borgen & Betz, 2008; Borgen & Lindley, 2008; Schwarzer, 2008). It can be seen as a precursor to well-being, or a well-being construct in its own right. Conversely, a sense of powerlessness is associated with experience of anxiety, and more particularly, depression (Gilbert, 2007, drawing on the work of Seligman).

Lent & Brown (2008) explore the conceptual relationship between well-being and job satisfaction. They equate subjective well-being (SWB) with hedonia and psychological well-being (PWB) with eudaimonia. Job satisfaction is seen as a domain specific aspect of SWB. Their model is complex, but a link between self-efficacy, personal goals and well-being seems to be central to their perspective:

“In the present context, self-efficacy refers to personal beliefs about one's ability to perform the behaviors necessary to achieve one's work-related goals (i.e. goal self-efficacy) or, more generally, to perform tasks required for success in one's work environment (task self-efficacy)...Among the many advantages of goal-directed behavior are that it enables people to participate in personally and culturally valued activities, may bring them into contact with others for mutual social support, and helps provide life structure and meaning, all of which can promote domain and life satisfaction. Moreover, by framing and pursuing personal goals, people are able to assert a measure of agency in their own well-being...” (Lent & Brown, 2008:14).

Goal achievement may bring its own benefits, but this argument is suggesting that belief in one's ability to achieve them relates more directly to job satisfaction:

“We posit that self-efficacy...and work conditions or outcomes...directly affect work satisfaction; that is, perceiving that one is efficacious at valued tasks and perceiving that one has received (or will receive) favorable work conditions or outcomes are, themselves, sources of satisfaction” (Lent & Brown, 2008:15).

A sense of personal agency is a key element in many approaches to work and to well-being, and there is a substantial evidence base to support its importance. Marmot & Bell (2010), briefly summarising a wide range of research, identify a sense of control over work as being a key health determinant.

Any psychological approach could be criticised for neglect of wider social factors: self-efficacy theory is no exception. It seeks to reduce the social context of experience to an individualistic cognitive conception. Now the discussion turns to those approaches to careers that emphasise complexity in the interplay between the individual and their social context.

2.2.7 Postmodern and constructivist theories

Constructivist thinking in career guidance represents a move away from traditional positivist conceptions of career, rooted in a culturally Westernised world-view, towards a more complex view in which a person cannot be understood except in context (Watson, 2006). Whilst much of this literature is firmly in the counselling tradition, its distinctive feature is the shift of epistemology towards a new paradigm conception. Audrey Collin (e.g. Collin, 2000; Collin & Young, 1986) has been prominent in articulating this approach to career theory. Key applications of this new paradigm thinking include the sociodynamic counselling of Peavy (1997), the narrative approach of Chen (1997), and the unification of counselling for work and relationships proposed by Richardson (2012). In the UK, Reid (2006) and Law (2006) have been

advocates of narrative approaches to guidance, which is perhaps the most influential approach on guidance practice emerging from this new paradigm.

Unlike these career sources, Bauer, McAdams & Pals (2008) explicitly link narrative identity to well-being. Hartung & Taber (2008) bridge the gap by providing direct discussion of constructivism and well-being as applied to the study of careers. The focus of their paper is on career construction as a way of thinking to promote job satisfaction for those in employment:

“Because career construction attends to people’s subjective careers, or the meaning they derive from their vocational behavior, it very well provides a useful lens for considering SWB relative to work and career development.”
(Hartung & Taber, 2008: 77).

Applications of narrative approaches to career guidance have derived from approaches that were therapeutic in intent (e.g. White & Epston, 1990). So as with most counselling approaches, it is a small leap of logic to suggest a therapeutic effect of guidance work. Narrative has also been employed both as a healing tool, and to describe the lived experience of recovery: re-engagement in society after an episode of mental illness. Examples of narrative accounts of recovery include Ridgeway (2001), Harris *et al.* (1997), and Barrett, Beer & Kielhofner (1999). Such accounts are personal and idiosyncratic. Social participation (including work) often plays a role, but it is not clear from these accounts if it is a consequence of recovery, a factor in promoting recovery, or (more likely) a bit of both.

The postmodern and constructivist conceptions of career are often presented uncritically in the career theory literature; however weaknesses can be identified. Firstly, it represents a contemporary trend in academic writing about career that has had relatively little impact on practice. Secondly, it has the potential to descend into an extreme relativism, privileging epistemology over ontology, to the extent that socio-economic realities are misrepresented as social constructions. Reframing personal constructions may have value, but is not powerful enough to address structural disadvantage.

Conversely, a third point is that some sources (e.g. Hartung & Taber, 2008) seem to fail to understand the 'new paradigm' epistemological position taken by these approaches and misrepresent them as a natural development of more established (positivist) approaches to careers. In fact, some new paradigm sources represent a radical departure, and reject conventional empiricism in favour of narrative enquiry (e.g. Blustein, Medvide & Kozan, 2012; Richardson, 2012).

Finally, applications of narrative to recovery do produce poignant personal accounts, but perhaps they are more representative of a small minority of educated people's experience of psychosis, rather than the mass of people experiencing common mental health conditions and socio-economic disadvantage (e.g. Scottish Recovery Network, undated). More generally it has been suggested that constructivist and narrative conceptions of counselling represent middle class sensibilities. Reid (2006) provides a discussion of this issue, and reviews the strengths and weaknesses of constructivist approaches to career counselling.

This critique must be tempered by two points. Firstly, this group of approaches is a very broad church so sweeping statements cannot be applied equally to all sources. Secondly as this study adopts a realist ontology, there is a clash of philosophy with some of these sources.

Perhaps the best developed of these approaches is the systems approach advocated by Patton & McMahon (2006a). This has a number of advantages. It is formulated at an abstract level, and represents one of the few potentially viable integrative models for career theory. It has been successfully applied in other domains of psychology, notably by the Tavistock clinic, such as organizational behaviour (Morgan, 1997), and family therapy (e.g. Dallos & Draper, 2000; Stevens, 2001), an area directly related to mental health.

Blustein & Spengler (1995) point to several perspectives including family systems and relational approaches as relevant to personal and career

adjustment. Blustein (2006) develop this by use of Patton & McMahon's systems conception of careers and links it in to a broader framework of thinking about careers in relational terms, contextualising work in a wider context of social relationships. He points out that concepts of social networks and social support in the careers literature have mostly focused on work–family issues: e.g. dual career families where both partners have the ability to exercise choice, but neglects describing the experience of more disadvantaged groups. Their patterns of employment are more fragmented and conceptions of the 'grand career narrative' do not apply. These groups have more complex, less predictable patterns of relationships.

2.3 Other relevant theoretical perspectives

2.3.1 Social capital, careers and well-being

In this section the discussion moves away from career theory to introduce other relevant theoretical perspectives, beginning with social influences on health. It is necessary to acknowledge that most contemporary career theory focuses on relational issues: the individual in their local social context. This trend can be traced to Law's (1981) description of local community influences on career choice, and is salient in Collin's (2000) use of contextualism. However, the ideas in this section have origins outside of career theory, so are treated separately.

There are reasons to consider social contexts seriously. Strong connections between social relationships and health, particularly mental health, are to be found in many diverse sources. For example, O'Donovan and Hughes (2006) note that there is strong epidemiological evidence for an association between poor social support, mortality and morbidity, particularly in relation to coronary heart disease.

“Social relationships have a powerful effect on happiness and the other aspects of well-being, and are perhaps the greatest single cause... The general explanation of these effects is that positive affect is caused by companionship in pleasant activities, and the exchange of positive non-verbal signals, mental health by close relationships buffering stress, and health by the emotional activation of biological systems and by better health behaviour. Extraverts and those with good social skills benefit the most from social relationships. Social support is central to some of these effects, but it can incur costs to both giver and receiver, and it should take the form of emotional support, companionship or problem solving rather than ruminating.” (Argyle, 2001:71 & 88).

A study of the impact of major life events on happiness using data from the British household survey found that:

“...what matters the most in people’s lives in Britain is to have good dynamic interpersonal relationships and to be respected at work with that respect being constantly renewed.” (Ballas & Dorling, 2007:1244).

Cantor & Sanderson (1999) explore the importance of taking part in everyday life for well-being, and draw on both the social capital and the evolutionary psychology literature to support the view. They point out that depression is closely associated with alienation & isolation. The work of Cacioppo has demonstrated the link between loneliness (subjective isolation) and detriments to physical and mental health, exploring the underlying physiology and causal mechanisms (e.g. Cacioppo *et al.*, 2002; Cacioppo *et al.*, 2006; Cacioppo *et al.*, 2008; Ernst & Cacioppo, 1999; Hawkey & Cacioppo, 2003; Cacioppo, Hawkey & Bernstein, 2003). Conversely, social support is often characterized as a protection against stress and a source of resilience. This is often described as a ‘buffering’ effect of social support (e.g. Argyle, 2001).

Social factors are believed to be relevant to health, not just at an individual level, but also at higher levels of analysis:

“Social support has a wide spectrum of action on health, from influencing mortality at one end, through physical morbidity to psychological morbidity at the other end. Social support is a very personal matter and yet research shows that it is influenced by social structural imperatives and becomes more than the sum of the individual links of networks in terms of social cohesion. At the level of society, social cohesion can have a powerful effect on health which transcends that available from individual social relationships.” (Stansfeld, 2006: 166).

The range of overlapping concepts used to describe social involvement is confusing. They include social networks (defined by number and frequency of contacts; density of network), social support (classified as emotional, informational, instrumental or practical), and social cohesion (relating to connectedness and solidarity between groups). Space precludes a comprehensive discussion of these ideas, so just one approach is presented here, chosen as it has become influential. In a discussion of the social

determinants of mental health and well-being, the WHO (2004b) uses social capital as the central concept. Social capital is a term that has begun to be used widely in the social sciences to refer to social networks and the benefits associated with them. It was popularized by Putnam's (2000) influential discussion of declining community ties in America. The concept is still not precisely defined:

"The definition and measurement of social capital are still evolving. It is generally used to refer to the collective value of all formal and informal networks." (Bowling, 2005a: 103).

Its overlap with the concerns of career theory becomes clearer in the following formulation. Social capital is a way of describing participation in work, learning and other activities:

"Social capital is a sub-set of social cohesion, and refers to the extent to which communities offer members opportunities, through active involvement in social activities, voluntary work, group membership, leisure and recreation facilities, political activism, and educational facilities, to increase their personal resources..." (Bowling, 2005a: 6).

These notions do not rule out the possibility that social groups could have negative consequences for participants or the wider community (e.g. criminal gangs), but the overwhelming thrust of the evidence suggests that higher levels of social capital are associated with trust, better health outcomes and self-reported quality of life. The link to careers is explicit here:

"The core idea here is very simple: social networks have value. They have value to the people in the networks – 'networking' is demonstrably a good career strategy, for example." (Helliwell & Putnam, 2005:438).

There have been attempts to measure the effect of social capital on health (e.g. Morgan & Swann, 2004). Helliwell & Putnam (2005) use data from large surveys: the World Values Survey; the European Values Survey; the Social Capital Benchmark Survey from USA. They also draw on Helliwell's earlier

work on suicide rates. They acknowledge methodological problems in linking social capital to well-being: their data are cross-sectional not longitudinal, and there are difficulties in confidently attributing causality. However they argue that the patterns they observe in the data are strong and pervasive, suggesting it:

“...confirms that social capital is strongly linked to subjective well-being through many independent channels and in several different forms.” (Helliwell & Putnam, 2005: 455).

This is backed up by a systematic review from De Silva *et al.* (2005), which concluded that there appears to be a negative association between an individual's (behavioural and cognitive) social capital and their level of mental health symptoms. However they pour cold water on enthusiasts for this perspective, arguing there is insufficient evidence to justify their influence on mental health policy makers. There is a paucity of evidence relating to causal mechanisms, indeed reverse causality is possible: social withdrawal could explain low network participation. Also evidence at an ecological level is more equivocal than at the individual level.

There are isolated examples of the concept of social capital as applied to the study of careers in the organizational literature (e.g. Tempest, McKinlay & Starkey, 2004). Social capital has been linked to careers success by Seibert, Kraimer & Liden (2001). They found that access to organizational information, access to resources and career sponsorship (i.e. support from a senior colleague, mentoring, selection for challenging assignments) were three mechanisms by which social capital contributed to career success.

Clearly the social capital and well-being relationship is strong, but there are some problems. Firstly, there is little standardization of measures used in research. Secondly, there are no clear prescriptions as to how to avoid the negative consequences of group membership. Thirdly, there is ambiguity between two different implicit views of social capital: a macro view which sees it as a 'community stock' which cascades benefits down, or a more bottom up approach which sees it as an aggregate of individual networks (Boardman,

2010a). Finally, the implications of social capital for careers, or more importantly vice versa, have not been fully explored in the literature.

Whether or not social capital is the concept used, it is becoming clear that the way in which a person is embedded in a social network has profound implications for health and well-being. Fowler & Christakis (2008) provided powerful new evidence that happiness is transmitted in social networks. The implications of this important finding are not yet understood. It follows logically that negative contagion is also possible, a point illustrated by this perspective:

“...we regard job loss as a *network event*, rather than as a loss with consequences only for the individual. For example we expect that family ties, friendship networks, and other aspects of the job loser’s social network are critically implicated in the job loss and its consequences. Job loss and the many other events it triggers reverberate through the social network and family relationships of the person, sometimes producing a cascade of subsequent strains in personal and family relationships.” (Price, Friedland & Vinokur, 1998: 303, their italics).¹⁰

2.3.2 Theory derived from positive psychology

Seligman & Csikszentmihalyi (2000) describe positive psychology as an approach that seeks to redress the imbalance created by the pathology-oriented approach that has dominated the discipline. It could perhaps best be understood as an influential movement in health psychology, arising from the study of happiness; it is not a sub-discipline in its own right.

The first approach considered here focuses on hedonic well-being; although not obvious, plausible links to careers can be postulated. Fredrickson (2005) describes her ‘broaden and build’ theory of positive emotion, and its supporting research base. She suggests that negative emotion is associated with a

¹⁰ Westman, Etzion & Horowitz (2004) in a study of working couples in Israel, found bidirectional crossover of anxiety between partners when one was unemployed, a finding consistent with this position.

specific action tendency e.g. fear with avoidance and escape, whereas positive emotions:

“1. broaden people’s attention and thinking; 2. undo lingering negative emotional arousal; 3. fuel psychological resilience; 4. build consequential personal resources; 5. trigger upward spirals towards greater well-being in the future; and 6. seed human flourishing.” (Fredrickson, 2005: 233).

This approach challenges the view that positive emotion is an end in itself, but rather seeing it as something which promotes divergent behaviours such as play and exploration, which in turn promote a virtuous circle of learning and growth, leading to more positive emotion. This viewpoint is interesting given the increasing recognition of exploration as a desirable goal for career guidance interventions (e.g. Krumboltz, 1996; McCash, 2006; Tavieria & Moreno, 2003). Although eudaimonic well-being has more obvious links to work and careers, it seems that to completely ignore hedonic well-being would be inappropriate:

“Overall the available data indicate that the causal pathway between hedonic and eudaimonic well-being is bi-directional. Positive feelings can produce positive functionings and positive functionings can produce positive feelings.” (Huppert, 2005: 321).

Another idea emerging from positive psychology relates directly to the study of interests discussed earlier, so presents more obvious links to the study of careers. This is the concept of ‘flow’. The term is used by Csikszentmihalyi (2002) to describe the experience of being absorbed in an activity to an extent that all sense of time is lost and self-consciousness is no longer present. He acknowledges the influence of Maslow’s ideas on self-actualisation, and also Eastern systems of thought where loss of the self through absorption in an activity is advocated (e.g. Zen, Sufi, and Yoga). Becoming absorbed in an activity and finding increasing complexity in it, is seen by Csikszentmihalyi as a source of well-being both during the activity and in its influence on the rest of the life-space. From this viewpoint, work does have an important role in generating happiness:

“Work can be prime time for flow because unlike leisure, it builds many of the conditions of flow into itself. There are usually clear goals and rules of performance. There is frequent feedback about how well or poorly we are doing. Work usually encourages concentration and minimises distraction, and in many cases it matches the difficulties to your talents and even your strengths. As a result people often feel more engaged at work than they do at home.” (Seligman 2002a: 175)

Csikszentmihalyi describes being absorbed in an activity as an ‘autotelic’ state. He suggests that some individuals achieve this more easily than others: the ‘autotelic personality’ finds absorbing activity even in an impoverished environment. He also suggests some kinds of work provide more opportunities than others for achieving an autotelic state. Here some parallels can be found between his work and P-E fit concepts of work stress. Nelson & Simmons (2002) suggest that the consideration of work stress be enhanced by consideration of the complementary concept of *eustress* (an idea they attribute to Hans Selye). This refers to the positive aspects of the stress response: being engaged, being hopeful, meaningfulness and manageability (i.e. resources perceived as adequate to cope). They suggest there is tentative evidence of a link between eustress and positive health, and advocate its promotion in the workplace.

Positive psychology is not without critics, among them Lazarus (2003), who describes it as an ideological movement in danger of becoming a fad. His central argument is that you can't separate positive and negative feelings, and still make good sense; emotional states can involve a complex blend of both. He also detects a ‘panglossian’ perspective, a complaint that positive psychologists reject: they claim to be rebalancing psychology by introducing the study of positive emotion, not neglecting the study of psychopathology. van Deurzen (2009) provides a more balanced critique of positive psychology from the perspective of an existential therapist, recognising its contribution, whilst still questioning the moral and philosophical basis for an excessive focus on happiness. She argues that experiencing and integrating negative emotions is a healthy process, and they should neither be avoided nor equated with pathology.

Another commonly raised concern about positive psychology is that it is culturally American and that it does not cross over well to other cultures, in particular British society, where demonstrative expression of positivity is not the norm. Positive psychologists occasionally make explicit reference to the inalienable right of 'the pursuit of happiness' outlined in the American Declaration of Independence (Jefferson, 1776). Evidence is produced that individualistic cultures with democratic governments produce the happiest citizens and that family-oriented, hard working religious participating people enjoy the highest levels of life satisfaction. This appears to be a validation of mainstream American culture, or at least the 'puritan' version of it (Sheldon & Lyubomirsky, 2006).

This viewpoint could be challenged by pointing to the empirical evidence from cross-cultural studies which is used to demonstrate the universality of well-being constructs. However, Diener & Seligman (2004) and Diener (2008), accept the comparative international evidence base is not yet strong enough to support policy prescriptions.

Nettle (2005) suggests that positive psychologists occasionally slip into prescriptive writing on how people *ought* to live based on moral judgments of what a good life is, rather than evidence. Furthermore, Seligman (2002a) explicitly suggests that positive psychology needs to link to spirituality, a position that could be viewed as problematic given the diverse and potentially incompatible views about what constitutes the good life in different spiritual systems. Indeed, some of the positive psychology literature, particularly popular texts intended for a non-academic audience (e.g. Seligman, 2002a; Diener & Biswas-Diener, 2008; Biswas-Diener & Dean, 2007), come over in passages as rather evangelical or grandiose in their claims.

More specifically attempts to apply positive psychology to careers have been limited, often relying too heavily on the notion of seeking a calling in life. This represents a prescription to find destiny and a non-financial purpose through work. A calling is contrasted with a job (for money), or a career (for

advancement). Examples of this include Steger & Dik (2009) and Harzer & Rich (2012). When this is turned into a prescription for career coaching by Biswas-Diener & Dean (2007) the result is an approach that is unlikely to survive a sociological critique: many people's careers are constrained by economic or structural factors to the extent that finding higher meaning in work is unattainable. More promising may be the application of positive psychology to work related coaching as described by Linley & Harrington (2007). They argue that positive psychology and coaching are natural partners, with the former providing a research evidence base to underpin the latter. Certainly coaching approaches are now influencing guidance in the UK (e.g. Yates, 2011), and the use of strengths assessment tools (e.g. Linley & Harrington, 2006; Park & Peterson, 2007; Lopes & Edwards, 2008) may fit comfortably into a guidance setting.

2.3.3 Psychological theories of unemployment

The foundations of the psychology of unemployment lie in the innovative work of Marie Jahoda and Paul Lazarsfeld done in the Austrian village known as Marienthal in the inter-war depression, and their contemporary Bakke in the USA (Jahoda, Lazarsfeld & Zeisl, 1933; Fryer, 1992a). Jahoda's (1982) theoretical contribution was highly influential. In this approach the more obvious, or manifest benefits of earning a living, are contrasted with less obvious, or latent benefits of work:

- Imposition of time structure on the working day
- Regular shared social contact outside of the nuclear family
- Links to goals and purposes that transcend their own
- Defining personal status and identity
- Enforced activity

Warr's vitamin model (1987, 2007) represents a sophisticated development of Jahoda's conception, providing a detailed description of the relevant psycho-

social factors. His approach is grounded in a cautious interpretation of an extensive empirical occupational psychology evidence base, and avoids the hyperbole that some positive psychology is prone to. Warr (1987) proposed that work offered a number of benefits to individuals, (their absence representing disbenefit) using the analogy of vitamins. These are:

- | | |
|-------------------------------|--|
| 1. Opportunity for control | 7. Physical security |
| 2. Opportunity for skill use | 8. Opportunity for interpersonal contact |
| 3. Externally generated goals | 9. Valued social position |
| 4. Variety | 10. Supportive supervision |
| 5. Environmental clarity | 11. Career outlook |
| 6. Availability of money | 12. Equity |

Factors 10 – 12 do not appear in the 1987 statement of the theory, representing later additions to the model that are specific to the workplace environment.

There are two other important later elaborations of this model (Warr, 2007).

Firstly, he places emphasis on the non-linearity of the relationship between these variables and well-being. Just as vitamin C is toxic if taken to excess, so it is possible with some of these environmental factors to be harmful to mental well-being at too high a level. For example, too high level of control could be associated with anxiety about personal responsibility for possible negative consequences. Another possibility is that some variables may have effects on well-being up to a threshold level and beyond that have little effect. Money is an example, it may have an important impact on well-being at low to medium level; at high levels it may have diminishing or neutral effects. Warr (2007) provides evidence to support the possibility that:

- Variables 1-6 exhibit 'additional decrement' i.e. curvilinear relationships with well-being
- Variables 7-12 exhibit 'constant effects beyond a threshold'.

An alternative way of describing non-linearity is that the generally positive correlation between each variable and well-being varies with the level of the variable (Warr, 2007).

Secondly, Warr suggests that the vitamin analogy represents a general psychological model applicable across a wide range of environments, not just formal employment. This is of considerable interest given the concern of guidance with education, training and other alternatives to work. The vitamin model is quite explicitly an analogy. It provides a good way of organising a range of broad range factors into an overview. Warr (2007) examines each variable in depth. It is a very effective descriptive model, but it is not a causal model as such, which is a weakness. Also it lacks an underpinning 'model of man', leaving it unable to give an integrated account of why people need the vitamins; rather each factor is taken in isolation.

Although not unique to his work, Warr (2007) suggests a taxonomy of well-being outcomes can be derived by separating cognitive and affective constructs, and also distinguishing the level of specificity involved: see table 2. This is a useful tool for navigating the complexity of well-being related constructs.

Table 2: Levels of well-being construct, from Warr (2007: 29).

<i>Level:</i>	Broad scope: Context free well-being		Moderate scope: Domain specific well-being		Narrow scope: facet specific well-being	
<i>Focus:</i>	<i>More Affective emphasis</i>	<i>More Cognitive emphasis</i>	<i>More Affective emphasis</i>	<i>More Cognitive emphasis</i>	<i>More Affective emphasis</i>	<i>More Cognitive emphasis</i>
<i>Example :</i>	Global affect	Life satisfaction	Feelings about one's job	Job satisfaction	Feelings about work colleagues	Satisfaction with pay on one's job

A contrasting approach is provided by community psychology. Walker & Fincham (2011) represents a recent attempt to address the relations between work, unemployment and mental health within a community psychology framework. For them a number of factors have combined to the detriment of worker well-being in recent years. These include target driven performance

management, new managerialist organisational culture, the individualisation of responsibility for stress, and the growth of the service sector with its associated demands for (servile) emotional labour. All of these occur within a wider context of a de-unionised, neo-liberal capitalist governance system.

However, Fryer's agency restriction theory (e.g. 1992b; 1999) has provided the best developed theoretical contribution on unemployment from a community psychology perspective. Here the emphasis shifts from the latent to the manifest benefits of work that cannot be accessed by the unemployed. He stresses the disabling effects of financial deprivation, and the way it undermines a sense of personal agency. This is a position that has some independent support, for example, this perspective on job loss:¹¹

“Our review of the literature makes it clear that job loss has its impact through two distinctly different pathways. One pathway is material; the other is symbolic.” (Price, Friedland & Vinokur, 1998: 310)

For them, material disadvantage can bring many secondary problems of debt or loss of savings, housing, transportation, relationship strain, poor nutrition or reduced access to health care. All of these have health implications and can undermine job seeking. Job loss also represents a status passage. Loss of roles or status within the family and friendship networks can have far reaching consequences for the construction of identity.

Blustein independently pursues similar themes to Fryer and seeks to apply critical psychology and an emancipatory communitarian perspective directly to careers (Blustein, McWhirter & Perry, 2005; Blustein, Medvide & Wan, 2011). Blustein similarly points to the limitations of quantitative research, and the dangers of colluding with potentially oppressive policy.

¹¹ This should not be taken to imply a unified view. Fryer & Fagan (2003) argue the work of Price & Vinokur (whose empirical contribution is important to this thesis) is not true community psychology. Their critique highlights a neglect of pathogenic social conditions, adoption of a positivist methodology rather than in depth participatory observation, and solutions that are not collaboratively generated with communities underpinned by collectivist values.

2.4 Generating possible causal mechanisms

From the preceding review it is apparent that when viewed through the lens of different theoretical perspectives, then different impact mechanisms linking guidance interventions and well-being outcomes can be postulated. Similar issues can arise from more than one source, so there may be partial overlap between ideas. This section seeks to integrate these ideas and group them thematically; not by source theory. This is the outcome of the process of using theory in a generative way.

A more comprehensive, but speculative listing of possible causal mechanisms derived from theory and linking guidance interventions to well-being is provided in appendix 4. It is informative to see such a large number of mechanisms can be generated: this in itself is suggestive of an important connection between guidance and well-being. However, this approach is appropriate only to the very early stages of inquiry; it is inadequate to offer a detailed explanation of phenomena with such a lack of focus. When empirical evidence is accumulated, a process which begins in chapter 3, it becomes possible to select those channels of impact that offer the most promising or parsimonious explanations for observations.

The following two pages provide an overview of the potential categories of causal mechanisms derived from theory.

2.4.1 Direct effects:

This section outlines in broad terms the mechanisms by which guidance may impact on the well-being of an individual via direct client contact.

The impact of a supportive helping relationship

Derived primarily from person centred and psychodynamic approaches to counselling. The helping relationship in guidance may be beneficial in itself, for the same reasons as it may be in therapeutic counselling.

Assisting in the management of distress

Derived primarily from psychodynamic and developmental psychology. Clients may be provided with emotional support and challenges to negative thinking.

Promoting a sense of personal agency

Derived primarily from social-cognitive theory. Clients may be empowered to be proactive and believe in their ability to make things happen.

Promoting a focus on the future and external goals

Derived primarily from positive psychology and social cognitive theory. Clients may be encouraged to be optimistic, set constructive goals, and focus on the future rather than ruminate on past or present problems.

Promoting constructive re-evaluation of past experience

Derived primarily from constructivist and narrative approaches. Clients may be encouraged to positively reframe the meaning of past experience, and identify resources and learning derived from their biography.

Strengthening identity and self-concept

Derived primarily from developmental approaches. Clients may be encouraged to redefine their social identity in a way that builds their self-esteem.

2.4.2 Indirect effects:

This section focuses on causal mechanisms that operate by virtue of guidance promoting participation in work or equivalent environments.

Promoting engaging activity

Derived primarily from P-E fit and positive psychology. Clients may take part in absorbing activities that give opportunities for use of skills, and a sense of control. Benefits may be enhanced to the extent that the activities are personally meaningful and well matched to individual interests, values, and abilities.

Promoting social participation

Derived primarily from social capital theory and the vitamin model. Clients have opportunities to belong to a social group, to forge friendships, to make useful contacts, avoid loneliness, and build their social capital.

Promoting access to income

Derived primarily from community psychology approaches to unemployment. Clients earn money that enables them to deal with debts and financial anxieties, fulfil valued social roles (such as breadwinner), and to exercise choices.

Facilitating adjustment to current positions

Derived primarily from P-E fit psychology. Clients may be supported to respond constructively to threats and challenges in the workplace, by proactively seeking solutions where there is a tension between their own needs and the demands of the work environment.

2.5 Summary

- In attempting to develop a rationale for a causal link between guidance interventions and well-being, career theory provides fertile ground to start from. Almost without exception, each career theory or model of guidance when applied to this problem would imply causal mechanisms for impact on well-being.
- In some cases this is unsurprising, as career counselling has freely adopted ideas from therapeutic counselling. However, in the case of concepts developed specifically for careers or work contexts, this does generate some novel reasoning, as these approaches have neglected to consider a health dimension.
- By broadening the scope to consider ideas of social capital, theories derived from positive psychology, and the study of unemployment, some additional ideas emerge that link careers, work and well-being.
- Multiple possible causal mechanisms linking guidance with well-being outcomes can thus be generated: this in itself is informative as it suggests deep connections between career and health. It is unambiguously clear that there is a potential to build a sound theoretical rationale to underpin the claim that guidance may influence well-being.
- Guidance interventions may be effective through direct impacts, in much the same way as personal counselling. A therapeutic relationship, combined with joint problem solving may bring its own benefits. Guidance may have greater effects indirectly. By giving access to activities and social group membership, and by matching people to suitable occupations, many health related benefits may follow.

- Potential mechanisms by which guidance may impact on well-being can be categorised under the following broad headings:
 - Direct effects
 - The impact of a supportive helping relationship
 - Assisting in the management of distress
 - Promoting a sense of personal agency
 - Promoting a focus on the future and external goals
 - Promoting constructive re-evaluation of past experience
 - Strengthening identity and self-concept
 - Indirect effects
 - Promoting engaging activity
 - Promoting social participation
 - Promoting access to income
 - Facilitating adjustment to current positions

- Identifying which mechanisms provide the most credible and parsimonious explanations, cannot be determined by a purely theoretical perspective, and requires an empirical approach. This is adopted in the next chapter.

Chapter 3: The empirical evidence

3.1 Overview

Having identified links between career guidance and well-being from a variety of theoretical perspectives, this chapter explores those links from the perspective of the available empirical evidence. There is a dearth of material that unambiguously assesses the impact of career guidance interventions on well-being. However a wide range of evidence with some bearing on the issue is available, if a broad approach is adopted.

The chapter begins with a summary of the extensive literature on the effects of unemployment and work on mental health and well-being. This is followed by a review of the equivalent but less extensive literatures relating to participation in education, volunteering and leisure. These are relevant because if work or alternative activities are health promoting, then there is the potential for guidance interventions that promote participation to have indirect impact.

The focus then shifts to evidence describing the relationship between careers and well-being. Sources linking workplace career variables, lifespan development and career decisions to well-being outcomes are explored. This evidence describes career and well-being links but does not address the impact of interventions; nonetheless it provides useful insights.

The second half of the chapter critically reviews the evidence for the direct impact of career guidance on psychological distress and well-being. As this is very limited, the scope is widened to include evidence concerning active labour market programmes (ALMPs). Evidence relating to variables that could be considered to be precursors of well-being is included in this review.

3.2 Unemployment and mental health

The sheer quantity of published research on unemployment and mental health is impressive. It has generated a series of summaries, literature reviews and meta-analyses, including Feather (1990), Hanisch (1999); Murphy & Athanasou (1999); McKee-Ryan *et al* (2005); Dodu (2005); Bartley, Ferrie & Montgomery (2006); Waddell & Burton (2006); Warr (2007); Stuckler *et al.* (2009); and Paul & Moser (2009). The evidence consistently and overwhelmingly points to an association between unemployment and detriments to mental health. Most recently, Paul & Moser (2009) used meta-analysis to synthesise the results of 237 cross-sectional and 87 longitudinal studies. They found clearly that that unemployment was associated with a greater psychological distress and reduced subjective well-being.

Some of the more recent meta-analytic studies attempt to assess effect size (notably Murphy & Athanasou, 1999). They found a negative change on job loss and a positive change on re-employment and conclude that the change is not merely statistically significant, but is also of practical importance. Perhaps the most thorough attempt to address effect size is provided by Paul & Moser (2009), who also correct for methodological issues they identify in previous attempts. They found that unemployed people have levels of mental health that are half a standard deviation below that of the employed population.

Persuasively, this holds true across a range of measures: general symptoms of psychological distress; anxiety; depression; psychosomatic symptoms; subjective well-being and self-esteem. This can also be captured by case rates, i.e. the number of participants in a study whose symptoms reach a threshold at which a diagnosis could be made. Paul & Moser (2009) conclude that unemployment more than doubles the proportion of people with clinical psychiatric conditions (34%) compared to those in employment (16%).

Some recent research has sought to predict the public health impact of the current global recession based on historic experience. Taking a macro perspective, a recent analysis of the impact on mortality of economic recession synthesised data from 26 EU nations between 1970 and 2007. Stuckler *et al.*

(2009) found evidence that suicide, homicide and alcohol related mortality increased with unemployment. Road traffic accidents and mortality associated with use of illegal recreational drugs reduced however, presumably reflecting lower disposable income. They recognise that mortality gives an incomplete picture of health. The economic link is confirmed by a recent UK analysis of statistical trends in suicides, demonstrating that the 2008-2010 recession accounts for two-fifths of a recent rise in suicide, with men in economically vulnerable regions most affected (Barr *et al.*, 2012). Hanisch (1999) notes that findings in relation to the alcohol and unemployment relationship are contradictory. More generally, Bartley, Ferrie & Montgomery (2006) point to evidence of health damaging behaviours among the unemployed.

Cross-sectional studies comparing workers with the unemployed, have repeatedly, clearly and unambiguously demonstrated an association between unemployment, reduced well-being, higher levels of psychological distress and suicide. This holds true when a range of demographic and economic variables are controlled for. However, the strength and consistency of this association does not in itself demonstrate a causal relationship (Bartley, Ferrie & Montgomery, 2006). Causality is a key question here, and the possibility of health selection effects is central to its consideration. When unemployed groups are found to have more symptoms of mental distress than employed groups this may be because those with less robust mental health are more likely to lose or voluntarily leave their jobs, and less likely to find a new job as a result of their condition. Butterworth *et al.* (2012) found strong evidence that poor mental health increased the risk and duration of unemployment.

The relationship is very likely to be bi-directional, but health selection is a less powerful effect; the evidence from longitudinal studies clearly points to unemployment as a major cause of mental ill health (Jefferis *et al.*, 2011; Paul & Moser, 2009). The transition to unemployment is associated with a subsequent deterioration in mental health: Murphy & Athansou (1999) found this effect in 14 out of 16 longitudinal studies reviewed. Job loss represents a high impact negative life event (Hanisch, 1999; Bartley, Ferrie & Montgomery, 2006). The mental health effects of unemployment are reversible. Studies focusing on re-

employment typically find a subsequent improvement in well-being and a reduction in symptoms of mental ill health. A systematic review found this holds true across a variety of contexts (Rueda, 2012), although not necessarily returning to pre-event levels (Lucas *et al.*, 2004).

3.3 Work and mental health

The Foresight Mental Capital and Wellbeing Project (2008) claims that 420,000 UK employees are experiencing depression, anxiety or stress at levels that made them feel ill. This is in spite of a growth in workplace well-being initiatives. One might be forgiven for thinking that work is intrinsically damaging to mental well-being. There is no doubt that work can be a source of hazards, and these have been extensively catalogued by the Health and Safety Executive, and protection enshrined in legislation. In recent years this concept has been extended to psycho-social hazards, and methods of assessing them identified (e.g. Rick *et al.*, 2001). There is strong evidence that psycho-social hazards in the workplace have consequences for physical as well as mental health. A case can be made that their management, although problematic, is an issue with implications for policy (Marmot, Siegest & Theorell, 2006). The matter is complicated by conflict between work or career priorities and home life, which can be a (bi-directional) source of stress (Hughes & Gration, 2009b).

The strength of the evidence that unemployment is detrimental to mental health, would seem to imply that being in paid employment must be associated with benefits to mental health. This is true at least relative to unemployment as the literature reviewed thus far demonstrates. However the picture is not so simple; it is by no means inevitable that the absence of the detriment of unemployment constitutes a benefit. Work that is marginal (low-paid, part-time, low status or servile, low-skill, temporary, seasonal, or otherwise insecure) may be most accessible to the unemployed. This kind of environment may offer only partial or negligible well-being benefits over unemployment (Friedland & Price, 2003; Broom *et al.*, 2006; Llana-Nozal, 2009). Neither is it safe to see reemployment as an end to a job loss episode:

“For individuals with less marketable skills or in labour markets subject to disruption through economic or technological change, unemployment can be a recurrent rather than a one time experience. In examining the impact of enforced joblessness on people’s happiness, it is thus necessary to think in terms of cumulative processes over time. Repeated periods of unemployment

can reduce a person's overall income, impair future employability, and lead him or her into jobs that are insecure, low-skilled and poorly paid." (Warr, 2007:77).

Thus marginal employment may lead to further periods of unemployment, contributing to detriments to self-esteem and well-being over a longer time period, producing biographies distinct from those in stable work. In the UK and USA policies to promote labour market flexibility have led to a relative increase in work of this kind, and there is mounting evidence of health effects of job insecurity (Bartley, Ferrie & Montgomery, 2006). Some have characterised this growing disadvantaged group as 'the precariat' (e.g. Bamba, 2011; Standing, 2011). Dooley (2003) suggests that the dichotomy between employment and unemployment is inadequate and that thinking in terms of continuum of employment status may be more useful.¹²

Evidence relating to the hidden economy is scarce, but Šverko *et al.* (2008) suggest that illegal working may offer some of the latent benefits of legal employment. However this might be mitigated by anxiety associated with its insecurity, and an increased risk of all kinds of occupational health threats including psycho-social hazards (WHO, 2007).

A useful synthesis of the literature on work and mental health is provided by Dodu's (2005) broad but balanced literature review, which finds that the relationship between work and well-being is a complex one.

"Being without employment is not always bad for our well-being but keeping active and having purposeful activities is good for our well-being...So the answer to the question 'is work good for well-being?', for the moment is 'It depends'. All we seem to be able to say for sure is that it is dependent on the individual and the situation. " (Dodu, 2009: 28-9).

¹² Part-time work is not necessarily of poor quality. Willson & Dickerson (2010) found positive effects of part-time employment for working mothers in the UK for life satisfaction and mental well-being, but only in higher skilled occupational groups; most part-time work was in low skilled occupations. This suggests interactions between gender, occupational status, work quality, hours worked and well-being. Availability of childcare is another factor they identify as influencing the 'trade off' made between job quality and work intensity by women in their sample.

A bolder position is taken by Waddell & Burton (2006), who provided an authoritative review of the published literature reviews for the Department for Work and Pensions (DWP). Still there are caveats:

“There is a strong evidence base showing that work is generally good for physical and mental health and well-being. Worklessness is associated with poorer physical and mental health and well-being. Work can be therapeutic and can reverse the adverse health effects of unemployment. That is true for healthy people of working age, for many disabled people, for most people with common health problems and for social security beneficiaries. The provisos are that account must be taken of the nature and quality of the work and its social context; jobs should be safe and accommodating. Overall, the beneficial effects of work outweigh the risks of work, and are greater than the harmful effects of long-term unemployment or prolonged sickness absence. Work **is** generally good for health and well-being.” (Waddell & Burton, 2006: ix; their bold typeface).

The preceding discussion would seem to point to unemployment as a status which tends to deprive people of access to psycho-social factors that promote well-being; conversely work may provide them, but the extent to which it succeeds or fails to do so is contingent upon local situational and individual factors interacting in complex ways.

3.4 Alternatives to work

Having reviewed the benefits of unemployment and work for mental health, it is now possible to consider the effects of participation in other analogous activities: education, volunteering, and leisure. Here there is not such a vast empirical literature to draw on, so conclusions are necessarily more tentative. Where economic concerns are dominant, these activities may be seen as a preparation or stepping stone to work. Where well-being concerns are in the foreground, this is not necessarily the case: they may be seen as a substitute source of the psycho-social benefits of work, or as elements of a valid lifestyle choice.

3.4.1 Education

The literature concerning learning participation differs from the work and unemployment evidence in two respects. Firstly, the benefits of education that are concurrent with participation are not the only focus; learning is often a temporary state and a means to an end, so longer term and indirect benefits are also considered. Secondly, learning programmes may contain elements of health education that are specifically designed to promote health behaviours. These are excluded from the current discussion. The topic of vocational training is also not addressed here, but reserved for a later section in this chapter.

Theoretical arguments can underpin the suggestion that education promotes well-being. For example, Schuller (2004) argues that education builds not just human capital, but also social capital and identity capital. But here the focus is empirical, not theoretical concerns. Jané-Llopis *et al.* (2005) identifies some robust evidence from developing countries of education having an impact on mental health, but it is doubtful that these examples are relevant to life in a developed economy. Of more interest is the international evidence presented by the Centre for Research into the Wider Benefits of Learning (2006). In their summary of findings from the USA and Sweden, it seems that each extra year

spent in education impacts incrementally on self-reported health, mortality rates, obesity level, health related behaviours (e.g. diet, exercise, smoking and take up of preventive health care measures). Similarly, Ross & Mirowsky (1999) found that health benefits increased with the number of years spent in education, and suggest that progressive development of human capital was a more powerful explanation than the symbolic value of qualifications attained or the status of institutions attended. Hammond (2004) suggests that most reviews show that the more years spent in education, and the higher the qualifications attained, the better the health outcomes. More specifically, Chevalier & Feinstein (2006) found positive effects of education on depression.

However this evidence base is not unproblematic. Those who drop out of courses are usually excluded from samples. Reverse causality and health selection effects cannot be ruled out: mental health status can predict educational outcomes (Cornaglia, Crivellaro & McNally, 2012; Suldo, Thalji & Ferron, 2011). Education may produce a number of disbenefits, including assessment related stress, unfulfilled expectations, or the weakening of family social ties: these are rarely captured by the research. Considered from a wider perspective, the beneficial effects of participation in education seem to represent a manifestation of the phenomenon of social gradients in health outcomes as described by Wilkinson & Pickett (2010). It may be that some of the observed effects of education on health can be explained by other factors such as income.

Focusing in on specific sectors within education, the evidence becomes less clear. There is reason to believe that students in higher education are often facing developmental challenges that make them susceptible to mental health conditions (Olohan, 2004). Some sources suggest this is a growing problem, or at least a growing concern (e.g. Fouad *et al.*, 2006). A number of studies have attempted to gauge the extent of the issues by comparing the HE population with a wider community sample of the same age profile, notably Stewart-Brown *et al.* (2000); Connell, Barkham & Mellor-Clark (2007). Unfortunately the findings they produced are equivocal. The Royal College of Psychiatrists (2003) found evidence of a growth in identified psychiatric conditions among

students, and growth in demand for student counselling services. Their assessment of the evidence suggests that students report more emotional problems, and seek help more readily, but they seem to be no more likely to reach the threshold of a psychiatric diagnosis than community based samples. These comparisons are not made with the unemployed population; we know that the general population has better mental health than the unemployed, so it may still be the case that HE participation is better than inactivity.

Turning now to adult and community education, Field (2009a & b) identifies a number of studies, showing positive impacts on well-being of educational participation. Reducing levels of depression is one effect noted in several studies, as well as improvement in life satisfaction, and optimism. Based on qualitative evidence, Field suggests that increased confidence is a widespread experience of participants in adult education, and that tutors believe that learning builds confidence. This view is supported by James & Nightingale (2005), who report on a survey of tutors. They also point out that some courses, such as those for women returners, are explicitly designed with self-esteem and confidence building as a learning outcome. In one survey of adult learners (Aldridge & Lavender, 1999), the positive effects on confidence, mental health, and also physical health are surprisingly strong, although this may reflect a highly selective sampling strategy that focused on the most successful learners. Dench & Regan (2000), focusing on learning in older adults, were similarly very positive.

There appears to be a lack of evidence that deals specifically with the further education sector. However, there are some studies that show positive health benefits to specific groups such as unemployed adult learners (Dench, Hillage & Coare, 2006), and to learners with mental health conditions (Westwood, 2003; Morrison & Clift, 2006; Mansbach-Kleinfeld *et al.*, 2007; Griffiths, 2009). There certainly seems to be a growing belief in the therapeutic value of education, as evidenced by the development of 'recovery colleges' adopting a mainstream educational cultural atmosphere, and student status for a targeted group of people with mental health conditions (Perkins *et al.*, 2012)

There is no convincing systematic review of health impacts of education available, so conclusions must be tentative. Notwithstanding question marks relating to the university environment, and some potential disbenefits, education seems on balance to have positive effects on well-being. Field (2009a) accepts that effect sizes are small, but argues that the findings are consistent, measurable and even small benefits have wider consequences. These effects may be most evident where they are most needed: with the least qualified and most disadvantaged groups.

3.4.2 Volunteering

Although volunteering is primarily intended to benefit the recipients of a service, here the focus is exclusively with the benefits accrued to the volunteers. Here there is a systematic review to draw on: Casiday *et al.* (2008) found evidence that volunteering had a salubrious impact on an impressively wide range of physical and mental health related measures including mortality, self-rated health, life satisfaction, functional ability in daily tasks, depression, stress, self-esteem, social support and interaction, and health behaviours. They note there was some evidence that these effects were context dependent: the setting and roles did make a difference.

Confirmatory evidence is provided by a literature review of recent research into the health benefits of volunteering in the USA from The Corporation for National and Community Service (2007). A clear trend emerges of a relationship between volunteering, reduced mortality and reduced incidence of health problems (particularly physical health). This finding appears to be robust as it is evident not only in individual studies, but also in comparisons between states, where a clear correlation emerges between longevity, reduced heart disease and rates of participation in volunteering. To gain the benefits of volunteering, however, commitment to participation needed to be substantial, equivalent to over 2 hours per week. This review does specifically identify mental well-being benefits of volunteering: a sense of accomplishment; a sense of purpose

compensating for loss of life roles; enhanced life satisfaction better than paid employment; reduced depression and pain related disability.

One caveat to these findings is that there is a bias in the research towards a focus on volunteering by older adults in retirement, rather than those of working age. Another is that it is not certain that volunteering offers a route back to employment for the long term unemployed; rather it may provide a substitute source for some of the health benefits derived from the workplace (Lee, 2010).

3.4.3 Leisure

Although adult leisure has been relatively neglected by health academics and practitioners, it represents an enormous area of activity as evidenced by its economic importance (Caldwell, 2005). It is an important part of individual's lives: time budgets show we have a lot of leisure (Argyle, 2001). It has attracted the attention of some career scholars (e.g. Roberts, 2006; Super, 1986). Its potential impact on well-being and health is great (Leitner & Leitner, 2005). Active leisure and social activities may offer the most benefits. There is some evidence linking leisure participation directly to the well-being of the unemployed. For example, Waters & Moore (2002) found evidence that leisure participation can be an effective mechanism for coping with unemployment, provided the activities were perceived as meaningful to the participants. They are not alone:

“...several studies that demonstrate the relation between leisure congruence and several well-being measures, including positive relations with self-esteem and negative relations with burnout, somatic complaints and anxiety... leisure participation has a moderating effect on satisfaction and distress for people who are undergoing stressful life events and that choosing leisure activities congruent with one's interests may help alleviate stress and burnout.” (Dik & Hansen, 2008: 94).

Boardman (2010b) cites evidence that leisure participation rates are lower among those with common mental health conditions, and also those with

psychoses. This cannot be attributed solely to their health, as financial barriers are also involved.

3.5 Career research involving well-being related variables

3.5.1 Outcomes in the workplace

The outcome measures used in career research predominantly focus on employment outcomes, e.g. attaining and retaining a job, hours worked, tenure of contract, pay rates, or job status. In addition to these objective measures there are four types of subjective or psychological variables of particular interest in the work environment. These are:

- a) job satisfaction: this represents a (work) domain specific aspect of life satisfaction
- b) stress: this umbrella term covers variables relating to psychological distress in the workplace context
- c) subjective career success: again a broad term, distinct from objective measures of success such as pay and status
- d) career well-being: considering well-being directly in a domain specific way.

Job satisfaction is more cognitive, whereas stress is more affective in focus. Taken together they offer reasonable conceptual coverage of the hedonic aspects of well-being, although they neglect experience of positive emotion. Both topics are extensively researched, often from the perspective of Holland's theory of vocational personality (1997). This is particularly true of the concept of congruence, i.e. the notion that consistency between vocational preferences and competencies, and the actual occupation undertaken, is a predictor of desirable outcomes such as job satisfaction, worker productivity and career stability.

The evidence that congruence (between vocational interests and work environments) predicts job satisfaction is not as strong as might be expected. Some reviews of the literature studies find the correlation to be weak or absent

(Tranberg, Slane & Ekeberg, 1993; Furnham *et al.* 1995; Hesketh, 2000; Jepsen & Sheu, 2003). Tinsley (2000), Spokane, Meir & Catalano (2000), Furnham (2001), and Arnold (2004) all provide authoritative reviews of the extensive empirical research literature on the model. Typically meta-analyses suggest that job satisfaction is moderately correlated with congruence, at around the 0.2 or 0.3 level.

Opinions are divided as to whether the cause of this should be attributed to problems with research methodology, with restriction of range (as most people choose congruent careers) or that the Holland model is invalid. There is some consensus here that P-E relationships are complex, and dynamic, with personality affecting the dynamics of the interaction. For example, Dik (2005, citing his own work) found the congruence-satisfaction relationship stronger in people with less investment in their work. Holland's model fails to adequately capture this complexity, although more recent P-E fit models attempt to do so.

If a modest association between congruence and job satisfaction is accepted, then that leaves the question of what that means for life satisfaction, a key well-being variable. There is clear evidence of an association between them (Judge & Klinger, 2008); indeed both job satisfaction and career satisfaction are strongly correlated with life satisfaction (Erdogan *et al.*, 2012). Does satisfaction in the work domain spill over into general life satisfaction, or is job satisfaction simply a reflection of a global assessment of life, perhaps influenced in a 'top down' way by personality factors? Lent and Brown address this problem of the direction of causality:

“Available evidence from cross-sectional research suggests support for both directional paths (e.g. Heller *et al.*, 2004), although some longitudinal findings suggest that the path from life satisfaction to job satisfaction may be the more potent of the two (Judge & Watanbe, 1993)...A stronger path from work to life satisfaction may exist in conditions where work is a particularly central life domain; the reverse may hold where work is of less salience to one's identity.” (Lent & Brown, 2008: 12).

Use of job satisfaction as a way to capture well-being in a career context is not unproblematic. Kidd (1998) suggests it can sometimes act as a spur to action. So it may not always make sense to see it as an outcome variable, but rather as part of a sequence of attitudes, feelings and behaviours. In a later work she reiterates this point about complexity:

“Ideas of well-being at work are often conflated with notions of job satisfaction and career satisfaction. But assessing how far people are satisfied with their job or career seems rather superficial, since these general states do little to capture the range, richness and intensity of emotional tones at work.” (Kidd, 2006b:5).

Although extensively researched as a topic in its own right, stress has received less attention than job satisfaction from the point of view of P-E fit in general, and congruence in particular (Sutherland, Fogarty & Pithers, 1995). This is surprising as it is an obvious step to suggest that poor fit would be associated with strain that could generate stress. They present empirical evidence that there is a significant relationship between congruence and occupational stress. However the relationship does depend on how congruence is measured and, as with job satisfaction, the relationship is smaller than might be expected.

Furnham & Schaeffer (1984) is one of few studies to consider the impact of P-E fit on both job satisfaction and mental health outcomes in the workplace. In their small sample, they found that good P-E fit, as operationalised by Holland's concept of congruence, was related to higher job satisfaction and fewer mental health symptoms, and inferred a causal relationship. Older workers showed higher levels of congruence, as predicted by Holland, who suggested that people gravitate towards a better matched occupation over time. Furnham & Schaeffer point out there are potentially diverse consequences of poor P-E fit, that may not be captured by these measures, such as poor productivity, staff turnover, absenteeism and sabotage.¹³

¹³ Fogarty *et al.* (1999) report four small studies exploring the inter-relationships between occupational stress and strain, job satisfaction, positive and negative affect, from which they build a causal path model.

More authoritative is the contribution of Faragher, Cass & Cooper (2005) who conducted a meta-analysis of 485 studies exploring the relationship between job satisfaction and health. Across all measures they found a correlation of 0.312 between job satisfaction and positive health. The relationship was strongest for measures of mental health and well-being (such as burnout, depression, self-esteem and anxiety), and weaker for measures of physical health. They argue that the finding is important because of the context: correlations in excess of 0.3 are rare in the work environment, making this a pointer to an important relationship. Acknowledging that correlational data that the study is based on does not provide evidence for causal inferences, they nonetheless argue that there is a strong case for workplace interventions to enhance job satisfaction with a view to improving health (so by implication they see job satisfaction as a causal factor in health, not as a mental health outcome in its own right).

The study of career success would appear to be an obvious starting point to consider the relationship between happiness and careers. In general the organisational careers literature that addresses career success is preoccupied with individual differences (e.g. Bozionelos, 2004) and work-life balance issues (e.g. Parasuraman *et al.*, 1996), and there is lack of clarity about the constructs used in research. The distinction between subjective and objective career success (e.g. Poole, Langan-Fox and Omodei, 1993) is useful, with the former being of more relevance to subjective well-being. A focus on social comparison (Heslin, 2003) as a key element of perceived career success rings true.

The most interesting finding to emerge from research in this field suggests that rather than happiness being a consequence of career success, in fact the reverse may be true; at least to some extent happiness precedes and facilitates success in the work context. One review of 225 sources exploring the links between success and happiness, found that:

Other than pointing to the inter-connectedness of the variables, this seems to add little to understanding of the issue, as causality cannot be confidently inferred from their concurrent data.

“In summary, although many researchers presuppose that happiness follows from successes and accomplishments in life, our review provides strong, albeit not conclusive, evidence that happiness may, in many cases, lead to successful outcomes rather than merely following from them.” (Lyubomirsky, King and Diener, 2005:840).

Similarly, Boehm & Lyubomirsky (2008) reviewed cross-sectional, longitudinal and experimental evidence on the effects of positive affect on a variety of work related variables. They concluded that happiness is not just associated with career success but it also precedes success and positive work outcomes. This evidence is both counter-intuitive and valuable. In general, however, the contributions from the career success literature are disappointing: the relationships between constructs are complex and the potential for generating meaningful links to the impact of career interventions seems to be lacking.

Kidd (2006) adopts a different perspective, considering career well-being in organisational settings as a (domain specific) outcome in its own right. She presents a model that derives from a cross-cultural study of administrative, professional and managerial roles in the UK (as an example of an individualistic culture) and Taiwan (a collectivist culture): see table 3. She found the most frequently reported career related emotions were excitement, pride, happiness, confidence, anxiety, unhappiness, frustration, and anger. Positive career events were often associated with positive emotions: excitement, pride, happiness, confidence; but these were very often tinged with anxiety and worries about performance particularly in women. Although this approach seems to be grounded in a consideration of emotion at work, there are clear commonalities with a number of the theoretical perspectives explored in chapter 2, notably Keyes (2006), with concerns such as relational issues, control, personal agency and the future featuring prominently.

Table 3: Features of career well-being identified by Kidd (2006b: 5)

Career characteristics	Conditions facilitating well-being	Threats to well-being
Career Transitions	Opportunities for voluntary mobility, successful adaptation to a new role	Involuntary mobility, lack of opportunities for mobility, problems adjusting to a new role
Interpersonal relationships	Support, feedback and recognition	Interpersonal difficulties, lack of support, feedback or recognition
Relationship with organisation	Autonomy, power	Adapting to organisational change, alienation, inequitable treatment
Work performance	Using skills, performing well	Dissatisfaction with performance, overload
Sense of purpose	Purposeful, optimistic orientation	Pessimism, uncertainty about the future
Learning and development	Developing skills	Lack of challenge, lack of opportunities to develop
Work-life issues	Work/life in balance	Difficulties with personal life spilling over into work

Considerable caution is needed in interpreting workplace evidence linking careers to well-being related variables. Much of the congruence research is concurrent: it explores relationships between variables for current employees at one point in time. There is no attempt to link outcomes to pre-entry guidance interventions. As a result, a leap of inference is required to suggest that any benefits from congruence could be enhanced by an intervention.

If guidance leads to a wise choice of work, then it may tend to boost job satisfaction, which tends to mean improved life satisfaction, and to reduce stress, perhaps with an equivalent impact on global affect. However, whether this chain of causality actually works for a particular individual is contingent upon many other factors. The positive effects of guidance postulated here are very indirect and may be swamped by powerful local situational variables, such

as organisational factors (e.g. culture), job and task design, rewards and benefits, social factors (such as relationships with colleagues and supervisors), and work-life balance issues that arise after occupations have been chosen. Job satisfaction and stress levels are distal outcomes of guidance, and therefore likely to be weak. Strong effects are more likely to be found by examining the proximal cognitive and attitudinal outcomes of guidance (Whiston & Rahardja, 2008).

3.5.2 Gender and lifespan development perspectives

Biographies are gendered, so lifespan development and gender are entangled issues: both relate to the allocation of life roles. They are therefore approached together here. Most moderator variables affecting well-being in the unemployed produce predictable effects; age and gender are less obvious, so it is necessary to briefly revisit the unemployment evidence base before focusing in on career issues.

There are gender differences in the prevalence of specific diagnoses of mental illness, with some being exclusively gendered (e.g. post-natal depression), some predominantly gendered (e.g. anorexia nervosa; anti-social personality disorder) and some moderately gendered, most notably the common mental health conditions of anxiety and depression which slightly more women present with. There may also be gender differences in disclosure of distress, in help seeking behaviour, or even in the response induced in support agencies (Pilgrim & Rogers, 2005). This is in contrast to the pattern for positive well-being, which often shows no strong gender difference (Richards & Huppert, 2012). Unemployment research suggests that women on average suffer less of a detriment to mental health when unemployed. This seems to be a clear and consistent effect (Paul & Moser, 2009). The reason for this is contested, but men's relatively greater reliance on work for the construction of social identity seems to be a leading suspect: work centrality may be the key variable, not gender.

Studies of age and well-being in positive psychology typically show a U shaped curvilinear relationship, with well-being lower for those in mid-adulthood, and higher for the young and older adults. Warr's (2007) review of the empirical evidence supports this position.¹⁴ This is explained by mid-adulthood being associated with caring for dependants and the financial burdens of family and mortgages. However in studies of unemployed populations, both Mckee-Ryan et al (2005) and Paul & Moser (2009) failed to replicate this finding, in fact weak evidence emerged that the younger and older groups were more vulnerable. Concerns about both the younger and older ends of the working population are widespread in the unemployment literature.

Some mental health conditions have a typical age of onset. For conditions with relatively strong genetic markers, mental health conditions are late onset; however compared to other major groups of illness affecting the working population (such as cardiovascular disease, cancer and muscular-skeletal conditions) they have a very early onset, frequently making their first appearance in young people at the start of their careers. Lakey, Mukherjee & White (2001) suggest that there are cumulative impacts of socio-economic disadvantage across the lifespan. For these reasons longitudinal evidence is of particular interest. The following examples clearly illustrate an inter-relationship between career development and health outcomes.

Friis *et al.* (2002) in a large community study on adolescence and early adulthood found that younger age, lower social class and negative life events were important factors in the onset of depression. They conclude that education, and work domains may be appropriate for early intervention. Levels of subjective well-being could reflect a personality trait; but they may also be malleable in young adulthood. In an 8 year longitudinal study in New Zealand, Roberts, Caspi & Moffit (2003) measured the personality of young adults age 18, then again in relation to their work at age 26. In addition to effects of work experiences on personality, they found that personality at 18 predicted both objective and subjective work experiences at 26. Of particular

¹⁴ Bryson *et al.* (2012) also report finding this U-shaped age and well-being relationship pattern, in their survey data using WEMWBS, the measuring instrument used in this thesis.

interest were positive well-being effects (and feelings of social closeness and achievement) when the requirements of high status jobs were satisfied at age 26. This suggests that achievement of life tasks such as career goals feeds directly back into well-being, and resonates with Erikson's notion of developmental challenges. Wiese & Freund (2005), in a 3 year longitudinal study of young professionals, found that self-reported progress against goals predicted affective well-being, work satisfaction, and subjective success at work. They found that only those who perceived their goals as difficult reported improvements.¹⁵

Vaillant & Vaillant (1981) describe a longitudinal study of 457 inner city men from blue collar backgrounds, followed from age 14 to 47. A wide range of psychological and social variables were measured and the findings related to Erikson's developmental life stage challenges. Unsurprisingly intelligence and family related social factors were predictive of outcomes. Of more interest was that the strongest predictive factor emerging was that participation and success at tasks in the age range 11-16 was predictive of adult career success and mental health. This variable was described in terms of Erikson's fourth life stage challenge (industry versus inferiority). Those participating in part-time work, household chores, clubs/ sports, who showed coping capacity and ability to plan in adolescence fared better in adulthood in relation to income, avoidance of unemployment, job satisfaction, measures of mental health, and were more likely to have achieved the 'generative' stage identified in Erikson's model.

The sociologist Clausen (1991) reported an analysis of a 50 year longitudinal study in California, with similar findings. In this study, higher levels of 'playful competence' in adolescence were associated with more stable and satisfying careers, higher educational attainment and greater marital stability with fewer divorces. They also had more stable personality profiles. This effect was stronger for men than women, reflecting the highly gendered nature of life roles

¹⁵ Nurmi & Salmela (2006) argue that personal goals will promote well-being, but only if they are appropriate to the person's stage of development, and successfully achieved. Brantstadter (2006) suggests goals can be a source of meaning or of depression in later life; a balance needs to be struck between pursuing goals tenaciously and adjusting them to fit the circumstances.

in this age cohort (born circa 1930). Clausen uses the concept of planful competence to capture qualities that lead to better life choices, eliciting more social support, goal achievement and better coping with work problems. Adolescents possessing more of this quality get a head start in life. It is associated with self confidence, dependability, effective use of intellectual resources, and realism.

Planful competence is clearly the kind of attribute that career learning interventions with young people are trying to promote. Measures of psychological health in this study are so closely related with measures of competence for Clausen to suggest they are almost synonymous. Although the terminology is different, there is resonance with Vaillant & Vaillant (1981): adolescent experience of task engagement, a sense of competence, of setting and achieving goals is associated with positive outcomes.

A much shorter time frame was adopted by Borgen, Amundson & Tench (1996) in a two year longitudinal study of the psychological well-being young people in transition from school found that employment or continuation of studies were less important to well-being than might be expected. This seemed to be because other age appropriate concerns were more powerful including finances, avoidance of boredom, avenues to express agency. In general, particularly in the earlier stages, personal concerns dominated over vocational ones. This provides some balance; career issues may not be the dominant determinants of well-being throughout life-span transitions.

Scandinavian studies point to the relevance of social and health factors in career development. Rönkä & Pulkkinen (1995) in a Finnish longitudinal study, found an accumulation of social disadvantage for men led to an unstable career at age 26: criminal arrests, financial problems, social adjustment issues and drinking problems were involved. This pattern in early adulthood was predicted by aggressiveness at age 8, and problems in school and family adjustment at age 14. Linking developmental factors and workplace stress outcomes, Kalimo & Vuori (1991) used historic data from a large longitudinal study of Finnish children from the early 1960s. They looked at the effect of childhood variables

and workplace variables on health outcomes. Surprisingly they found that childhood health was a poor predictor of health (including mental health) symptoms compared with self-reports of current working conditions. However, they did find evidence that psychological and social limitations in childhood (weak intellectual qualifications; poor self esteem; deficient social conditions) effectively limited the development of coping resources later in life, leading to poorer working conditions and adult health outcomes.

Van der Wel, Dahl & Thielen (2011) analysed a large longitudinal sample in rural Norway, and looked at the interaction between health and education, and their impact on employment. They found that health problems had a more serious effect on young adults at the start of their career, most particularly those with lower qualifications, and fewer employability resources to draw on. The work accessible to this group was in unsuitable environments for those with health conditions. Influenced by the work of Bartley, they suggest that the transition from school to work can be seen as a social equivalent to the biological process of birth: it is a 'critical period'. Exposure to risk at this time can have profound and long lasting impacts on a range of important social economic and health outcomes. Whitehead (2007) writes along similar lines, suggesting that there may be critical periods in the life course when health interventions can have far-reaching impacts. Adolescence may be one such period. Furlong (2002) suggests that the risk factors facing young people are increased by a trend towards a prolonged and complex period of transition from youth to independent adulthood, during which unemployment is likely. He suggests this has the potential to increase not only this not only to stress and mental health issues, but also increased risky health behaviours such as use of drugs, promiscuity and teenage pregnancy, eating disorders and self harm.

Whilst many longitudinal studies focus on negative outcome measures of distress or deviance, Richards & Huppert (2012) looked at a large representative British sample aged 53. Historic ratings by teachers of positive behaviour at age 13 and 15 predicted positive outcomes at mid-life such as well-being, work satisfaction, social contact and engagement, and reduced emotional problems. Socio-economic factors at childhood seemed to be less

important as predictors of positive well-being in late life; a finding which contrasts with the evidence for psychological distress. This hints at a potential for early interventions to encourage positive behaviour that might achieve long term gains in spite of powerful socio-economic factors.

Johansson, Huang & Lindfors (2007) provide valuable evidence in their longitudinal study exploring the relationship between women's career patterns and their health and well-being. They supplemented self-report questionnaires with use of physiological indicators of stress. They demonstrated a relationship between occupational status and well-being variables. These findings are consistent with the notion of social gradients in health outcomes (Marmot, 2010; Wilkinson & Pickett, 2010), a phenomenon that has been demonstrated in organisational settings in the Whitehall studies (Stansfeld *et al.*, 1999; Ferrie *et al.*, 2002). However, no clear relationship with health and well-being was apparent when they looked at how the women's career patterns were sequenced over time (in terms of age at childbirth; working full or part-time; working while raising children; withdrawing from the workforce). They speculate that because they looked at women born in the 1950s in Sweden, this was a group that in general enjoyed good baseline health, a supportive welfare system and a cultural environment that facilitated women making lifestyle choices: the associated sense of control being potentially valuable to health.

Carr (1996) in a large sample longitudinal study of women in Wisconsin also found strong evidence for a consistent socio-economic gradient in positive well-being, and self-assessments of career success. Interested in the fulfilment of women's career dreams at midlife, Carr compared the occupational status of women's stated career aspirations at age 35, with actual employment outcomes at age 53. She found that those who fell short of their aspiration reported lower levels of well-being and higher levels of depression. However this effect accounted for only a small proportion of the variance, with other factors (such as family background, education, current marital status and physical health) being more powerful. A curious finding was that those women who surpassed their goals demonstrated no benefits to mental health and well-being, in fact showing some detriments if they surpassed their career status goal by a large

margin. The reason for this was unclear, but Carr's suggestions include a recalibration of expectations following success at work, or a shift to a (more problematic) male social comparison group.

The longitudinal evidence is hard to interpret, but it seems that the quality of early experiences in work and learning can shape later health outcomes, with proactive behaviour and career engagement having positive effects. This is likely to be bi-directional with early health experiences having long term consequences for working life. There are some gender differences in these effects, and the phenomenon of socio-economic gradients in health is strong enough to emerge in longitudinal career research. Hughes & Gration (2009b: 19) identified a key fact from the research evidence:

“Childhood socialisation influences adult work performance and job satisfaction: We know that attitudes towards work are formed early in life, so career education, information, advice and guidance policies and programmes should begin at an early stage”.

This could be taken to imply that early career interventions may have health impacts that are not manifested until much later.

3.5.3 Career decisions and psychological distress

Fuqua & Seaworth (1987) found a clear relationship between anxiety and career indecision in a student population, consistent across a variety of measuring instruments. Similarly, Saunders *et al.* (2000)¹⁶ looked at the relationship between depression, dysfunctional career thoughts and career indecision in a sample of undergraduate students, using a number of self-report

¹⁶ This represents one of a number of studies linking dysfunctional thinking or psychopathology and career planning adopting the Cognitive Information Processing (CIP) approach, and originating from Jim Sampson & colleagues at Florida State University. Other examples include Henderson (2009); Klieman *et al.* (2004); Peterson & Gitens (1990), Sampson *et al.* (1996 & 1998). Their contributions must be acknowledged, but their focus on assessment means they are peripheral to the arguments in this thesis.

questionnaires, including measures of vocational identity, anxiety and locus of control. Dysfunctional career thinking predicted career indecision; depression on the other hand was related to indecision but explained no additional variance. In both these studies the variables were closely related but causal relationships were difficult to discern.

A study of French high school students found some gender differences in the effects of anxiety on career exploration (Vignoli *et al.*, 2005). For girls, career exploration was related to low anxiety, secure attachment and fear of failing. For boys, fear of disappointing parents was the factor positively related to career exploration.

There are clearly dangers of conflating state and trait measures. Chartrand *et al.* (1993) explicitly focus on personality traits, and identify neuroticism as the 'big five' personality trait that stands out as related to career indecision, dependent decision making style, and poor problem solving skills.

As mental health conditions are known to be associated with (often temporary) cognitive impairment, it is unsurprising to find decision making affected. Performance at any task is likely to be better with moderate rather than high levels of anxiety, so the task of making a career decision may be no different.

3.6 Intervention impact research

Having considered research describing experiences of careers and well-being, the focus now turns to the central concern of this thesis: the extent to which career interventions may impact on well-being.

3.6.1 The guidance impact literature

Any consideration of therapeutic effects of interventions needs to be located in the context of the developing literature on the impact of guidance. Whiston & Rahardja (2008) summarise the findings from the available meta-analysis studies by suggesting that interventions have a positive impact and service users are satisfied with the help they receive, or reacted positively to interventions. They found effect sizes to be small to moderate, an issue raised earlier by Kidd & Killeen (1992). Much of the research used in the meta-analyses concerns variables that are choice-related, and not of direct interest here. Two surveys of published studies in the USA found evidence for the positive impact of career interventions on learning outcomes (Whiston, Sexton, & Lasoff, 1998; Whiston, Brecheisen, & Stephens, 2003).

Guidance may have an impact via developing the attitudes and motivation that enable people to progress into work, education or training. To put it another way, progress on subjective outcomes may lead on to enhanced participation rates, or improved decision making. Killeen & Kidd (1991) reviewed the literature and found 17 studies reporting impacts of guidance on precursors to effective career management. Similarly, in their meta-analysis Whiston, Brecheisen and Stephens (2003) found career interventions had a positive impact on career planning and decision-making skills, and identify these were necessary precursors to subsequent economic and educational outcomes.

Arguably the literature concerning subjective outcomes addresses facets of well-being or precursors to it. However studies directly addressing the impact of guidance on positive well-being or psychological distress are surprisingly few in

number. As a result it is necessary to broaden the scope of this review to consider a wider range of interventions for unemployed job seekers.

3.6.2 Active labour market programmes

The term 'active labour market programme' (ALMP) encompasses all Government interventions to improve the functioning of the labour market, including job brokering services, support for job seekers, training and skills support, and job creation (Hirst, 2011). Job creation is a demand side intervention which is excluded from this discussion; its effectiveness as a health measure would likely be limited by the quality of jobs created (Lakey, Mukherjee & White, 2001). Occupational training is considered here, rather than as a sector of education, because the literature on ALMPs sometimes treats training, career guidance and other forms of job seeker support as closely related. This blurs the distinction between different types of provision (Watts, 2009), a problem occasionally aggravated by poor reporting of intervention characteristics.

Whilst ALMPs often have supportive intentions, the outcome variable of most interest to researchers and policy makers alike has been employment. Hasluck and Green (2007) provide a review of research on UK labour market activation initiatives for the DWP. This takes a broad approach to the evidence, but still impacts on participation in work or substitute activities, and participant satisfaction with services received, remain in the foreground; therapeutic outcomes are not addressed. Reviews specifically focussing on health outcomes in the ALMP literature complain of a dearth of evidence (Lakey, Mukherjee & White, 2001; Coutts, 2010). Nonetheless there are some studies of considerable interest.

3.6.3 Vocational training

Some pessimism has been expressed about the health promoting value of Government funded vocational training in the UK, for example:

“...youth opportunity type schemes are almost as detrimental to psychological good health as is unemployment itself.” (Dorling, 2009:b829).

Training is associated with low rates of pay, perhaps low status, and uncertainty of employment on completion, which may reduce its potential to provide the psycho-social benefits of work. Some studies have found that the youth trainees have a level of psychological well-being in between that of young workers and young unemployed (Korpi, 1994; Oddy, Donovan & Pardoe, 1984). The closer the training resembles work, then the better the outcomes (e.g. Donovan *et al.*, 1986; Stafford, 1982¹⁷). Haworth & Evans' (1995) study of YTS suggests that the match between levels of challenge and levels of skill has implications for positive (flow) experiences in trainees, is not inconsistent with this view of training as a work substitute. More weight is added to this view by a large longitudinal study comparing the mental well-being outcomes of three types of Swedish ALMPs (Strandh, 2001): the category described as 'workplace participation' (work experience and training with an employer) outperformed vocational training or participation in activity outside of the labour market.

A recurring finding in this literature is that training offers benefits to well-being, but they do not endure beyond the end of the programme. Vouri & Vesalainen (1999) in a large longitudinal study found that vocational training courses undertaken by the unemployed did reduce levels of psychological distress; but

¹⁷ Branthwaite & Garcia (1985) failed to replicate Stafford's results, instead finding that YOP status resembled unemployment in a measure of depression, as Dorling suggested. However in research interviews, YOP trainees on a project scheme were more disillusioned and pessimistic than those on a work based scheme. This is suggestive that training provision more closely resembling employment results in better mental health outcomes.

the effect was of short duration, only lasting as long as participation. A smaller Australian study found similar results: Creed, Hicks & Machin (1998) found positive effects on a range of well-being and distress related measures of participation in an occupational training programme for the unemployed. Using a pre, post and follow up measures and control group, they were able to demonstrate that these effects were short lived: none of them persisted beyond 3 months after the end of the course (with the exception of an improvement to global life satisfaction). They note that those with lower baseline functioning at the start of the course seemed to show the strongest improvements. Machin & Creed (2003) also found short term improvements in well-being associated with the participation of unemployed adults in occupational training. This effect was found in UK studies (Donovan *et al.*, 1986; Stafford, 1982). It was also found in a Swedish study focusing on a six month duration labour market programme for women that used physiological measures of stress: Westerlund, Bergström & Theorell (2004) identified transient improvements but not lasting effects.¹⁸

Not all studies find unambiguous improvement in well-being resulting from training. Creed, Machin & Hicks (1996) found participation in training did enhance self esteem, but had no effect on levels of psychological distress; in fact trait neuroticism was the variable predicting this. It seems that individual difference factors may sometimes swamp intervention effects. Behle (2005; 2010) reports a study into the impact on mental health of the German 'Jump' ALMP intervention for young people. No net overall impact was found but this concealed considerable individual change in mental health, with nearly half the group improving, balanced by deterioration in a similar number. Having compared outcomes in East and West Germany, she concludes that ALMPs can have positive impacts on mental health but labour market demand conditions act as a limiting factor.

¹⁸ Westerlund, Bergström & Theorell (2004) used the relative balance of anabolic (regenerative) and catabolic (energy mobilisation) processes as proxy for stress. They also applied the HADS scale, as used in this thesis, and found a transient improvement in depression associated with participation in the programme.

Some training interventions are short pre-vocational courses. These are intended to promote labour market participation, and may include elements specifically targeted at personal development. These interventions more closely resemble guidance than occupational training. Two Australian studies suggest they can be effective in promoting well-being. Muller (1992) found positive impacts of an intervention for long-term unemployed women on a variety of measures; improvements in depression and self-esteem compared to controls were sustained at 6 month follow up. Harry & Tiggemann (1992) also found positive impacts of a short 're-entry to the workforce' course for female single parents that were sustained 7 weeks after the end of the programme.

3.6.4 Vocational rehabilitation (VR)

VR interventions may involve a variety of activities including vocational guidance, assessment and training. Some relevant UK evidence relates to the now defunct Employment Rehabilitation Centres (ERC) which offered intensive courses of 6-7 weeks duration to enable people to re-enter the workforce after health episodes or acquired disabilities (a minority of participants had mental health conditions). Cornes *et al.* (1982) found that participants showed improvements in work confidence, self-esteem and feelings of inadequacy. Although there was no change in levels of depression, there was a modest improvement in levels of anxiety, but this was strongest for those with the biggest impairments.¹⁹ Kemp and Mercer (1983) found a dramatic improvement in mental health and reduction in psychiatric 'caseness' in ERC participants. This effect was strongest in those with more severe physical disability. Arnold & Partridge (1988) were able to replicate this finding, and found the same pattern. Although a less dramatic change was found, it was still statistically significant; most participants improved, a minority deteriorated. These three studies show

¹⁹ Cornes *et al.* (1982) cite three unpublished MSc studies (Wing; Hartmann; and Bagwell) all of which found decreases in levels of psychiatric symptoms when comparing participants at the start and finish of ERC programmes. There is no evidence about the durability of these gains. Although Cornes *et al.* found that the most impaired showed the greatest improvement in their own study, some in this sub-group also showed greater deterioration. Adjustment to acquired disability or emotional instability were identified as potential reasons.

consistent findings, but each rely on pre and post measures, and neglect to conduct a follow up: it is therefore impossible to say if the effects are enduring.

Juvonen-Posti *et al.* (2002) describe a return to work rehabilitation programme for disabled middle aged long-term unemployed in Finland. The intervention design was comparable to the ERC provision, involving vocational guidance, assessment, 6 weeks of training, followed by work sampling placements. They found a substantial decrease in levels of distress, and improvement in perceived competence, but no change in sense of coherence. Employment outcomes at follow up were low, but still better than control group. Pathways through the intervention were individually tailored; they suggest that this was a key feature in the success of the programme. Individualisation of interventions appears to be a common feature when guidance is a key element.

In a study of severe mental health conditions, Dickson & Gough (2008) found inconsistent and inconclusive evidence relating to the effects of vocational interventions on outcomes such as self-esteem, social capital, and quality of life. The evidence relating to support to engage in volunteering and education was slightly more promising.

3.6.5 Cognitive Behavioural Therapy (CBT)

ALMPs can include elements specifically designed to promote mental health. CBT has the most extensive evidence base of any talking therapy; the relevant literature relating to other types of therapy is very limited.²⁰ This makes assessments of their value in occupational settings difficult. CBT has been the prominent therapeutic approach in these settings for other reasons in the UK:

- It is recommended for some common mental health conditions by the National Institute for Health and Clinical Excellence (e.g. NICE, 2004)

²⁰ Two exceptions include motivational interviewing applied to VR for people with mental ill health (Lloyd *et al.*, 2008), and solution focused brief therapy (SFBT) applied to work focused interviews (WFI) in JobCentre Plus (Wells, 2007).

- The Layard proposals argue that CBT is a method for reactivating the economically inactive (e.g. Centre For Economic Performance, 2006)

CBT has been adapted for use in career counselling (e.g. Dryden, 1979; Sheward & Branch, 2012). Here we are concerned with its use in programmes for the unemployed, either as a stand-alone intervention, or as an adjunct to VR, training or job seeker support programmes. It is an approach to emotion management, but can be adapted to focus on the stress associated with job seeking or transitions into work, either for individuals or groups. Clark, Layard, & Smithies (2008) found evidence for modest improvements to employment outcomes from CBT interventions for the unemployed, a finding that has been used to justify the expansion of CBT into services for the unemployed. However, it is the health outcomes that are of interest here, and mixed evidence emerges from Australia and the UK.

Creed, Machin & Hicks (1999) examined the effect of a 3 day intervention for a small group of unemployed youth. This was based on CBT principles and also Seligman's idea of 'learned optimism'. The results showed that the intervention group showed improvements on a range of psychological well-being related variables, including coping, compared to the (waiting list) controls. Some but not all elements of this improvement persisted to follow up at approximately 15 weeks later. Those with the lowest baseline level of well-being benefited the most from the intervention.

Machin & Creed (2003) used a similar 2 day intervention as an adjunct to a short (5 week) occupational skills training course for adult unemployed. This also had stronger effects for those with lower levels of general self-efficacy and higher levels of psychological distress at baseline. However both the treatment and the control group (who participated in the occupational training without the additional input) showed improvements over the duration of the programme. At follow up it appears that a dispositional measure of positive and negative affect explained outcomes better than intervention variables.

Proudfoot *et al.* (1997; 1999) describe a short-stand alone CBT group intervention for unemployed professionals. They report reduced levels of psychological distress and improved employment outcomes, and conclude that CBT is beneficial for the unemployed. However their conclusions are not safe without replication (McManus, 1997). Their control group received alternative training and also showed a reduction in psychiatric 'caseness'; effects were not sustained as those who did not get a job returned to baseline levels of distress after 3 months. Harris *et al.* (2002) was unable to replicate these findings with a more typical population of long term unemployed adults in Australia. They point to evidence that CBT is effective only for clients that intellectually grasp its logic. They also found improvement in the (training) control group and problems in sustaining effects for those who did not achieve employment.

Rose and Harris (2004) draw a distinction between clinical efficacy and effectiveness in context. Describing three different contexts for the application of CBT with unemployed groups (employment agency; primary care; specialist mental health service) they report that implementing these interventions sustainably was problematic. As Gilbert (2009) points out, CBT was never intended to provide a model for service delivery. Similarly, Lindsay & Dutton (2010) report problems in the application of CBT for unemployed adults in the UK context as a condition management programme (CMP) for Incapacity Benefit (IB) claimants, a context discussed in chapter 4.

There is also evidence relating to more specifically defined clinical populations, but this is on a much smaller scale, Rose and Perz (2005) found CBT effective in promoting the well-being of unemployed people with psychiatric disability (mostly schizophrenia), but argue that it should be used in a vocational rehabilitation context; not as a stand-alone input. Washington (1999) reports a group therapy approach incorporating cognitive behavioural elements to help chemically dependent adult women (predominantly African American). Improvements in self-efficacy and precursors of employability were noted. Della-Posta & Drummond (2006) describe a small study of workers who had lost jobs through injury. They compared job search support delivered with, and without CBT: the intervention with the therapeutic elements achieved reductions

in depression and anxiety, improved employment outcomes and physical health.²¹

In spite of the polarised debate it provokes, it seems the evidence for CBT in unemployment settings is promising but remains inconclusive (Winspear, 2005). However, in perhaps the most persuasive study to date, Kellett *et al.* (2011) provides evidence in the form of a large UK study with a strong design of a CBT based group psycho-educational intervention in a CMP/IB setting. They found improvements across a range of psychological well-being measures for half the sample, that were maintained at follow up.

3.6.6 Group support for job seekers and students

Group interventions have been a focus of research since the contribution of Azrin on job clubs in the 1970s (e.g. Azrin *et al.*, 1980; Azrin *et al.*, 1981; Azrin, Flores & Caplan, 1975). Typically this focuses on employment outcomes. Fortunately there is a source of persuasive evidence directly addressing the health outcomes of job seeker support, from a group of researchers including Amiram Vinokur and Richard Price, working with colleagues at the Michigan Prevention Research Center (MPRC), and internationally, notably Jukka Vuori in Finland. The MPRC Job Search Programme is a short group based intervention for adults who have experienced job loss and is designed to promote both reemployment and to reduce psychological distress (for an overview, see Price, Vinokur & Friedland, 2002). It is theory derived and has five key features:

1. Job search skill training: intended to promote job search self-efficacy
2. Active teaching and learning methods: including problem solving, discussion and role play

²¹ Case study evidence of showing the effectiveness of CBT for the unemployed is also available. Brown (1999) describes the successful use of CBT with an unemployed man experiencing anxiety and physical health condition; Winspear & Robertson (2005) describe an individual intervention integrating CBT with career counselling; Binnie (2008) provides case study evidence of CBT effectiveness with the severely mentally ill.

3. Skilled trainers: people with personal experience of unemployment, given focused training in the method, monitored and given feedback to ensure treatment fidelity, seek to build a relationship of trust with participants
4. Supportive learning environment: Trainers offer positive feedback and draw on group support for participants
5. Inoculation against setbacks: participants are taught to expect setbacks in their job search, and associated coping strategies, so that the intensity of their job search will be sustained in spite of rejection by employers.

This clearly has many similarities to a career education intervention design, indeed a later study (Vuori *et al.*, 2008) replaces the term 'job search skills' training with 'career management skills'. However inoculation against setbacks (attributed by Vuori & Vinokur, 2005, to the work of Meichenbaum) is a novel element.

Two major research projects by the University of Michigan team explored the effectiveness of this strategy. The first of these was known as the Jobs I programme (described by Caplan *et al.*, 1989; with longitudinal follow up studies and re-analyses of the data set described by Vinokur, Price & Caplan, 1991; Vinokur *et al.* 1991; Price, van Ryn & Vinokur, 1992; Van Ryn & Vinokur, 1992; Vinokur *et al.*, 1995). This is a well reported, large sample, longitudinal study with a randomised control group design: as such it represents the most robust quantitative research design available. The results showed that compared to controls, the intervention group:

- was more likely to get a job, and more likely to get a good quality job e.g. permanent
- was more likely to be motivated if still unemployed
- had higher job seeking self-efficacy
- showed lower levels of psychological distress among the reemployed
- experienced less negative mental health effects of unemployment compared to controls (not significant, but still of interest in a large sample study).

The Jobs II programme was a replication with some minor methodological refinements, and again was large scale, longitudinal randomised control group design. This is reported by Vinokur, Price & Schul (1995) with longitudinal follow up studies and reanalyses reported by Vinokur & Schul (1997); Vinokur, *et al.* (2000); Vinokur & Schul (2002). Jobs II confirmed the results of the previous study although job outcomes were affected by a harsher labour market environment.

There have been international replications of the MPRC Job search programme in China, South Korea, Ireland (Barry, 2005; Price, 2001; 2006) and most notably in Finland, where a project derived from it adopted a similar research strategy. This is the *Työhön* job search programme (Vuori *et al*, 2002; Vuori & Vinokur, 2005), and it set out to explore how effective the Jobs programme would be in a Scandinavian policy environment with high unemployment, relatively generous welfare benefits, and inclusive labour activation interventions. At six months improvement in re-employment and reduced psychological distress were found. At the 2 year follow-up improvements in self-esteem, reduced depressive symptoms, and increased labour market participation were apparent (Vuori & Silvonen, 2005).

A feature of particular interest in the MPRC studies (initially identified by Price, van Ryn & Vinokur, 1992, in the Jobs I data set, and subsequently explored in the Jobs II and *Työhön* programmes) is the effect of the intervention on those at risk for depression. Although clinical cases were excluded from the sample, an 'at risk' subset was identified by measuring levels of depressive symptoms. A consistent finding of these studies is that it is the high risk group that benefits the most from the interventions. This is a very promising result, but it remains unclear if this effect would be sustained if the high risk group were isolated and targeted for intervention, or if the presence of low risk participants contributes positively to the group dynamic.

Participation in the MPRC Jobs & *Työhön* programmes was voluntary. Malmberg-Heimonen & Vuori (2005) used a longitudinal control group design to compare voluntary and mandatory (i.e. enforced by financial penalty)

participation. Whereas previous research had found mandatory participation slightly increased employment outcomes, no significant effect was found in this study; in fact the effects on re-employment of long term unemployed were detrimental. This study also looked at psychological impacts, and found evidence that compulsion slightly reduced the positive mental health impacts of participation. Self-efficacy improved in the voluntary group and deteriorated in the mandatory group. The advantage of voluntary participation was most apparent for the sub-group of participants identified as vulnerable to mental illness.

Other Finnish studies find positive impacts on well-being. Vastamaki & Moser (2009) found that an intervention combining personal support with training and work experience impacted positively on measures of sense of coherence, for a small unemployed adult sample.

Not all studies detect a positive impact on well-being. Vuori & Vesalainen (1999) conducted a large study of interventions for the unemployed in Finland, looking at outcomes after one year. They found that participation in a short (60-100 hour) 'guidance course' to promote reemployment had no effect on psychological distress, unlike vocational training which had a short lived positive effect. However they did find participation in guidance programmes predicted re-employment, whereas taking part in vocational training and subsidised employment did not have this effect. Unfortunately the reporting of the nature and content of guidance interventions in this study was inadequate.

Audhoe *et al.* (2010) conducted a systematic review of the literature (published between 1990 and 2008) on employment and mental health outcomes of vocational interventions for adults. Only five studies met their inclusion criteria, of which two related to the Jobs II intervention and two related to the Työhön programme. The remaining one, also relating to a group training intervention, was Creed, Hicks & Machin (1998). They conclude that there was weak evidence that vocational interventions promote employment, and limited evidence that they reduce mental distress for the unemployed. This view is considerably more cautious than the MPRC authors' own interpretations. It is

perhaps over cautious once the observation of strong effects on the most vulnerable is taken into account.

The MPRC approach is not entirely limited to the welfare-to-work arena. Although modest in scale, scope and quality, some isolated studies suggest that group based career education interventions may impact positively on well-being or psychological distress. Koivisto, Vuori & Nykyri (2007) describe an intervention called the *School-to-work group method* aimed at 17-25 vocational college leavers. This was a 5 day (20 hour) intensive course incorporating the main elements of the MPRC and Työhön job search programmes. It also incorporated proactive skills for organisational socialisation, i.e. elements of career management to support young people with the stress of entering employment for the first time. A medium sized sample, and a randomised control group design with follow ups was used. They found that the experimental group had enhanced employment outcomes compared to controls, and the intervention promoted the setting of personal work and financial goals. They did not find a positive impact on mental health, perhaps because the group had study alternatives to unemployment, and some had a job at baseline. However those most at risk of psychological distress again showed a positive effect on mental health outcomes.

Similarly Vuori *et al.* (2007) evaluated the impact of a career education programme for school pupils based on a social cognitive approach, using a controlled experimental design. They found that the programme increased participation in academic education, and reduced the incidence of depression among those most at risk of it. They also found that the programme increased the number of participants' adult social ties in the education and work domains.²²

Blenkinsop *et al.* (2006) looked at the organisation and curriculum underpinning career education in secondary schools, and found an impact on young people's decision making. Of particular interest here is that schools with more effective

²² In a subsequently published erratum they accepted this effect was not statistically significant.

provision produced young people making decisions that were not just more rational, but more likely to feel happy with them six months later. Conversely, schools with weaker provision were more likely to produce young people with 'comfort-seeking' or 'defeatist' mindsets.

Peng (2005) similarly explored the effects of an 18 week career education programme on freshmen at a Taiwanese 'junior business college', again using an experimental design with a control group. They found evidence that participation resulted in reduced levels of state anxiety. Although this is not a longitudinal study, this is interesting evidence when seen in the context of the link between career indecision and anxiety (both state and trait).

It seems that there is evidence for the effectiveness of group interventions to promote employability on health outcomes, and that this evidence comes from studies with very robust designs, and is supported by international replication. The most vulnerable appear to demonstrate the strongest benefits from receiving support. Isolated studies that focus on group career interventions in educational settings also suggest positive impacts are possible, but this evidence is weak.

3.6.7 Guidance interventions and well-being related variables

This section will review the evidence for interventions which involve individual support. This is problematic for three main reasons. Firstly, individual guidance is often inextricably linked to its context, and is sometimes embedded in educational programmes or linked to group or hybrid interventions, so it is difficult to isolate its effects. Secondly, the nature of the intervention provided is often poorly described, if reported at all, severely limiting interpretation. Finally, a wide range of relevant psychological variables have been used in outcome studies, but these are rarely direct measures of well-being or psychological distress (Blustein & Spengler, 1995). More often they are variables that could either be considered to be an aspect of well-being, or a precursor to it. As a

result this section focuses on the outcome variables of confidence (including self-efficacy), self-concept, and future goal orientation.

One study apparently designed specifically to address the effects of career counselling on personal adjustment using multiple relevant measuring instruments is disappointing as the authors appear to have reported only its methodology, and not its findings (Spokane & Fretz, 1993). It is necessary to turn to more broad brush sources.

Joyce *et al.* (2010) report qualitative research using focus groups and interviews with 84 individuals, into 13 diverse employment initiatives in an area of low labour market demand in the North East of England. Although the context was welfare-to-work provision, participation in each of the initiatives was voluntary, and they included health related programmes to support the retention of workers who were absent for reasons of sickness as well as education, training and vocational advice interventions for the unemployed. The details of these multi-intervention designs are unfortunately not reported, but individual guidance clearly featured. In addition to positive lifestyle changes and employment retention outcomes from health focused interventions they report:

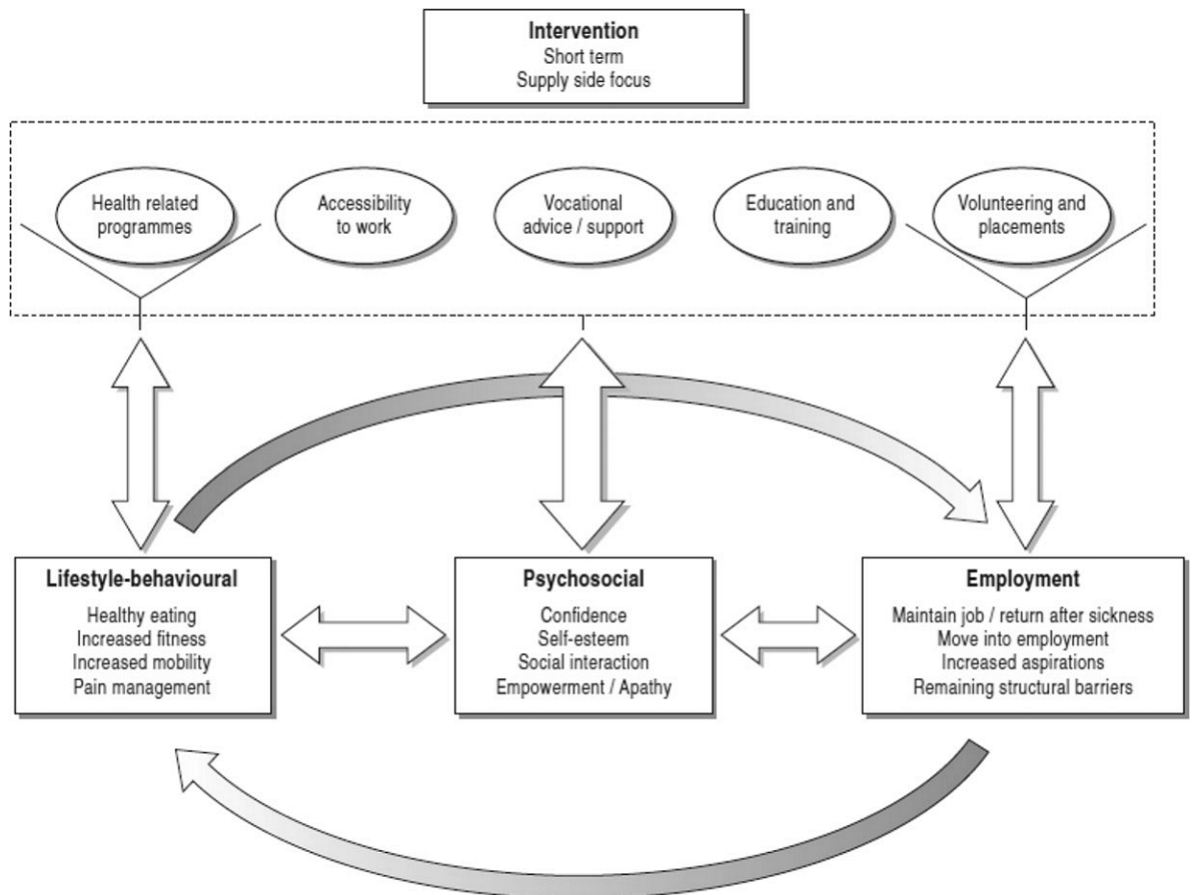
“The most commonly cited effect was a sense of increased self-confidence...The issue of increased self confidence did not appear to be noticeably gendered. Indeed this theme was expressed in different guises by participants from *all* of the intervention types, but it was most notable amongst participants in the vocational advice and support programmes.” (Joyce *et al.*, 2010: 343).

Another consistent finding was benefits from social interaction associated with these programmes: reduced feelings of isolation; sharing problems and getting peer support; making sense of their own experience; knock on effects for improved family/friend relationships; also making a contribution – particularly for volunteers.

It is unambiguously clear that Joyce *et al.* (2010) see a relationship between guidance interventions and health outcomes, even though they are careful to

point to the limitations of exclusively supply side labour interventions. The model they suggest is reproduced in figure 1:

Figure 1: Diagram from Joyce et al (2010: 342) linking guidance to health outcomes



This finding is strongly supported elsewhere in the literature. Hughes & Gration (2009a & b) concluded that there is evidence at the highest level of rigour that in depth guidance increases confidence in getting a desired job. There seems to be a very sound basis for this position as many studies, both of guidance in adult/community and in educational contexts do report positive impact on confidence. Hughes *et al.* (2002) cite seven studies that found evidence for increased motivational and attitudinal benefits including self-confidence & self-esteem. A caveat to this valuable contribution is that the sources (including non-academic 'grey' literature such as project evaluation reports) are not always clear on what is meant by confidence. Confidence could be thought of as having an affective component equivalent to tolerable levels of anxiety with negligible levels of depression and pessimism; and also a cognitive component

relating to a self-assessment of capacity to perform a specific task. However this observation makes sense only from the perspective of operationalisation of constructs for quantitative research. From a qualitative research perspective it seems that increased confidence is an important outcome that users of guidance services choose to report, even where they have not made a career change as a result of the intervention. Notably, improvements in self-confidence were reported by Bimrose, Barnes & Hughes (2008), in what is arguably the most rigorous evaluation of the impacts of guidance yet attempted adopting a longitudinal qualitative design.

Fortunately the literature reporting positive effects on confidence can be bolstered by an extensive evidence base focused on its cognitive component. Self-efficacy is perhaps the nearest psychological construct to confidence that can be adequately operationalised for measurement, although it focuses more on the cognitive aspects of confidence, and less on the affective components. Research into career-related self-efficacy is now well established, such that Gainor (2006) was able to offer a 25 year review of its history. She concludes that there is evidence for the effectiveness of career interventions designed to improve participants' self-efficacy beliefs, particularly in contexts where low confidence is an issue. The self-efficacy evidence is not only abundant, but also includes studies of good quality (Betz, 2007)²³. It could be considered to offer independent support to the qualitative reports of improved confidence experienced by users of adult guidance services. Self-efficacy represents a desirable outcome in its own right, as there is evidence that it moderates the effects of occupational stress (e.g. Jex & Bliese, 1999) and more specifically career-related self-efficacy moderates psychological distress (e.g. Matsui & Onglatco, 1992; Rottinghaus, Jenkins, & Jantzer, 2009). It is also related to more distal outcomes, such as career success and occupational satisfaction (O'Brien, 2003). The effectiveness of guidance in promoting self-efficacy, and

²³ Small scale research into career related interventions for people with severe and enduring mental health conditions suggests self-efficacy may play an important role in achieving positive outcomes (McDonald, 1999; Regenold, Sherman & Fenzel, 1999; Waghorn, Chant, & King, 2007).

the close relationship between self-efficacy and well-being therefore represents important evidence.

Self-concept was highlighted by developmental career theory, but now cuts across many perspectives; it is a recurring theme in the well-being literature. Blustein (1994) argues for the centrality of self-concept in vocational psychology. More specifically he suggests that a useful integrating idea is that of 'embedded identity' i.e. self-concept understood in terms of the social context. Self-esteem is an aspect of self-concept that involves a global evaluation of value. Career factors may form one component of this evaluation. There is evidence of career interventions having a positive impact. For example, Morris *et al.* (2000) found that career education and guidance in school had positive effects on a variety of variables such as pupil self-esteem.

Holland's own research seems to indicate that vocational identity is an important variable. It seems to have a strong inverse relationship to career anxiety (Holland, Daiger & Power, 1980). It is also positively related to the 'Big Five' personality traits extraversion and conscientiousness, and inversely related to neuroticism (Holland, 1996). Thus it is linked to the key well-being variable of anxiety (both state and trait). Whiston & Rahardja (2008) confirm that there is evidence that career guidance has an impact on vocational identity as an outcome measure, and that effect sizes are relatively strong compared to some other variables. Hirschi (2011) presents evidence from an adolescent sample suggesting that an orientation to happiness focused on meaning and engagement are associated with a better developed vocational identity than a pleasure orientation, suggesting eudaimonia rather than hedonia is linked to healthy career development.

The notion of goals features in self-efficacy research, and beyond it, and is also well supported by evidence:

“...the evidence suggests that to some extent people pursuing personal goals or projects that are meaningful tend to report more psychological well-being and a PE process that is for the most part rewarding.” (Walsh, 2003: 116).

Similarly Lent & Brown (2008) cite evidence to the effect that progress towards personal goals is a precursor to well-being. Independent support for this can be found in a qualitative study of rehabilitation work by occupational therapists with clients with mental health conditions (Sumsion, 2004) who reports that therapists believed the work was more effective when the goals were chosen by the service user, not by the therapist. In a very different setting, Wiese, Freund & Baltes (2002), conducted a small longitudinal study and found that specific goal oriented career management approaches predicted both career success and subjective well-being.

One way of making sense of this is to invoke the concept of hope. Arguably hope is a pre-condition for successful therapy, or indeed willingness to participate in a helping process at all (van Deurzen, 2009). There is no single agreed definition of hope, but some consider the concept worthy of operationalisation for research purposes (e.g. Lopez, Snyder & Pedrotti, 2003; Juntunen & Wettersten, 2006).

A related idea is the concept of outcome expectations. Fouad & Guillen (2006) suggest that although they are related to self-efficacy, outcome expectations are a valuable construct in their own right, and one that has been relatively neglected in the career literature. Future orientation does seem to be involved in mental health. Drawing on Antonovsky's (1984) concept of salutogenic health with its focus on coping, the WHO suggests that:

“Optimism seems to be the dominant cognition of the mentally healthy, and optimists have better coping mechanisms...” (WHO, 2004b: 20).

Some of the variables explored here are closely inter-related. For example Betz (1994) links self-esteem to self-efficacy. Lent & Brown (2008) firmly place goal directed behaviour in a social-cognitive perspective on career and well-being. It would seem to make sense that:

- positive self-efficacy would lead to positive self-esteem

- task specific self-efficacy is more meaningful with a goal orientation
- goal setting implies hope for the future
- a sense of identity is influenced by what an individual feels they can do, and what they are trying to achieve.

Thus we are not dealing with isolated variables, but overlapping constructs that are inter-related in complex ways. It seems clear also that activity which has therapeutic benefits does not act on just one variable in isolation. For example, Mee, Sumsion & Craik (2004) found evidence that occupation (in the sense of activities delivered by occupational therapy) helped to build motivation, a sense of competence, and self-identity in patients with mental health conditions.

3.7 Summary

- The evidence that unemployment is associated with detriments to mental health and well-being is overwhelming. Evidence for a causal link is now also strong, although weaker health selection effects may still be present.
- Conversely there is evidence for positive effects of work on mental health and well-being, for most people, most of the time. However the presence and scale of this effect is dependent on the extent to which the job in question provides a healthy psycho-social environment.
- The quality of work is important. Insecure and low status work may offer an unfavourable balance of benefits and detriments to health. Some workers may move in and out of such work, and develop employment histories that are distinctive and disadvantaged.
- The relationship between work and mental well-being seems to be complex, and contingent on individual and situational factors. Detrimental effects are also possible, for some people, some of the time.
- Although a smaller literature, there is evidence for the benefits of participation in post-compulsory learning. Balanced reviews suggest overall benefits of participation in learning, particularly for the least educated groups. The evidence relating to higher education is equivocal.
- Evidence relating to occupational training is limited, but seems to suggest that it offers benefits to well-being that endure as long as the programme, and are proportional to the extent that the training environment resembles work. Low income and uncertain employment outcomes place a ceiling on these benefits. Also the benefits may not necessarily endure beyond the end of the programme.
- Similarly there is evidence for health benefits associated with volunteering and also participation in leisure activities. Much of the benefits can be

attributed to enhanced social contact.

- In very general terms, participation in work, education, training, volunteering and leisure tends to be associated with higher levels of subjective well-being and reduced incidence of mental health conditions. Also movements into work, such as re-employment after job loss, are associated with improved levels of well-being provided that it is a good quality job. This implies that interventions promoting such transitions might be beneficial to well-being.
- Extensive research on workplace well-being variables such as job satisfaction and stress suggest modest relationships with congruence between career interests and work environments. P-E fit may influence well-being outcomes but local factors may be more powerful than matching.
- Although the contribution of the career success literature is limited, one interesting finding is counter-intuitive: career success may be a consequence of, rather than a cause of happiness.
- Pre-entry career decision making may be impaired by mental health conditions, or non-optimal levels of anxiety.
- Career well-being in organisations may be affected by a variety of factors including relationships and sense of control.
- Longitudinal studies of development through the lifespan suggest that early career related experiences, and positive behaviour may have long term effects with consequences for health (and vice versa). Lifespan development factors interact with gender. Evidence for socio-economic gradients in well-being can be found in the career literature that takes this wider perspective.
- Evaluation of interventions for the unemployed is dominated by employment outcomes; health related outcomes are neglected. However a rigorous body of work emerges from the MPRC studies demonstrating that brief job search

support interventions can also reduce psychological distress, in addition to their economic impacts. Isolated studies of career education suggest that group interventions in educational settings can also reduce distress.

- Direct measurement of well-being outcomes of individual guidance interventions is similarly rare. However there is a strong body of research demonstrating impact on self-efficacy, and this is independently supported by qualitative evidence from adult guidance suggesting service users report enhanced confidence. Similar, though less extensive bodies of work relate to positive effects on self-esteem, goal orientation, vocational identity and self-concept.
- The most vulnerable groups may benefit the most from participation in work and learning, and also gain the most from interventions. Hints at this conclusion can be found in diverse sources relating to participation in adult/community education, occupational training, job seeker support or CBT programmes for the unemployed, and career education for pupils. The curvilinear relationship between income and happiness, also suggests that the poorest make bigger gains in well-being from incremental improvements in income.

Chapter 4: The Policy Context

4.1 Overview

Thus far, the literature review has explored theoretical and empirical perspectives linking career guidance interventions to well-being outcomes. The data in this study derives from an evaluative case study of the work of one particular guidance organisation, whose client group is unemployed adults with mental health conditions. Whilst the broad argument presented in the thesis is applicable to all career guidance users, this group throws the issues into sharp focus as they are on the cusp between economic inactivity and social participation, and their mental well-being is a salient concern. To move from the general argument to the specific empirical study, it is necessary first to locate this research in a context of UK government policy. Relevant policy relates to health in the working age population, welfare benefits, labour activation measures and the wider labour market, and current service provision for unemployed groups with mental health conditions.

Critical policy analysis is largely a background issue in this study, with impacts on well-being in the foreground, hence the coverage of these issues is in the form of a brief summary. An in-depth analysis is not attempted, but some consideration is necessary to underpin a later discussion of the implications of findings for policy. The focus on service provision provides an opportunity to review some additional empirical evidence of guidance impact that is linked closely to the practice context.

No attempt is made to systematically address issues of skills development, human capital and employability (e.g. Devins, 2011; Lindsay, Mcquaid & Dutton, 2007). These are important perspectives on Government responses to worklessness, but are not the main focus of this thesis.

4.2 UK Government policy

4.2.1 The health, work and well-being strategy

The International Labour Organisation (ILO, 2000) described the UK's policy in relation to mental health and work as proactive. A wide range of legislation pertains to mental health. For example, the creation of the Equality and Human Rights Commission and the Equalities Act (Great Britain, 2010)²⁴, is of direct relevance to those with mental health conditions in so far as an individual disability model is accepted (Boardman, 2010c). In recent years, the UK government has published a number of key documents linking work with mental health (Black, 2008; DH, 2009; DWP, 2008; HM Government, 2005; Social Exclusion Unit, 2004; Perkins, Farmer & Lichfield, 2009).

A picture emerges of Government policy aspiring towards 'joined up thinking' in the development of cross-departmental strategies to address public mental health needs. These strategies locate work as central to health. They advocate interventions to support mental health in the workforce and to reduce mental distress in the unemployed by improving access to work. The Black Report has been particularly influential, with its critique of the 'historic failure' of healthcare and employment services for those on incapacity benefits (Black, 2008). Many of its recommendations have been implemented, including improvements to the management of sickness absence.

4.2.2 Welfare-to-work policy

The need to reduce the numbers of people of working age who are economically inactive for health reasons is the key economic driver behind these policies. People inactive for reasons of mental health related conditions represent anywhere from a quarter to a third of these claimants, varying across the regions of the UK (Anyadike-Danes, 2010).

²⁴ This superceded the landmark Disability Discrimination Act (DDA) (Great Britain, 1995).

The Government strategy does show sensitivity to the complexity of the problem, the way it inter-relates with other social problems, and the need for a wide range of steps to be taken across government (e.g. Department of Health, 2009). It has been argued that the strategy is right to prioritise new claimants before their employability declines, as the chances of successful outcome are greater than historic claimants who are distant from the labour market (Beatty *et al.*, 2010; Houston & Lindsay, 2010; Kemp & Davidson, 2010). These strengths must be acknowledged. However critics have highlighted a number of weaknesses in UK welfare-to-work policy, and some of the most salient issues are highlighted below.

It has questionable underpinning assumptions (Houston & Lindsay, 2010). One is the location of responsibility in individual rather than structural factors. The belief that IB claimants have a poor work ethic, and their health is no barrier to work is not supported by the evidence (Kemp & Davidson, 2010). The extent to which claimants have substantive health conditions, or are a manifestation of hidden unemployment, remains contentious (Bambra, 2011).

It is not sensitive to regional issues. Reductions in the public sector may particularly hit regions of long term economic decline, or these which are over-dependent on Government spending (Clayton, 2009). It is known that that regional differences in welfare benefits are entrenched, with two or three times as many IB claimants per head of population to be found in the 'north' than the 'south', although the percentage with mental health conditions is higher in the south (Anyadike-Danes, 2010).²⁵ In post-devolution Scotland, although responsibility for skills and vocational training is devolved, control over welfare benefits and employability initiatives is largely reserved to the UK parliament, limiting responsiveness to regional conditions.

The acceptance of the proposition that unemployment is bad for you, has led to a cross party consensus that accepts work is good for mental health, a position

²⁵ The north-south characterisation used by Anyadike-Danes should not be taken to imply a simplistic approach. He also points to concentrations of IB claimants in the Celtic nations, notably South Wales.

underpinned by Waddell & Burton's (2006) review. This has turned an academic critique of Government employment policy, articulated in 1980s, into one pillar of support for a new vision of work as healthy, promoting both personal and national economic development. Whilst this position undoubtedly has some merit, there are dangers that it neglects the complexity of the work-health relationship. This seems to represent the convergence of moral, economic and social agenda developed under New Labour, and continued by the Coalition: a belief in Government that promoting health at work and employment for the economically inactive simultaneously improves well-being at the population level, improves business productivity, and reduces the burden on the public purse (Grover & Piggott, 2007; Walker & Fincham, 2011). The research evidence is taken to point to the potential for a virtuous circle, provided that the support structures in place are sophisticated enough to facilitate it. Seeing work as fundamentally healthy has become an ideological position (Bambra, 2011).

It results in work activation policies that may encourage participation in marginal employment of questionable health value, with detriments in the long term. Policies aimed at improving well-being at work may benefit those in large employers, but may not reach the most vulnerable workers on the fringes of the labour market, particularly those in small employers. Thus aggressive labour activation measures could have perverse consequences for health and careers:

“A major worry is that in the desperation to get people off welfare, low paid, low skilled, entry level jobs are promoted and longer term investment in skill and career development has remained relatively neglected...” (Scott, 2006:680).

It is over-reliant on supply side measures, and places too little emphasis on the demand for labour (Grover & Piggott, 2007). There seems to be a tendency to view demand side measures, such as job creation, as less effective (Hirst, 2011); but recent evidence suggests that demand side factors are more powerful. Webster *et al.* (2010) argue that a period of reduction in claimant rates in Glasgow after 2003 should be attributed to labour market improvement, not to policy interventions targeted at individuals. Another consequence of

over-reliance on labour activation measures is that relatively less emphasis is placed on rehabilitation provision, workplace support measures, workplace mental health and safety measures, disability discrimination prevention, and staff training in mental health awareness (Curran *et al.*, 2007). The policy also favours private and third sector provision over state sector, in spite of an absence of evidence to support this position. There are indications that providers have experienced difficulties in meeting their targets, and some evidence of greater levels of trust for state providers involved in rehabilitation, notably the NHS (Clayton *et al.*, 2011; Lindsay & Dutton, 2010).

The reforms to Incapacity Benefit (IB), initiated by Labour, were designed in a time of a prospering economy: the introduction of Employment Support Allowance (ESA) to replace IB, more stringent assessments of fitness (Barnes *et al.*, 2010; Citizens Advice Scotland, 2010), and stronger work activation measures may not be appropriate in a time of recession. Nonetheless the reform agenda is being pursued vigorously by the Conservative–Liberal Democrat Government. A major challenge the coalition has set for itself is the rationalisation and simplification of the highly complex systems of benefits, with a view to ensuring that work is incentivised at all levels of engagement: hence the *Welfare Reform Bill* which recently passed its final stage prior to royal assent (Great Britain/House of Lords, 2012). In tandem with this is a rationalisation of initiatives to re-engage inactive workers most notably through the introduction of the *Work Programme* (DWP, 2011), and also *Work Choice* (DWP, 2012) which is targeted at those with disabilities and health conditions. It remains to be seen if low economic growth and regional stagnation will allow sufficient new job opportunities to become available to enable providers to achieve the necessary employment placements, to trigger their payments; new funding mechanisms are heavily weighted towards sustained outcomes.

Analysis of past recessions gives a partial guide to the employment effects that might be expected in the current economic downturn. Higher unemployment is certainly associated with detriments to health, but recessions affect the whole population and the macro level health effects seem to be mixed (Stuckler *et al.*, 2009; Bambra, 2011). Unemployment has risen during the period of this

project, and we can expect young people and disabled groups to be particularly affected (Stafford and Duffy, 2009; Youth Access, 2009). The Royal College of Psychiatrists (2009) suggest that unemployment, debt, and home repossession may be important factors facing people with mental health conditions, adversely affecting their health and placing an extra burden on support structures.

The combination of chronic illness, low qualifications, deindustrialisation and recession, have reduced the employment prospects of marginalised groups, but some countries have done better than others at mitigating these effects (Holland *et al.*, 2011a). There is partial evidence from international comparisons to support the suggestion that investment in ALMPs is effective (Holland *et al.*, 2011b), but the UK spends a smaller percentage of Gross Domestic Product (GDP) on these policies than comparable European nations (Dageurre & Etherington, 2009).

4.3 Service provision for unemployed adults with mental health conditions

4.3.1 Vocational rehabilitation provision

There is evidence that the bulk of people with a mental health condition, including the long-term unemployed, see work as a goal. It seems there is a potential demand for rehabilitation services. However health services have not tended to view employment as a priority, even though there is clinical evidence that it tends to be therapeutic (Secker, Grove & Seebohm, 2001; Grove, 2001).

Provision for the vocational rehabilitation of people with mental health conditions is most often found in small agencies and is patchy and inconsistent across the UK (Boardman *et al.*, 2003; Booth, Francis & James, 2007; Joss, 2002). Funding is often short term and from multiple sources (Wistow & Schneider, 2007) such that local factors, unrelated to the level of need, often determine provision the nature of provision (Crowther & Marshall, 2001).

There is strong evidence for one approach being effective in achieving employment outcomes: *Individual Placement and Support* (IPS) (e.g. Bond *et al.*, 2001). This has been influencing UK policy sources (e.g. Rinaldi & Perkins, 2007), which are strongly advocating its adoption as a result of its evidence base. IPS has a limited focus, being primarily concerned with part-time work for a small number of people with severe and enduring conditions. It has a number of key features including employment specialists based in clinical teams, early placement into open employment, service user choice of work, and ongoing support that is not time limited. Essen (2012) is a lone voice dissenting from the consensus in the VR literature in arguing that the claims for IPS are overstated, going beyond that sustainable by close examination of the evidence.

4.3.2 NHS Provision

A wider range of rehabilitation services is provided by the NHS, of which vocational provision is just one small element. There are trends towards NHS mental health trusts employing their own service users (e.g. Department of Health, 2002; Seebohm & Grove, 2006). This follows the public spending review in 2007 which introduced a Public Service Agreement which set performance indicators for the Government's key objectives in the period 2008-2011. PSA16, pertinent to secondary mental health care services, is to increase the proportion of vulnerable adults in settled accommodation and employment, education or training (Boardman, 2010c; Pilgrim & Rogers, 2005).

Primary care services are occasionally involved in a way that goes beyond sickness certification by GPs. James (2001a & b; 2004; 2005) and Aylward & James (2002) describe evaluations of the *Prescriptions for learning* initiative in which learning advisers were embedded in primary care settings. This is not only outreach educational guidance, but also an example of a wider movement towards 'social prescribing'. Although there are inadequacies in the detail of reporting, and no rigorous measurement, the qualitative self-report findings are striking. Widespread improvements to mental and emotional well-being are reported by their sample of frequent GP attendees. These included improvement in self-esteem and confidence; physical health and pain management. There were reports of reductions in levels of blood pressure, use of painkillers, tiredness and sleep problems, and rumination on health problems. Wider benefits such as better health behaviour (e.g. reduced smoking or drinking, participation in exercise), and improved family health were also noted.

These benefits may be primarily arising from participation in learning rather than the guidance itself. However it seems that guidance interactions provided a sense of feeling listened to (health professionals lacked time to do this) and encouraging being active, able to make decisions, and an improved ability to cope with stress. A minority reported disbenefits to learning participation (e.g.

stress, tiredness, frustration), and learning advisers had to overcome drawbacks of the clinical setting, in which they could be perceived as counsellors or psychiatrists, which was detrimental.²⁶

Similar initiatives have focused on employment advice in GP surgeries (e.g. Booth, 2006; Sainsbury *et al.*, 2008) and have also suggested a well received service. Pittam *et al.* (2010) reported on an initiative to support existing workers to retain their jobs: evidence of success at this objective is provided, although the numbers involved are very small. They identify the career guidance element of the support provided as most useful, but do not explain what is meant by this.

Overall the evidence from primary care needs to be interpreted with caution. In general it relates to pilot initiatives, and the quality of reporting is variable. A more rigorous approach can be found in an analogous field: Adams *et al* (2006) conducted a systematic review of the health, social and financial impact of welfare rights advice delivered in healthcare settings (mostly UK based primary care). In the 55 studies they considered they found clear evidence that welfare rights advice resulted in improved financial outcomes. However, they found the quality of the evidence base was inadequate to judge whether impacts on health could be attributed to the interventions.

4.3.3 Department for Work and Pensions initiatives

Clayton *et al.* (2011) conducted a systematic review of 31 studies, published between 2002 and 2008, into the effectiveness of UK Government initiatives to support individual benefit claimants with disabilities or long term illness to return to open employment. They focus on three main programmes, the *ONE Advisory service*, *New Deal for Disabled People* (ND/DP), and *Pathways to Work* (PtW). They also identify other support initiatives usually delivered as part of a package with these three programmes. Financial support (*Return to Work*

²⁶ In reporting the *Prescriptions for learning* pilots, Kathryn James explicitly locates them as attempts to build social capital, within a wider context of a concern to address social inequality and poverty as causal factors in health outcomes, and the literature on the wider benefits of learning.

Credit; Disabled Person's Tax Credit; Permitted Work and Condition Management Programmes (CMPs).

Clayton *et al.* (2011) make a number of observations suggesting the impact of these programmes may be modest. Firstly, the evidence may tend to overestimate the effects of interventions, due to selection of the most able to be put forward to employers, and confounding with the effects of more stringent assessments of fitness to work. Secondly, most job seekers re-enter work without using specialist initiatives instead the mainstream JobCentre Plus service; awareness and take up of initiatives for the long term sick is low.

Clayton *et al.* (2011) are similarly cautious about the effects of CMPs, which help claimants to manage health conditions to facilitate return to work. Acknowledging they seem to be most appropriate to those furthest from the labour market, they note a lack of clear evidence of their effectiveness.²⁷ CBT is the key mental health element of CMPs, and as discussed in chapter 3 (3.6.5) there is some mixed evidence concerning their effectiveness in employment contexts.

Economist Richard Layard, has argued for a greater focus in policy making on happiness, and that there is both a moral and an economic case for greater efforts to reduce the distress caused by mental health conditions (Layard, 2005a; 2006). Together with David Clark, he has extended this perspective to argue for a large scale increase in the availability of psychological therapy services in the UK (Layard, 2005b; Centre for Economic Performance/LSE 2006). These arguments successfully swayed Government, leading to the creation of the *Increasing Access to Psychological Therapies* (IAPT) Initiative. More specifically they argue for an expansion of CBT services to reactivate the unemployed.

²⁷ Barnes & Hudson (2006) report that in spite of acknowledging the official employment goal of PtW, CMP practitioners themselves would also unofficially work towards health outcomes for their clients such as reduced medication, increased functioning and quality of life.

Support for CBT is evidence based, but the evidence of clinical efficacy seems to have been accepted in an uncritical way, and the vocational consequences of other therapies have not been systematically explored. The Layard arguments, whilst accepting the detrimental health effects of unemployment, suggest that these effects are reversible by symptom focused treatment, with re-employment as a result. The resulting gains in taxes and savings from benefits mean it is self-financing. This position involves some extrapolation beyond the available evidence. In practice, however CBT has not been used in isolation. Rather it is located in DWP initiatives as part of CMPs sitting alongside a range of health related services which complement employment support, rather than replace it.

4.3.4 Career guidance provision

Career guidance provision for adults in the community, like VR services, has historically been patchy and inconsistent (Peck, 2004), a situation only partly remedied by devolution, and the creation of national services in Scotland, Wales and Northern Ireland. In general, UK services are tending towards call centre and web-based mass provision to promote lifelong learning (Watts & Dent, 2008), in a process of rapid evolution (Hooley, Hutchinson & Watts, 2010a). This model has pragmatic merits, but may have drawbacks with some members of vulnerable groups who lack digital literacies (Hooley, Hutchinson & Watts (2010b). Some, but not all, unemployed people with mental health conditions may need face to face support, may have limited access to computers, or lack the ability to act on information alone.²⁸

Career guidance services are ignored by all the Government Strategy documents relating work and well-being, which focus on JobCentre Plus (JCP) and VR services, Primary Care Trusts (PCTs), and occupational health (OH) services. Whilst career guidance services in the UK have incorporated counselling approaches to a greater or lesser extent since the 1970s, the use of

²⁸ This generalisation does not rule out the possibility that specific technologies, such as computer based therapy applications, may be an effective treatment for mental health conditions.

counselling to support job seekers seems to have been re-invented in the IAPT initiative and in calls for counselling skills training for JCP staff, without reference to existing guidance structures. This has been done in a way that emphasises therapeutic rather than career counselling. This development is ironic in the light of Jayasinghe's (2001) critique of the UK Government's history of resistance to counselling conceptualisations of career guidance in statutory services.

A balanced critique must acknowledge that the career guidance profession has shown little or no interest in the work and well-being policy agenda: the key DWP or DH policy documents are rarely cited by guidance policy commentators. More generally, insufficient effort and resources has been invested by the profession in the development of an evidence base for practice. Only in unpublished MSc dissertations from Harvey (1998) and Chambers (2010) can practitioner research be found that attempts to link guidance work to mental health and well-being outcomes. Funding bodies and leaders of guidance agencies have neglected impact research in general, and health related impacts in particular.

4.4 Summary

- Services for the support of unemployed jobseekers exist in an environment that is shaped by Government policy on welfare benefits and labour activation. The large number of people of working age who are economically inactive for reasons of health represents a major concern. Mental health conditions feature prominently in this group.
- UK policy since the late 1990s has aimed at promoting work for both economic and health reasons, and seeks an integrated agenda for change. Benefit reform is a key element of the strategy.
- Politics of the left and the right have converged in relation to this issue. Thus current coalition policy continues an agenda begun under New Labour, and has set the ambitious goals for rationalising welfare benefits, and labour activation initiatives.
- Government policy has some strengths, notably in seeking to prevent worker disengagement from the labour market at an early stage. However, the policy is based on assumptions that are questionable, including its poor fit with the wider UK and regional labour market context.
- Services for unemployed adults with mental health conditions are provided by a range of organisations including the DWP, the NHS, and small vocational guidance providers; provision is fragmented and lacks strategic integration.
- Career guidance services have been largely ignored in Government thinking and strategy for work and well-being. Conversely, the profession has largely ignored this area of policy making.

Chapter 5: Methods

5.1 Overview

This chapter will outline the methods adopted in the study. Throughout the approach is underpinned by a critical realist research philosophy. The chapter is structured in the following way. Firstly, the research methods can only be understood in relation to the intervention that is the object of study. This requires a brief introduction to the service provider in question: Fife Employment Access Trust, with a focus on the interventions to be evaluated.

Secondly, an overview of the research design is provided and its key features are highlighted. Both quantitative and qualitative approaches are then described separately in more detail. The former necessitates a discussion of the operationalisation of constructs for measurement. The latter requires a discussion of reflexivity.

Thirdly, the evolution of the methodology is outlined. This section departs from strictly procedural reporting, so as to give a narrative sense of the challenges facing the research design and attempts to respond to them.

Fourthly, the ethical issues that arise and the approach taken to managing them will be outlined. Finally, a detailed critique of the methodology identifies the limitations of the study, with a particular focus on the quantitative design. This ensures that subsequent interpretation is undertaken with due consideration to the rigour and reliability of the findings.

5.2 The intervention

5.2.1 The partner agency

Data was generated in collaboration with Fife Employment Access Trust (FEAT), a small voluntary sector agency. FEAT specialises in providing employment support to unemployed adult job seekers with mental health conditions. It operates in the Scottish local authority area of Fife, a region with a moderately weak labour market. The nature of the organisation and its local labour market context is described in more detail in Appendix 5. Here the focus is on the nature of the services provided by the agency: reporting the design of interventions is an essential step in evaluation.

5.2.2 FEAT services

After an initial assessment and screening appointment, FEAT offers service users an individualised package over a flexible time period typically six months but may be up to a year. A system of credits is used to manage the level of service to individuals. A typical initial allocation may be 42 credits. One credit roughly equates to an hour of contact time with staff or a single one-to-one consultation. The system is not operated rigidly, with further credits being allocated if it is considered appropriate. This is a soft form of resource rationing, used successfully to manage a problem of service users remaining on the programme indefinitely with no satisfactory outcome, preventing the organisation from taking new referrals. The credit system has enabled a flow of service users to be supported with the following services:

Individual support from an employment adviser

One credit per meeting/hour. In addition to a job seeking focus, this is generic pragmatic and emotional support on a one-to-one basis. It also represents the main relationship through which access to all other services is mediated.

Typically at initial assessment a programme of five employment advice sessions will be allocated to an individual, although this can be extended up to a

maximum of 20 sessions.

Confidence building/motivational workshop programmes

Participants sign up for a series of sessions held in small groups. They are not related to job search, but have material suitable for people with mental health conditions. Two programmes are available:

- *STEPS (Steps to Excellence for Personal Success)*: 25 credit/hours. This programme originates in the work of Lou Tice (Pacific Institute, 2007). It is influenced by cognitive behavioural therapy and focuses on challenging negative thinking, and peer support. It is supported by brief DVDs and includes elements to encourage service users to 'move beyond their comfort zone'. This is an 'off the shelf' package and may only be delivered by accredited trainers.
- *STARS (Steps to Achieving Real Success)*: 14 credit/hours. This programme was inspired by STEPS but developed in-house in response to the problem of high costs associated with STEPS. This is a shorter programme which does not use Pacific Institute licensed or copyright materials.

Work placements

Work placements are made available to service users in a variety of industry sectors. These are unpaid, aside from expenses. Typical duration is 6 – 12 weeks. Attendance patterns are negotiable, and normally part-time. For example, an initial arrangement of 2 half days per week may rise to 3 full days per week if all goes well.

Prior to placement a psychiatric risk assessment is conducted. There is also a workplace specific health and safety/employer liability insurance checking process in place run by FEAT's placement officer. Placements are monitored on a fortnightly basis, normally by a visit in person from the employment adviser. It is not unusual for a placement to lead to an offer of paid employment. A small minority of placement providers may be motivated to exploit the unpaid labour offered by this scheme.

Group workshops for job seeking skills

Two credits per session. These focus on developing skills and confidence in applying for jobs and follow a traditional format. There are four workshops offered: job search; application forms; CV writing; interview skills. They are stand alone, so it is not expected that all will be attended as a programme.

Less frequently used services

- *Brief therapeutic counselling*: This is generic, not work related. It seems to be rarely used as most service users can access counselling provision elsewhere.
- *Mentoring*: This is a form of volunteering whereby service users are given the opportunity to act as peer mentors within the STARs or STEPs programmes.
- *Support into work*: Individual support can continue after achievement of an employment outcome.

5.3 Overview of the research design

5.3.1 Sources of data

Three sources of data were used, and these are described below:

Self-report questionnaires

These represent an attempt to detect effects of intervention on well-being, mental distress, and their pre-cursors. Three instruments were used, presented in paper format booklet to appear as one questionnaire (see appendix 2):

- The Warwick Edinburgh Mental Well-Being Scale (WEMWBS), used to assess changes in hedonic and eudaimonic well-being;
- The Hospital Anxiety and Depression Scale (HADS), used to assess changes in anxiety and depression.
- A specially designed scale based on Peter Warr's vitamin model, used to assess perceived changes in quality of psycho-social environment.

A sample blank questionnaire is included in appendix 2. Their presentation deviates from the publisher's recommendations in two respects. Firstly they are presented so as their visual appearance is consistent, i.e. participants experience it as one questionnaire. Secondly, this necessitated minor changes in instructions. The reference time period adopted was two weeks, consistent with the WEMWBS, but different from the HADS, which concerns feelings over the previous week. References in the HADS instructions to doctors were also avoided, as this was a non-clinical context. These adaptations were made in the anticipation that the advantages in simplified questionnaire presentation to participants would outweigh any threats to validity or reliability made by these minor changes.

These questionnaires were deployed at initial assessment stage (T1), after six months (T2), and again after twelve months (T3).

Research interviews with service users

These were used to gain an understanding of participant's experiences as job seekers, and as FEAT service users. A particular focus was their perceptions of the impact of FEAT on their life-career, and attributions they made as to the causes of change, career development or recovery.

The FEAT client database

This represents the opportunistic use of a pre-existing data set; the database was designed for administrative purposes, not for research, and is not ideal for the latter purpose. However the data potentially allows for linkages to be made between key sets of variables, and can be combined in analysis with the subjective data generated by questionnaire. The client database operated by FEAT contains:

- demographic data enabling a characterisation of the service user group
- baseline data on entry, such as length of time unemployed and identified barriers to work; data on interventions provided by FEAT to individuals
- outcomes achieved by individuals, such as open employment or attending an educational programme.

5.3.2 Key features of the research design

An overview of the research design is provided in table 4 below.

Table 4: Summary of the research design

	T1: Pre <i>At point of registration</i>	Intervention <i>Variable: typically 3-6 months</i>	T2: Post <i>6 months after registration</i>	T3: Follow up <i>12 months after registration</i>
Objective measures	Demographic & baseline data	<i>Individual employment advice</i>	Achievement of job, course or equivalent	Achievement or retention of job, course or equivalent
Subjective measures: well-being	Questionnaire comprising: WEMWBS HADS 'Vitamin' scale	<i>STARS/STEPS personal development groups</i> <i>Job search/CV/ applications skills workshops</i>	Questionnaire repeated	Questionnaire repeated
Process & meaning		<i>Work placement</i> <i>Personal counselling</i>	Semi-structured research interviews	Follow up research interviews with same sample

Some key features of the design can be highlighted. First, this is a mixed methods design, drawing on both qualitative and quantitative methods, as advocated by Haverkamp, Morrow & Ponterotto (2005) for counselling psychology research. Following Teddlie & Tashakkori (2003) and Hanson *et al.* (2005) it is possible to be more specific. The approach adopted involves complementary and concurrent use of qualitative and quantitative methods: they are equally important, and conducted in parallel.

Quantitative data describes the sample population, and detects if there are changes in levels of well-being; qualitative data provide supplementary evidence of these changes. Qualitative data are also used to determine if

participants attribute changes in their well-being to the intervention, and to identify causal mechanisms intervention as they perceive them. The research is confirmatory in that it seeks to establish if there is evidence for an expected effect on well-being of guidance interventions. It is exploratory in that it seeks to explore possible causal mechanisms that would explain such an effect, without strong preconceptions as to what they would be. Quantitative data generation is cast primarily in a confirmatory role, seeking to detect an effect; qualitative data are in an exploratory role, seeking to understand the nature of effect mechanisms.

Second, a related point, this study involves triangulation between three complementary sources of data. Similar to Lee, Mitchell & Sablynski (1999) the prime purpose of quantitative well-being measures is in an attempt to detect effects of guidance interventions; the prime purpose of qualitative methods is to interpret and explain the connection between interventions and participants' experience. Audit of the database adds information about client, intervention and outcome variables, so may help interpretation of findings.

Third, this is a longitudinal design. This is in line with the recommendations of Savickas (2002) and Bernes, Bardick & Orr (2007). This is an important feature, as it is likely that most career-related processes of interest unfold over the medium to long term, and that outcomes are best understood over longer time scales.

Fourth, this design represents an attempt at evaluation: to determine the impact of interventions provided by an agency in a naturalistic setting. This has a twin function: it is both for purposes of research, and for purposes of service improvement. Evaluation is implicitly predictive, being concerned with what intervention will work (best) in future. This places some constraints on the nature of the questions that can be asked and the data that can be generated. Rallis & Rossman (2003) suggest that multi-method research is appropriate for service evaluation settings.

Fifth, the central focus on this study is on the perspective of the service user (as opposed to that of employers, or employment advisers for example). Whilst other perspectives are valid and interesting, the emphasis here is on the subjective experience of the research participants. However the decision to augment the data by use of the FEAT client database means that not all the available data are subjective.

Finally, in use of the six month measuring point when some service users may still be engaged with FEAT, some partial attempt is made at measuring change in process. This is consistent with Huxley's (1998) argument that concurrent measurement at intermediate points is desirable to inform treatment development.

5.4 Quantitative design

5.4.1 Operationalisation of constructs for measurement

In the light of the conceptual debates surrounding the construct of well-being, the issue of operationalising constructs for measurement purposes presents some challenges to the researcher. Some choices need to be made given the plethora of definitions available. Firstly, the concept of hedonia alone seems inadequate to capture the kind of well-being that career interventions are most likely to promote. Including the concept of eudaimonia would allow for personal growth and healthy functioning, that successful adjustment to work would promote.

Secondly, as the target client group is recovering from a mental health condition it seems appropriate to measure psychological distress. The negative concept of distress is inversely related to positive well-being; but there is reason to believe that it is also partially independent. Huppert & Whittington (2003) found evidence for this and argue that both positive and negative well-being should be measured. Their rationale is adopted in this study.

Thirdly, psychological distress can be broken down into three sub-components such as anxiety, depression and generalised somatic disturbance, i.e. disturbance of sleep, digestion and sexual functioning (Clark & Watson, 1991). It is not inconceivable that these could move partially independently. For example unemployment is most often associated with depression, but the transition into reemployment may bring new social and performance stresses, so could increase anxiety. It is therefore of interest to measure anxiety and depression separately. Measures of generalised somatic distress are of less interest, and were not attempted, thus avoiding some intrusive questioning, and a clinical focus.

Fourthly, multiple outcome measures are desirable in occupational research (Dunnette, 1963), and this seems particularly applicable to well-being, as it is clearly a complex, broad and multi-faceted construct (O'Connor, 2004; Huxley,

1998; McCrum, Burnside & Duffy, 1997; Warr, 2007).

5.4.2 Measurement tools

Drawing on a number of sources (including O'Connor, 2004; Bowling, 2005; McDowell, 2006), a number of criteria for use in selecting suitable instruments can be identified. These need to be considered in relation to the proposed context for assessment, as tools do not have technical properties in isolation from their usage:

- technical properties of the instrument (validity, reliability, sensitivity)
- instrument format (e.g. instructions; length; verbal, paper or computer based; response scales; need for supervision)
- appropriateness for the target population (i.e. suitability for use with adults in community/non-clinical settings; intrusiveness)
- practicality (e.g. administration, costs, scoring, availability of manuals)
- the construct to be measured (e.g. positive well-being vs. distress; cognitive vs. affective; global vs. specific).

The GHQ (Goldberg, 1972) represents an obvious choice as it is the most widely used instrument. It has become a recommended measure for use in unemployment research, and its consistent adoption has enabled comparison across studies in more recent research. Extensive benchmarking data are available for its use in occupational settings (Stride, Wall & Catley, 2007). However it has three important drawbacks: firstly, it does not separate anxiety from depression. Secondly, it has a restricted range: designed as a psychiatric screening tool it can only discriminate between half the population with the most distress so it lacks sensitivity for the 50% most mentally healthy. Thirdly it conflates positive well-being with distress as some items have positive wording.²⁹ The GHQ has therefore been rejected in favour of two instruments,

²⁹ This problem of conflating positive well-being and psychological distress afflicts most relevant measuring instruments, not just the GHQ.

the Warwick-Edinburgh Mental Well-Being Scale, and the Hospital Anxiety and Depression Scale, to address the positive and negative aspects of measurement respectively. These are described below.

The Warwick-Edinburgh Mental Well-Being Scale (WEMWBS)

This is a recent development resulting from collaboration between researchers at the Universities of Warwick and Edinburgh. It is based on an existing scale, the Affectometer 2, from New Zealand, and has a number of advantages:

- It is short and easy to administer (14 items).
- It focuses exclusively on positive well-being, making it distinct from psychiatric disturbance measures, and relatively unusual for tools of this kind.
- It is user friendly for the respondents, it has face validity and is non intrusive
- It addresses both hedonic and eudaimonic aspects of well-being. It does not produce separate scores for these components, but it does have a seven item short form, described as focusing more on eudaimonia.
- Although a new instrument, evidence for its validity and reliability is encouraging. Tennant *et al.* (2007) describe it as psychometrically robust.
- The development of the tool is supported by the Scottish Government. This may give political credibility to evidence generated using this instrument at the current time.
- With part of the development work taking place in Scotland, it is possible to be confident that the instrument is culturally appropriate to a Scottish population.

Further evidence is needed to assess how sensitive the WEMWBS is to detecting changes in individual or population well-being over time. However Tennant *et al.* (2007) found no ceiling effects, which is an encouraging sign that the instrument may be sensitive. WEMWBS is an affective measure; it does not address the cognitive construct of life satisfaction. Indeed no attempt to measure life satisfaction is made in this study, although it must be acknowledged that it may have important implications for the work domain

(Erdogan *et al.*, 2012) and there are precedents for its use in counselling and guidance outcome research (e.g. Dauwalder *et al.*, 2011). This construct may make more sense for those in settled lifestyles than for those in dynamic transition from unemployment to work. Also, Forgeard *et al.* (2011) suggests that measures of life satisfaction can be distorted by mood and by contextual factors, and this would seem to be a potential problem with this target population. Similarly measures of the domain specific construct of job satisfaction are clearly inappropriate to an unemployed population.

Hospital Anxiety and Depression Scale (HADS)

This is a screening tool developed by Zigmond and Snaith (Bowling, 2005a; Zigmond & Snaith, 1983). It has some advantages:

- It is brief (14 items) and easy to self administer
- The design is based on clinical experience, not factor analysis. It is intended to improve differential diagnosis between anxiety and depression
- Seven items relate to anxiety and seven to depression (with a focus on anhedonia, a key characteristic of depression), keeping these two concepts and their measurement quite distinct.
- It ignores physical or psychotic symptoms which are of less interest to this study. Also, it does not include well-being measures reducing the risk of overlap with the WEMWBS.
- Evidence for the validity and reliability of the HADS is good
- It is a screening, not a diagnostic tool. In spite of the 'hospital' label it has been used successfully in community settings.

A study of the use of the HAD with a sample of employees increases confidence in its use. Andrea *et al* (2004) found that it did measure anxiety and depression as two separate constructs effectively in the working population. They also found that sub-clinical anxiety and depression was very prevalent among employees in their large sample study in the Netherlands.

Although it cannot equal the GHQ for volume of evidence of validity and reliability, there is some evidence that it can perform as well (Bowling, 2005a). Systematic reviews of HADS are available in the literature (Herrmann, 1997; Bjelland *et al*, 2002). Andrews & Wilding (2004) represents an interesting application of the HADS scale in an educational context: a longitudinal study of undergraduates. This demonstrates the appropriateness of this scale for community based longitudinal studies of mental distress. Overall, it is widely used and receives favourable judgements from reviewers as fit for purpose (McDowell, 2006).

Vitamin scale

In addition to the WEMWBS and HADS instruments, a questionnaire was designed specifically for this study. This was based on the Warr's (1987; 2006) vitamin theory. It contains one item for each of the 12 psycho-social factors identified by Warr as key variables influencing well-being. This questionnaire has not been validated, so its technical properties are unknown. Its use here is strictly exploratory and data generated does not have the same status as that produced by the WEMWBS and the HADS. Interpretation must therefore be extremely cautious.

The rationale behind its use is that career guidance interventions may have an indirect effect on well-being by virtue of providing access to work, learning or equivalent activities. If this is the case then one of the early signs of this effect may be a change in perception of the psycho-social environment. To put it another way, vitamin levels may move closer to the optimum in the transition from unemployment into activity. Scoring of the scale allows for additional decrements in vitamins 1-6.

5.4.3 Sampling strategy

Audit data from the FEAT database was available on all *Journey to Work* service users who registered in the period May 2007– July 2011. All new service users registering between February 2009 and July 2010 were invited to consent to participate in the study, and to complete questionnaires.³⁰ Wherever possible, FEAT staff collected questionnaire data in person by inviting participants to complete the forms during their appointments. Where this was impossible, as is likely to be the case at the follow up measurement points, questionnaires were issued by post and supported by telephone contact and follow up letter. Sample size is indicated in table 5, and the demographic breakdown provided in table 6.

Table 5: Sample size and attrition

Number of new registrations with FEAT in the period May 2007– July 2011	694
Relevant registrants included in analysis of sample characteristics (i.e. excluding those not participating in FEAT ' <i>Journey to work</i> ' services and therefore not relevant to the study)	597
Relevant registrants included in analysis of outcomes, excluding 35 (5.9%) who registered but had not received any services	562
Number completing consent forms and initial questionnaire at T1 (registration) In the period February 2009 and July 2010.	114
Number completing a questionnaire at T2: approximately 6 months after registration.	47
Number completing a questionnaire at T3: approximately 12 months after registration. This includes 5 cases who did not complete a questionnaire at time 2.	26
Number completing three questionnaires	21

³⁰ The original intention was to collect data on service users who registered within a 12 month window; this period was extended in response to an inadequate sample size.

Table 6: Sample demographic characteristics

Total 'Journey to work' clients			N= 597
Gender	Male =	284 47.7 %	n=596
	Female =	312 52.3%	missing =1
Age (years)	Mean =	39.8	n=593
	Standard deviation =	11.3	missing = 4
	Minimum =	18.0	
	Maximum =	68.0	
Ethnicity	<u>Ethnicity</u>	<u>n</u> <u>%</u>	
	White Scottish	487 85.7%	n = 568
	White English	40 7.0%	missing = 29
	White Other Brit	24 4.2%	
	White Irish	3 0.5%	
	White Other	7 1.2%	
	Other ³¹	7 1.4%	
Scottish index of multiple deprivation (SIMD) Derived from post code and expressed as a decile where: 1 = most disadvantaged 10 = least disadvantaged	<u>Decile</u>	<u>N</u> <u>%</u>	
	1	54 9.5%	
	2	102 18.0%	
	3	67 11.8%	n = 567
	4	75 13.2%	missing = 30
	5	69 12.2%	
	6	60 10.6%	
	7	36 6.3%	
	8	36 6.3%	
	9	45 7.9%	
	10	23 4.1%	

The sample demonstrates a gender balance. The very low numbers of visible minorities in this sample is consistent with the profile of the Fife community. Service users tend to come from more deprived neighbourhoods.

³¹ The data for Asian Bangladeshi, Asian Pakistani, Black African and Other has been collapsed here into a single category for reasons of confidentiality, as numbers are so small.

5.4.4 Quantitative data analysis

The quantitative data analysis approach was informed by Tabachnik & Fidell (2007).

Data cleansing

O'Connor's (2004) suggestions on preventing and handling missing data were used as a guideline for data cleansing. Removal of outliers was considered as three cases showed extremely high levels of well-being, which would not be expected in a sample of this kind. However they were not removed for the following reasons:

- one of the cases was in the research interview sample and her verbal self-reports were consistent with the questionnaire responses
- none of the cases was identified as having bipolar disorder, so a manic phase could be ruled out.
- These cases showed high well-being across all measuring points, not dramatic changes, so they were unlikely to substantively affect the analysis.

Measurement at times T2 and T3, did not conform consistently to the intended six and twelve month periods. Reasons for this include variability in time periods between adviser-participant contact and delays in response from participants to postal questionnaires. This problem has been managed by broadening out the time periods for each measurement point such that:

Time 2 = 16 - 40 weeks: mean = 29.2 weeks; standard deviation = 6.4 weeks

Time 3 = 41 – 85 weeks: mean = 51.6 weeks; standard deviation = 8.9 weeks

In a small number of cases this means a measurement is recorded for time 3 but not at time 2. Responses do cluster around the target times, but there is considerable variation as indicated by the standard deviations. Also two time anomalous individual questionnaires (not cases) are excluded from analysis.

Analytic statistics

In addition to descriptives, the following analytic statistics were used:

- Repeated measures ANOVA to assess change in well-being related constructs between T1, T2 and T3.
- Reliable Change Index (RCI) to test for clinical significance in these changes in the WEMWBS scale
- Principal components analysis to assess inter-relationships in the well-being and psychological distress related variables, and identify underlying factors.
- Regression analysis to identify the factors associated with subjective and objective outcomes respectively.³²

³² Use of regression analysis in vocational rehabilitation research has clear precedents (e.g. Beveridge & Fabian, 2007; Bolton, Bellini & Brookings, 2000; Hoyt, Leierer & Millington, 2007).

5.5 Qualitative design

The use of qualitative methods in this study is informed at a general level by McLeod (2001) and Mason (2002). Data generation was by means of semi-structured research interviews, recorded and transcribed for analysis. Appendix 3 includes an outline of the interview structure, a sample transcription and analysis. Interviews were of approximately one hour duration. Follow up interviews with the same sample were conducted, with two objectives:

- to provide participant validation: allowing research participants to comment on the findings of the initial qualitative analysis of the first round of interviews, and
- to achieve a longitudinal perspective by giving participants an opportunity to update their story six months later.

5.5.1 Reflexivity

The need for a reflexive approach is widely discussed in qualitative research texts (e.g. Mason, 2002), and is particularly highlighted by Finlay (2002) as an activity central to all stages of social research. In this study the adoption of a traditional reporting style obscures the reflexivity in this research process. Some key elements of reflexivity are therefore made explicit below.

Firstly, the process of identifying the axiology for the study required making explicit researcher values and preconceptions as they pertain to the study. This is an important pre-cursor to adopting a reflexive stance. Secondly, a log was kept of the research process incorporating not just events but also reflections on them, together with key developments in thinking. However, Finlay (2002) notes the continuous thoughtful conscious self-awareness demanded by reflexivity should not be reduced to mere post-hoc reflection: It is a wider concept and involves a political awareness. The incorporation of a critical policy perspective in this study goes some way towards this recommendation.

Thirdly, an acknowledgement of the nature of IPA is necessary. It is phenomenological in nature and seeks to make sense of how participants make sense of their experience. Although the method suggests the researcher to seek to 'bracket off' their own experience, it must be acknowledged that this is not entirely possible, as phenomenology implies subjectivity. Furthermore it is an actively interpretive approach – the researcher brings their own sense making frameworks to the process (Smith, Flowers & Larkin, 2009). In this instance interpretations of evidence are strongly influenced by the review of theoretical perspectives outlined in chapter 2. Thus both analysis and interpretation of findings cannot be seen as arising purely from the data, but rather from an interaction between the data and the interpretive mind set of the researcher.

5.5.2 Sample characteristics in the research interviews

The choice of sampling strategy for the research interviews was severely constrained by practicalities, specifically the very high likelihood of non-attendance given the nature of the client group in question, and the need to conform to project timescales. All new FEAT service users who registered after the end of February 2009 were invited to attend a research interview approximately six months after they first attend the service, so long as they are still using the service. Written invitation proved inadequate to gain participation, so verbal invitations by FEAT EAs was used to follow it up. Their involvement made it possible to balance the sample in terms of gender, geographical location, and to ensure some diversity in the issues facing participants.

Interviews were on the same day as an appointment with the client's EA, but were scheduled to take place just before that appointment to avoid the conversation becoming excessively focused on that single interaction. Three FEAT service delivery locations were used: Cupar, Dunfermline, and Kirkcaldy.

The interviews took place in a private room in a Fife Opportunity Centre³³, while the FEAT employment adviser was on site, in an adjacent room.

A target of 10-12 initial interviews was set, and appointments offered until 10 interviews had been successfully recorded. This sample size is consistent with the guidelines suggested by Smith, Flowers & Larkin (2009) as appropriate for a PhD study adopting an IPA analysis. Invitations to attend follow up interviews took place approximately twelve months after their initial registration, and the sample of invitees restricted to those who attended the initial interviews. Six participants attended follow up interviews. An indication of sample characteristics is provided in table 7.

³³ At the time the research took place, the network of Fife Opportunity Centres was well established. These Fife Council premises were locations for delivery of local authority adult guidance services, and employment support for the unemployment. They also hosted services provided by other agencies including Careers Scotland (subsequently Skills Development Scotland).

Table 7: Sample characteristics - interview participants

Participants in the initial research interviews at T2 (6 months after registration)	Total:	10
	Male:	5
	Female:	5
Number of participants also involved in follow up interview at T3 (12 months after registration months)	Total:	6
	male:	3
	female:	3
Age	Youngest:	28 years
	Oldest:	51 years
	Mean age:	41 years
Ethnicity	White Scottish:	9
	White other:	1
Psychiatric diagnosis type (broadly defined)	Anxiety or depression:	9
	Other condition:	1
Highest level of qualification (approximate level based on interview)	None:	3
	SVQ 2 or equivalent:	2
	HND or equivalent:	2
	Undergraduate degree:	3
Work history (characterisation based on interview)	Limited work experience:	1
	Patchy/varied short term jobs:	3
	Consistent in earlier years, but not recently :	2
	Extensive and consistent prior to recent unemployment:	4
Duration of unemployment	Up to 1 year:	2
	1-5 years:	3
	5 years +:	3
	Unclear:	1
	Not applicable: (in work but underemployed)	1
Interview locations (follow up interviews in brackets)	Dunfermline:	4 (1)
	Kirkcaldy:	4 (3)
	Glenrothes:	2 (2)

5.5.3 Qualitative data analysis

The IPA approach to analysis was adopted (e.g. Smith & Eatough, 2006; Smith, Flowers & Larkin, 2009). It is concerned with understanding the lived experience of participants, and the meanings they place on those experiences. There are a number of reasons for this choice of approach:

Firstly, for reasons of ontology and epistemology: IPA has a realist ontology making it more readily compatible with a critical realist paradigm than alternative approaches. Research participants' subjective lived experience is central to the focus of this study, and thus a phenomenological approach is a natural choice. Willig's (2001) discussion of phenomenology in psychology in general, and IPA in particular, would support this view. Whilst acknowledging the importance of language, IPA does not privilege language over experience. Although recognising they can only be accessed indirectly through interpretive filters, cognitions are treated as real and as the object of the process. IPA represents an attempt to make sense of an individual's sense making via interpretation. The term 'doubly hermeneutic' has been used to capture this aspect. Whilst IPA is both inductive and reflexive, like most qualitative approaches, it explicitly permits and requires the researcher to actively interpret data, and thus allowing pre-existing theoretical perspectives of relevance to be brought to bear on the data.

Secondly, for reasons of methodology: IPA is often used in research studies adopting semi-structured interviews as the data generation approach, as is the case in this study. IPA adopts an idiographic approach, with initial analysis of interviews done independently, resembling a case study approach in its initial phases. This is appropriate given the nature of career, which is best made sense of by considering an individual biography. It is frequently used in mixed methods designs, and its realist ontology facilitates combination with quantitative approaches. Its application to career research by McIlveen, Patton & Hoare (2008) in a multi-method design represents a relevant precedent. Clear guidance on IPA methods can be found in the literature, and support from an experienced IPA researcher was available

Thirdly for reasons of topic: as mental well-being is the central issue of concern, a health related approach is appropriate. IPA has been most widely used in health psychology research and is frequently applied to questions of personal identity and transformation in health psychology. Transitions affecting employment status, and health status are explored in this study, with clear implications for identity.

Finally for reasons of popularity and flexibility: Broki & Wearden (2006) conducted a critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology, reviewing 52 studies. They found use of IPA on the increase. They also found that IPA was applicable to a wide range of research topics. Thus IPA appears to be not merely currently popular for use in psychology, but also to have many specific features that are highly appropriate to this study.

Appendix 3 provides sample materials relating to the analysis of research interviews. This includes:

3A: The semi-structured research interview schedule, indicating broad topics, and opening questions

3B: A sample interview transcription

3C: The systematic process adopted for analysis

3D: Idiographic analysis of the themes in the interview, with complementary biographical analysis

Some additional steps were taken to ensure the quality of analysis. The exemplar interview in the appendix was independently analysed by an experienced IPA researcher who confirmed that the approach adopted and analysis outcomes were consistent with IPA methodology. Also systematic storage of interview analysis materials was consistent with an approach that would allow their audit, as proposed by Smith, Flowers & Larkin (2009).

5.6 Evolution of the methodology

This section departs from procedural reporting, instead adopting a narrative approach to outline how the methodology evolved and the responses made to challenges as they arose.

5.6.1 Piloting

A small scale pilot of the questionnaires, involving six service users, was conducted by FEAT staff. All six were able to complete the proforma quickly, including one person attending adult literacy classes, who completed within 10 minutes unaided. Informal feedback was obtained, and it seems that none found the questionnaire intrusive or difficult to complete. Some ambiguities in instructions and in wording of the 'vitamin' scale were identified. Following feedback from FEAT staff, some modifications to improve the questionnaire design were implemented.

The first day of interview appointments was designated as a pilot. Following this the interview structure was subtly revised. Initial questions concerning participant's household were removed as they appeared to cause discomfort as a result of highlighting isolation. These were replaced by broad brush questions about career biography. Data from the pilot was included in analysis as these changes were very minor and the bulk of interview content was pertinent to the enquiry.

Similarly a trial attempt was made at analysis of the FEAT database using historic data, prior to the analysis of the data set relating to clients registered in the period of study. This was used to identify issues in data cleansing, and approaches to statistical analysis. This indicated that recording of levels of service received and of outcomes was not consistent.

5.6.2 Administration issues

Table 8 lists practical challenges encountered and how they were resolved.

Table 8: Administrative challenges to data generation

Issue	Response by researcher
Gaining initial commitment of FEAT staff beyond the service manager.	Attended a team meeting and explained the study and its methods.
Decision by FEAT to issue initial questionnaires at first EA meeting rather than at first contact with the service for initial assessment due to concern about the administrative burden at that meeting. This led to an unworkably low percentage of initial registrants being requested to complete the questionnaire by EAs.	Gained agreement to issue the questionnaires at initial assessment contact point. This resolved the problem.
Departure of service manager who had championed the research partnership. The named administrative contact also left FEAT.	Visit to FEAT to meet and brief replacements
Consent forms were issued to all existing FEAT registrants (not just new registrants completing questionnaires) for the purposes of using the client database information, proved unworkable. FEAT reported the administrative load could not be undertaken and response rates by post would be extremely poor. FEAT questioned the necessity of this.	<p>Review of the ethical requirement for consent involving consideration of:</p> <ul style="list-style-type: none"> - Data protection guidelines - BPS ethical guidelines - Edinburgh Napier guidelines - NHS service audit practices - Views of experienced colleagues including project supervisors <p>This led to a decision to view this data source as service audit. This removed the requirement for consent, whilst assuring that the anonymisation of the data was thorough prior to data transfer to the researcher.</p>
Low completion rate of questionnaires at T1 and T2: 6 and 12 months follow up points. This was partly due to inconsistency in administration by EAs, due to loss of face to face contact by that time.	Data collection extended over a longer period to boost sample size with new registrants. Attended a follow up briefing to remind EAs and inform new appointees of the purpose of the study, and the importance of follow up data in analysis. E mail reminders sent to the EA team. Improvements in response rates were achieved, although attrition remained a concern.
Inconsistency in the timing of follow up questionnaires: measurement at T1 and T2 did not conform to the intended 6 and 12 month points.	This was handled in analysis by designating bands of time periods rather than points.
EAs reported a small minority of participants had difficulty in completing the questionnaire due to literacy difficulties.	This was not detected at pilot stage even though one pilot participant had attended adult literacy classes. The issue arose too late in the project to be remedied.

5.7 Ethics

Ethics as a topic of concern is relatively undeveloped in the career guidance profession compared to related fields of practice (a notable exception is the contribution of Mulvey, 2002). As a result there are no ethical guidelines for researchers in the field, so here it is necessary to turn to the parent discipline of psychology. The British Psychological Society (BPS) *Code of Ethics and Conduct* (2006) makes explicit reference to the 'British eclectic tradition' as its underpinning philosophical basis. The code represents a deontological (rule or duty based) approach, but the rules are broad general principles, not specific commands, and thus require interpretation in context.

Bryman (2004) identifies that there is an issue in relation to how rigidly ethical principles are applied. This project adopts a position of universalism (i.e. ethical principles must never be violated) tempered by pragmatism, in that the BPS ethical guidelines are followed with some judgements being made to adapt to the specific context. The BPS (2004) identifies minimum standards for ethical approval in psychological research. The principles identified in this model are applied below in relation to the specifics of this study:

5.7.1 Ethical principles applied to the study

Ethical approval for all research

The research design was scrutinised and approved by PhD supervision team and the Faculty of Health & Social Science ethical approval committee, prior to implementation.

Protection of participants

Whilst this study is judged to represent a low risk to participants, risk is never entirely absent (BPS, 2004). The activity involved in the questionnaire stage and also the interview stage require participants to reflect on their state of well-being and it is not entirely inconceivable that this may not benefit some participants as rumination is associated with depression (Gilbert, 2007).

However the WEMWBS and HADS questionnaires chosen have a track record of use in community based research, so this risk has been judged as minimal by other researchers.

The approach to the interview research is influenced by the Scottish narratives of recovery project (Brown & Kandirikirira, 2007). This identifies the process of telling the story of recovery as intrinsically therapeutic. Thus positive impact from the research process is not inconceivable, but again likely to be minimal.

Informed consent

Consent was obtained for participation in the research, each using two separate consent forms (samples are provided in appendix 1). A briefing sheet and consent proforma was used with new registrants in their initial assessment meeting. This related to consent to participate in the project by completing well-being questionnaires, to be combined with their client record data. Consent to participate in research interviews was obtained using a separate and specific briefing sheet and proforma in face-to-face meetings. As EAs obtained consent in person, this made it possible for participant questions and concerns to be identified and further information given.

No coercion

Given that this research concerns people recovering from mental health difficulties it is necessary to be particularly cautious in respect to this principle: sensitive people may feel coerced in conditions that may not normally be seen as coercive. The potential power imbalance between researcher and participant may be greater in these circumstances than in research with a general population sample. For this reason all FEAT staff involved in inviting participation were briefed to take great care in introducing the idea. This is particularly critical when seeking participation at the project entry and assessment stage. Whilst this represents an essential baseline measurement exercise which is central to the quantitative elements of the project, there was the danger that 'new recruits' might see it as a condition of joining FEAT. As a result, the relevant FEAT staff were instructed to repeat the information that it is

optional, and that identical FEAT services would be provided whether or not consent is provided.

The right to withdraw

It was made clear that participants had the right to withdraw from the study at any stage, and also to withdraw their data from analysis at any stage. This was communicated both verbally, and in the documentation.

Anonymity and confidentiality

All identifying data (names/addresses/other contact details) were removed from the database; date of birth was converted to age. Post code was converted to a variable using the Scottish Index of Multiple Deprivation (SIMD) prior to analysis. This ensured that the database as stored was entirely anonymised. Similarly, the questionnaires contain no names or contact details, and were passed to the researcher for analysis; no questionnaire data will be retained by FEAT. The database contains a 'case number' and this was used for linking questionnaire data across time periods, and for integrating with the client database.

Interviews were conducted in person by the researcher at community locations used by FEAT to deliver services, near to the participants' homes. Thus interview participants are inevitably known to the researcher. In analysis and reporting the names were changed to a code letter, and potentially identifying information obscured.

Appropriate exclusion

FEAT staff were asked to identify any individuals who they felt may be too vulnerable to participate in the research, and these were treated as exclusions without question by the researcher. No specific situations or diagnoses were to be excluded, the matter was left to the discretion of FEAT.

Monitoring

FEAT staff were in direct contact with research participants and they were briefed to advise the researcher when participation for an individual should be terminated due to concerns about their well-being.

Additional safeguards for research with vulnerable populations

This research does involve a potentially vulnerable group, so additional safeguards were in place. The researcher holds an Enhanced Disclosure Scotland criminal record clearance. In the event of a research interview participant becoming distressed in the course of the enquiry, the interview would be terminated and support provided. During interviews the participant's EA was present on site in a neighbouring room. This allowed for easy access to a familiar supportive individual with whom an existing relationship was in place. This procedure was not implemented as the situation did not arise. In addition it served to partially address potential risks to the researcher associated with lone working.

Duty of care

FEAT staff were provided with a plain English summary of the outcomes of the research to distribute to participants, so the knowledge created by their participation is transparently available to participants.

5.8 A critique of the methodology

The research design adopted here is inevitably imperfect, and it is necessary to establish its limitations to inform the interpretation of findings. The key issues are identified and discussed below:

Absence of a randomised control group design

This places a major limitation on the conclusions that can be drawn from the quantitative study, as any effects detected cannot confidently be attributed to the intervention. Hughes & Gration (2009a & b) propose a hierarchy of evidence for career guidance impact studies and locates the classic randomised experimental design with strong counterfactuals as the gold standard. Thus the absence of a control group is not desirable, but represents a forced choice. No satisfactory comparator group was available, a 'waiting list' comparison was not possible, and it was neither ethical nor practical to delay or deny interventions to a sub-group of service users in the context of this researcher-agency relationship. The existence of other helping agencies means it would be problematic to guarantee that control group members did not receive an intervention with guidance elements to it, particularly over a time scale as long as a year. The availability of population norms for WEMWBS and HADS goes some way towards compensating for this deficit in counterfactuals.

Maturation

An issue closely related to the absence of a control group is the likelihood that the participants will change over time. As a result it is difficult to attribute change to the intervention. People may adapt to unemployment, limiting the impact of problems. Conversely if a subjective assessment suggests deterioration then it is likely to be a genuine effect (O'Connor, 2004).

Inadequate data on medical variables

From the perspective of clinical research design there is a lack of adequate data on:

- diagnosis (only very broad brush data available),
- prognosis, severity of symptoms and duration of illness (no data available)
- medication and changes in drug regimes (no data available)
- comorbidity with physical health conditions (no data available)
- co-morbidity involving use of alcohol and recreational/illegal drugs (lack of disclosure at initial assessment)
- cognitive impairment (only dichotomous data was available: self-report of perceived barriers recorded at initial assessment).

As an employment agency, FEAT does not systematically collect medical data, so this information is not available without creating a more intrusive questionnaire, which has ethical implications. Nonetheless, these are important issues, and there is reason to believe that substance abuse comorbidity in particular may impact on work outcomes (e.g. McGurk *et al.*, 2009).

Treatment integrity

The interventions received by service users are not standardised, but represent the outcome of a series of choices, made collaboratively between the service provider and user. Support services for the unemployed are typically heterogeneous and a variety of activities can go under one label. Sometimes one activity, such as an interview, can have multiple purposes (Hasluck & Green, 2007). The intervention received by individuals or groups can change and evolve over time. As a result it is difficult to attribute effects to the intervention or to isolate the effects of single elements in a composite guidance intervention (Magnusson & Roest, 2004). It is not just the modality of treatment that is of concern, but also the level and frequency of inputs, or ‘dose size’ (Brown & Lent, 2008): this was not recorded consistently on the FEAT administrative database.

Choice of measuring instruments

Whilst care has been taken to select appropriate tools, each option has its limitations. As a relatively new measure the evidence base of the WEMWBS is not yet substantial: specifically there is inadequate data on its sensitivity to detect change.

The HADS scale was chosen because it clearly distinguishes depression and anxiety, constructs that are conflated in some measures. However it neglects generalised distress that is common to both conditions (e.g. sleep disturbance). Also the focus on anhedonia in the depression sub-scale may mean that it provides redundant information: the WEMWBS is measuring hedonic well-being. Another issue is that the standard instructions of the HADS have been modified to avoid clinical references and to harmonise instructions with the WEMWBS. Whilst strictly speaking this does mean using a form that is not standardised, the impact of the change in instructions is likely to be negligible.

The scale based on Warr's vitamin model of the psycho-social environmental, is an untested measure with no evidence of reliability or validity. There are difficulties in item wording arising from the need to make it general enough to cover a range of possible environments that service users may be exposed to. It covers a broad range of psycho-social factors, and may not address each in adequate detail (for example it addresses quantity, but not quality of social support). As a result no conclusions can safely be drawn from data generated by this instrument; its use must be seen as strictly exploratory.

Response bias and demand characteristics

There is a possibility of social desirability bias in responses: people may say they are happier than they actually are. There may also be a similar bias arising from seeking to satisfy the expectations of the researcher, or FEAT, that interventions are effective: this latter point particularly applies to participants in face to face interviews.

Timing of measurements

A difficulty arises in measuring outcome variables because interventions provided by FEAT of a very variable duration. The research has three stages of measurement: a pre; post; and follow up design. At the 6 month point it was very likely that some people would still be active service users, at the 12 month point a small minority may still be engaged with the service. Furthermore, difficulty in questionnaire data collection meant that the timing of measurements

did not consistently conform to the planned intervals. As a result the quantitative design approximates, rather than strictly adheres to the classic clinical pre/post/follow up model. In contrast, the research interviews did conform closely to the planned timescales.

Systematic bias in sampling

It seems likely that there may be some effects arising from self-selection of the sample at consent stage or data collection stage. There may be people in specific states of mind, such as shame, paranoia, or rational fear of benefits sanctions, are less likely to participate in the study. More generally people who are less well, or feel less positive about themselves may be less likely to respond. The sample may therefore be biased towards a better functioning sub-set of service users, and this would distort results.

Attrition

The initial sample size for the questionnaires was limited by the flow of new service users into the agency, the percentage of them agreeing to participate, and the consistency of FEAT staff in asking them to participate and collecting the questionnaires. Further limitations result from a high rate of attrition which, as might be expected, has produced disappointing response rates at T2 and T3. This has two problematic effects. Firstly it limits the confidence that can be placed in results by virtue of reduced sample size. Secondly it substantially increases the risk of systematic bias in the data, as discussed above.

Fluctuating environmental conditions

The onset of global economic downturn in 2008-9 led to a weakening in the Fife labour market, followed by an improvement in 2010. These contextual factors may affect FEAT referrals and outcomes in ways that cannot be controlled for. The behaviour of other labour market intermediaries in the area may also be a factor.

Factors affecting service users' accounts

The approach adopted relies on asking participants about their recollections, both in questionnaires and in face-to-face interviews. Recollections over a time period of a year may be subject to selective recall and bias. Also interviewees may have understandable concerns about self-disclosure. The interview data suggests that this was not a factor in the great majority of cases; participants were frequently open, and disclosed more in depth and personal information than was asked of them. Initial measurement of well-being at registration may be affected by optimism and anticipation of using the service: this could elevate scores above their pre-intervention baseline, and lead to underestimates of effect size.

Bias in interview questioning

As the research question involves service impact, this requires that some of the questions asked of participants are more specific than might ideally be the case in an IPA study. This has been addressed by seeking a balance between very broad and more specific questioning. Attempts to evaluate the impact of the service were contextualised in much broader questioning on the experience of being unemployed and recovery from a mental health condition.

5.9 Summary

- FEAT is a specialist employment support agency for unemployed adults with mental health conditions. It provides an individually tailored package of interventions, including one to one support, confidence building programmes, job seeker workshops, and work experience.
- A multi-method design to evaluate FEAT services was adopted, drawing on three data sources:
 - o self-report questionnaires measuring well-being (WEMWBS), depression and anxiety (HADS), and perceptions of the psychosocial environment (vitamin scale), with pre, post and follow up measurements at registration, 6 and 12 months
 - o semi-structured research interviews at 6 months, with a follow up at 12 months
 - o a pre-existing administrative client database.
- Maintaining consistency in the generation of questionnaire data presented some challenges; the research interviews proceeded smoothly.
- IPA was adopted as the qualitative data analysis approach as it is compatible with multi-method research adopting a critical realist philosophy, and offers a number of practical advantages.
- Ethical considerations included taking steps to protect the potentially vulnerable adult participants, for example ensuring they were not coerced into participation.
- A number of limitations can be identified in the methodology and taken into account in the interpretation of findings. Chief amongst these is the absence of a randomised control group design, and the effects of attrition.

Chapter 6: Quantitative results

6.1 Overview

This chapter reports on the quantitative data generated by use of self-report questionnaires, and seeks to address the research sub-question 2: *To what extent do service users report experiencing changes in their subjective well-being, during and after guidance interventions?* This is supplemented by analysis of anonymised audit data extracted from the FEAT client database, addressing demographics, status at registration, and objective outcomes. Data was analysed using SPSS v.18.

After describing the sample population, results from univariate analysis of each of the three instruments used in the study are provided in turn. Initially descriptive statistics are presented, and then a comparison of the three measuring points (T1, T2 & T3) is presented and the effects of attrition on results is considered. As it is a new measure, some item analysis is also provided for the vitamin scale.

As it is a small sample with health related measures, the clinical significance of change is considered. Then a multivariate analysis is presented. Inter-correlations give an accessible overview of patterns in the data. Factor analysis is used to detect an underlying variable explaining much of the variance in the data.

Finally the questionnaire data are integrated with the audit data. Regression analysis is used in an attempt to identify factors associated with outcomes.

6.2 Baseline, intervention and outcome data

This section reports data, predominantly in dichotomous form, from the FEAT client database, which includes baseline information gathered at the initial assessment, the interventions received by individuals, and objective outcomes, such as achievement of a job or place in education.

6.2.1 Baseline data gathered at initial assessment

Tables 9 and 10 provide baseline data.

Table 9: Sample health condition and employment history

Variable	Number and percentage of FEAT clients		
Severe and enduring condition	N = 181 (30.3 %)		
	n = 597 missing = nil		
Common mental health conditions	N = 404 (68.8%) (Total of depression + anxiety/phobia)		
Illness category	<u>Illness</u>	<u>N</u>	<u>%</u>
	Bipolar	50	8.5%
	Schizophrenia	42	7.1%
	Depression	329	56.0%
	Anxiety & phobia	75	12.8%
	OCD	6	1.0%
	Other (mostly psychotic)	86	14.6%
	n = 588 missing = 9		
Period of time unemployed	<u>Period</u>	<u>N</u>	<u>%</u>
	Up to 6 months	91	16.0%
	7-12 months	74	13.0%
	13-24 months	69	12.1%
	25-36 months	50	8.8%
	Over 3 years	278	48.9%
	Not applicable	6	1.1%
	n = 568 missing = 29		

Approximately two thirds of the sample could be said to have a common mental health condition, and a third are identified at assessment as having a severe and enduring condition, although it should be noted that the two categories are not mutually exclusive. The sample largely comprises long term unemployed: nearly half have been out of work for over three years. Unfortunately education or qualification data was not available.

Table 10: Perceived barriers to employment

Specific Barriers	Barrier	N	%	
The number and percentage of service users reporting a particular issue at registration	Benefits Trap	175	29.3%	n = 597 missing = nil
	Childcare	49	8.2%	
	Communication/social skill	150	25.1%	
	Concentration	287	48.1%	
	Criminal record	92	15.4%	
	Dependency issues	0	0%	
	Dependents	74	12.4%	
	Housing	69	11.6%	
	Lack of confidence	447	74.9%	
	Lack of motivation	299	50.1%	
	Lack of training	222	37.2%	
	Literacy/numeracy	117	19.6%	
	Mental health	472	79.1%	
	Relationships	52	8.7%	
	Stigma/discrimination	186	31.2%	
	Support	0	0%	
	Transport	167	28%	
Working conditions	101	16.9%		
Total barriers³⁴		Mean =	6.0	n = 555 missing = 42
Aggregate number of perceived barriers reported at registration		Standard deviation =	11.3	
		Minimum =	1.0	
		Maximum =	14.0	

Most registrants identify multiple barriers to employment, consistent with the literature (e.g. Arthur *et al.*, 2008). Their mental health and also level of confidence are prominent (a key issue identified by Joyce *et al.*, 2010, and Bodman *et al.*, 2003). No-one identified dependency or support issues as a concern, suggesting a reluctance to disclose. It is known that both co-morbidity, and problems with lack of support in close relationships are commonplace (e.g. McGurk *et al.*, 2009; Vinokur, Price & Caplan, 1996).

³⁴ The data has been aggregated to create a variable representing the total perceived barriers faced by an individual. There are precedents to creating a single scale (e.g. Corbiere, Mercier & Lesage, 2004; Lee & Vinokur, 2007). This step requires an assumption that barriers are of equal importance; this may not be the case.

6.2.2 FEAT Interventions

This data represents the number of service users receiving each type of intervention. Where contacts can be multiple, chiefly with individual support, data has not been recorded consistently on the database. This information has been collapsed to dichotomous data. The data in table 11 represents the numbers of service users who have received each intervention type.

Table 11: Interventions received by FEAT registrants

Variable	Number and percentage of FEAT clients in the questionnaire sample receiving an intervention		
FEAT service/type of support n = 564 missing= nil	<u>Individual support</u>	<u>n</u>	<u>%</u>
	EA support	529	93.8%
	<u>Confidence workshops</u>		
	STARS	401	71.1%
	STEPS Workshop:	96	6.0%
	<u>Job seeking workshops</u>		
	Applications	299	53.0%
	CV writing	300	53.2%
	Interviews	306	54.3%
	Job search	307	54.4%
	<u>Work experience</u>		
	Work placement	349	61.9%
	Volunteering ³⁵	172	30.5%
	<u>Other activities</u>		
	Counselling	20	3.5%
Mentoring	20	3.5%	
Support in work	34	6.0%	

Service users who registered but did not subsequently engage with any interventions (n=33) are excluded above and in the consideration of outcomes.

³⁵ Volunteering is problematic as it could be considered to be either an intervention or an outcome. Its role as an intervention is complicated by the fact that even where FEAT initiates or supports it, the placement is often set up by a separate specialist agency. As a result its impact is hard to attribute to FEAT so it is excluded from subsequent quantitative analysis, but discussed in the qualitative evidence in chapter 7.

Nearly all service users receive EA support, and most participate in confidence building workshops. Counselling, mentoring, and support continuing after entry to employment, are rarely used options.

6.2.3 Objective outcomes

The client database allows the recording of two outcomes at different follow up points, and this is done in a minority of cases. For clarity of analysis only one outcome has been considered with priority given to employment outcomes.

Outcome	<i>n</i>	%
Open Employment	124	22.0%
Education or training	79	14.0%
Volunteering	47	8.3%
Informal learning	26	4.6%
No outcome recorded: i.e. either continuing as unemployed or not responding to follow up	288	51.1%
Total	n= 564	100.0%

Some comments can be made about these tangible outcomes:

- Data concerning the number of hours worked is not recorded consistently, so meaningful averages cannot be calculated. Both part-time and full-time work feature as outcomes. There is diversity in the occupations listed, but entry level work features prominently.
- Of those achieving an employment outcome, 'permitted employment' is recorded in 23 cases (4.1 %). This refers to paid employment, normally less than 16 hours per week, which is allowed while simultaneously claiming benefits, such as ESA.
- The time that service users took to find a job was highly variable, but a mean of 23 weeks indicates that six months of support from FEAT is the norm.

6.3 Univariate analysis

This section reports results separately from the three subjective outcome measuring instruments: WEMWBS, HADS and the Vitamin scale.

6.3.1 Warwick Edinburgh Mental Well-Being Scale (WEMWBS)

Descriptive statistics for this scale are reported below in table 12, for its full (14 item) form indicated as WEMWBS. In addition, for time 1 only, scores for those 7 items that make up the short form of the scale were extracted and are also reported, indicated as SWEMWBS.

Table 12: WEMWBS descriptive statistics

Scale	Time	N	minimum	maximum	mean	standard deviation
WEMWBS	T1	113	14	64	40.39	9.37
	T2	47	20	70	43.38	10.91
	T3	26	19	70	48.58	11.07
SWEMWBS	T1	113	8	32	20.67	4.52

The lowest possible score on the full WEMWBS is 14, and the maximum possible is 70. In the absence of a control group, some counterfactual data are available from population norms. Useful comparison can be made with a large Scottish population sample of WEMWBS data as reported by Stewart-Brown, Janmohamed and Parkinson (2008) reproduced in table 13:

Table 13: WEMWBS Scottish population norms from Stewart-Brown et al. (2008)

Scale	N	mean	standard deviation
WEMWBS	1749	50.7	8.79

They also report student samples used in the process of validating the instrument in which the WEMWBS means are in the region of 49. This would suggest that the questionnaire sample population, at the point of registration, is roughly one standard deviation below the wider population mean for well-being. Another useful benchmark is Bryson *et al.* (2012), who provide WEMWBS data from the 2010 Health Survey in England, and usefully separate out mean scores by employment status and gender, see table 14:

Table 14: WEMWBS English population norms from Bryson et al. (2012)

	Mean WEMWBS Score for men	Mean WEMWBS Score for women
Whole population	51.0	51.0
Employees	51.6	51.5
Self-employed	51.6	52.4
Unemployed	49.0	49.7
Otherwise economically inactive (non-retired)	48.6	48.6

Although gender differences were very small, they did find a U-shape relationship between well-being and age, with lower scores in middle age, consistent with most well-being research.³⁶

Paul & Moser's (2009) meta-analysis evidence suggests that unemployed people have levels of mental health that are half a standard deviation below that of the employed population. The Bryson *et al.* (2012) WEMWBS data suggests a less dramatic difference, but this sample may include a higher proportion of short term unemployed. Taken together, this suggests the FEAT clientele has levels of mental well-being clearly below that of the wider adult unemployed or economically inactive groups, as might be expected of a sub-clinical population. However those continuing to participate in the study show evidence of converging on the mean values for the unemployed or economically inactive population over time.

³⁶ Bryson *et al.* (2012) also provide evidence to reinforce the argument that job quality is related to well-being and health. They found WEMWBS scores clearly related to measures of autonomy, support, security and control in an individual's job. WEMWBS scores were also associated with self-rated health.

A repeated measures within subjects ANOVA was carried out on the 21 cases for whom data was available at all three measuring points. WEMWBS scores were compared at times T1, T2 and T3, and for this subset of the sample mean scores were as follows:

WEMWBS means(n=21): T1 = 41.52 T2 = 45.95 T3 = 49.14

Sphericity was not assumed, so the Greenhouse-Geisser correction was applied. The overall difference between measurement points was $F = 5.812$, $p = 0.013$, significant at the .05 level.³⁷

Well-being has improved over time, at least for those retained in the study.

6.3.2 Hospital Anxiety and Depression Scale (HADS)

Descriptive statistics for the the HADS are reported in table 15:

Table 15: HADS descriptive statistics

Scale	Time	N	minimum	maximum	mean	standard deviation
HAD Anxiety	T1	114	1	19	10.9	4.15
	T2	47	0	20	9.34	4.68
	T3	26	1	19	9.12	5.10
HAD Depression	T1	114	0	19	8.16	4.18
	T2	47	0	17	6.87	4.48
	T3	26	1	19	5.50	4.13

³⁷ Repeating the comparison ignoring T3, WEMWBS scores for 47 cases at T1 and T2 were analysed with a t-test which produced: $t = -1.662$; $p = 0.103$ (not significant).

The above data from the FEAT sample can be compared with published norms derived from a large UK general population (non-clinical) sample (Crawford *et al.*, 2001) in table 16.

Table 16: HADS UK population norms from Crawford et al. (2001)

	Mean	Standard Deviation
HAD Anxiety	6.14	3.76
HAD Depression	3.68	3.07

These indicate that at registration (time 1) the FEAT sample population has levels of anxiety and depression more than one standard deviation higher than the UK mean.

A repeated measures within subjects ANOVA was carried out comparing the HAD scores at T1, T2 and T3 for the 21 cases who completed at each stage. For this subset of the sample the mean scores at each measuring point were as follows:

HAD Anxiety means (n=21): T1 = 10.71 T2 = 8.62 T3 = 8.62

HAD Depression means (n=21): T1 = 7.38 T2 = 5.67 T3 = 5.48

Sphericity was not assumed, so the Greenhouse-Geisser correction was applied. The overall difference was:

HAD Anxiety: F = 2.578 p = .106 (not significant)

HAD Depression: F = 1.355 p = .270 (not significant).³⁸

This suggests rather less confidence can be placed in the observed improvements in anxiety and depression, than in the improvement in well-being.

³⁸ Repeating the comparison ignoring T3, 47 cases were compared at T1 and T2 using t-tests produced the following results:

HAD anxiety: t = 2.216; p = 0.032 (significant at 0.05 level)

HAD Depression: t = 1.861; p = 0.069 (not significant).

6.3.3 Vitamin scale

As the vitamin scale is a new questionnaire, before reporting the results it is appropriate to conduct some item analysis. Considering how individual items performed may inform interpretation. A very consistent pattern emerges, as indicated in table 17, with almost all of the 12 items showing modest increases from T1 to T2, and also from T2 to T3.

Table 17: Vitamin scale items descriptive statistics

Item	Psycho-social factor or 'vitamin'	T1: Registration n= 110		T2: Approx 6 months n= 47		T3: Approx 12 months n = 25	
		Mean	SD	Mean	SD	Mean	SD
1	Opportunity for control	3.40	.98	3.36	.90	4.08	.94
2	Opportunity for skill use	2.82	1.01	3.02	1.05	3.5	1.18
3	Externally determined goals	3.23	.93	3.49	.96	3.69	.93
4	Task variety	3.18	1.00	3.21	1.04	3.81	1.06
5	Environmental clarity	3.55	.95	3.6	1.04	3.85	1.29
6	Social contact	3.33	.98	3.47	1.02	3.88	.86
7	Money	2.89	1.20	3.13	1.27	3.04	1.31
8	Physical security	3.59	1.10	3.62	1.15	4.08	1.02
9	Valued social position	2.61	1.09	3.09	1.14	3.5	1.24
10	Supportive supervision	3.55	1.04	3.91	1.1	4.04	.89
11	Career outlook	2.51	1.08	2.57	1.10	3.12	1.14
12	Equity	3.71	1.07	3.96	.96	4.12	.95

This is not a validated scale, and there is no prior evidence to argue that it is psychometrically robust. Nonetheless, in spite of each item relating to a conceptually distinct construct, a case could be made that responses are consistent across the items suggesting it is not entirely unreasonable to consider them as a scale. Use of inter-correlations in table 18 allows further exploration of the 12 items in the Vitamin scale:

Table 18: Inter-correlations between vitamin scale items at T1

Q	1	2	3	4	5	6	7	8	9	10	11	12
N =	114	114	114	114	114	114	114	114	114	110	113	113
1	1	.562**	.521**	.245**	.521**	.295**	.256**	.414**	.366**	.277**	.303**	.345**
2		1	.638**	.577**	.494**	.513**	.101	.339**	.591**	.305**	.619**	.129
3			1	.547**	.566**	.364**	.014	.344**	.428**	.208**	.384**	.137
4				1	.335**	.567**	.045	.221**	.526**	.170*	.485**	.011
5					1	.353**	.129	.416**	.399**	.193*	.356**	.202**
6						1	.204*	.378**	.498**	.265**	.390**	.065
7							1	.202*	.184*	.171*	.246**	.245**
8								1	.296**	.315**	.204*	.124
9									1	.294**	.533**	.026
10										1	.314**	.366**
11											1	.201*
12												1

* Significant at the $p < .05$ level; ** significant at the $p < .01$ level using a one tailed test.

This demonstrates that most items are highly inter-correlated in a consistently positive way. This could also indicate that it is not unreasonable to take an aggregate scale score as a measure of the perceived availability of psycho-social 'vitamins'. However, item 7 (money) is less consistently correlated to the others: it may be that most participants regard their financial situation as less than ideal. It is also one area where participants may have access to objective information (such as their rate of benefits payments).

Items 10, and 12 are also showing less consistent patterns of inter-relationships. Arguably the last 3 items (supportive supervision; career outlook; equity) do not make sense for all non-employed participants; a few participants omitted them or indicated not understanding the questions. This problem was not detected at piloting stage. However, omitting these three items seems to make little difference to the analysis as the 9 item and the 12 item form are closely correlated (see section 6.5: table 25).

Descriptive statistics for the full vitamin scale are reported below in table 19:

Table 19: Vitamin scale descriptive statistics

Scale	measuring point	N	minimum	maximum	mean	standard deviation
Vitamin scale 12 items	T1	110	23	58	38.37	7.57
	T2	47	22	60	40.43	8.40
	T3	25	25	60	44.56	8.89

A repeated measures within subjects ANOVA was carried out comparing the vitamin scale 12 item scores at times T1, T2 and T3, for the 21 cases with data at each point. The means for this sub-group are as follows:

Vitamin scale means (n=21): T1 = 39.30 T2 = 42.43 T3 = 45.53

Sphericity was assumed. The overall difference between times was $F = 5.248$, $p = .010$ (significant at the .01 level).³⁹ This suggests that some confidence can be placed in the observed improvements in these scores, however considerable caution is still required in interpretation of this finding as discussed in section 6.5.

³⁹ Ignoring T3, 46 cases were compared on the Vitamin scale 12 items at T1 and T2 using a t-test: $t = -1.490$; $p = 0.143$ (not significant).

6.3.4 Effect of attrition on univariate analysis

Substantial subject attrition makes the possibility of systematic bias in sampling more likely. Available data can be used to assess the extent of the problem.

The demographic character of the sample can be compared at each stage.

Mean scores can be tracked through the three measuring points; by segmenting the sample into sub-groups of those who completed the questionnaires at each stage: see table 20.

Table 20: Effects of attrition on WEMWBS & HADS

		T1 Registration	T2 6 months after registration	T3 12 months after registration
Response rate & demographics				
Total respondents at each measuring point (n)		114	47	26
Gender balance		Female 47.4% Male 52.6 %	Female 51.1% Male 48.9 %	Female 50.0% Male 50.0%
Mean age (years)		37.31	38.85	37.88
Sample segmented by completion at T1, T2 & T3				
WEMWBS mean scores	People completing at T1	40.39 (n=113)		
	People completing at T1 & T2	40.87 (n=47)	43.38 (n=47)	
	People completing at T1, T2 & T3	41.69 (n=26)	45.95 (n=21)	48.58 (n=26)
HAD Anxiety mean scores	People completing at T1	10.90 (n=114)		
	People completing at T1 & T2	10.85 (n=47)	9.34 (n=47)	
	People completing at T1, T2 & T3	11.58 (n=26)	8.62 (n=21)	9.12 (n=26)
HAD Depression mean scores	People completing at T1	8.16 (n=114)		
	People completing at T1 & T2	8.26 (n=47)	6.87 (n=47)	
	People completing at T1, T2 & T3	7.54 (n=26)	5.67 (n=21)	5.50 (n=26)

There appears to be no important demographic differences between initial registrants and those who also completed a questionnaire at T2 and T3 in terms of gender and age. There seems to be little difference in questionnaire scores between those who were retained to T2 and those who were lost at that stage.

The group retained to T3 show marginally more positive scores throughout for well-being and depression; yet their initial anxiety scores were elevated. A t-test was used to compare the means on the WEMWBS scale at T1 between those who were retained as participants throughout the project, and those who were lost. The results were clearly not significant: $t=0.951$; $p=.343$ (two tailed; equal variances not assumed).⁴⁰

Overall this would suggest that in at least terms of demography and initial levels of well-being, anxiety and depression, attrition has not introduced a substantial degree of systematic bias.

⁴⁰ As demonstrated in section 6.5, the HADS adds little incremental information beyond that provided by the WEMWBS, so an equivalent analysis using the HADS here is redundant.

6.4 Clinical significance

Subject attrition in this study means that sample size is small, particularly by T3. This limits the confidence in ANOVA analysis, and could lead to an underestimate of effectiveness, particularly since mental health conditions are known to fluctuate and deteriorate in unpredictable ways. An alternative approach is to consider whether the number of clinical cases in the sample has been reduced. This clinical significance perspective is appropriate to small samples, and represents a partial alternative to use of a control group in counselling research (McLeod, 2003). The HADS has recommended cut-off scores for psychiatric diagnostic screening. There is some discussion about cut offs in the HADS literature, but the test designers recommend that a score of:

7 or below indicates non-clinical

8 – 10 indicates a borderline or mild case

11 + indicates a clinical case

This makes it possible to identify 'caseness' in the FEAT sample: the rate of clinical level anxiety and depression as defined by these cut-offs. A substantial proportion of the sample meets the threshold for clinical identification, but at a lower rate for depression than anxiety, and the proportion decreases at T2 and 3. Fortunately, available evidence suggests that the HADS is also suitable for clinical populations (Johnston, Pollard & Hennessey, 2000; Bjelland *et al.*, 2002). Scores above the clinical threshold are not in themselves diagnostic; it is a screening tool so they are merely indicative.

The proportion of the sample reaching these thresholds is indicated in table 21.

Table 21: HADS caseness in the FEAT sample

	T1 n=114		T2 n=47		T3 n=26	
	n	%	n	%	n	%
HAD Anxiety						
Score of 8 + Borderline/mild case	88	77.2%	31	66.0%	13	50.0%
Score of 11+ Clinical case	61	53.5%	18	38.3%	11	42.3%
HAD Depression						
Score of 8 + Borderline/mild case	59	51.8%	17	36.2%	7	26.9%
Score of 11+ Clinical case	28	24.6%	10	21.3%	2	7.7%

Andrea *et al.* (2004) provide a good source of comparison data here as they measured the 'caseness' rates of anxiety and depression in a working age sample:

Table 22: HADS caseness in the Andrea et al. (2004) sample

Scale	Threshold	Total		Not at work		Chronic health issue		Psychological problem	
		% male	% female	% male	% female	% male	% female	% male	% female
HAD-A	<i>Sub-clinical anxiety</i>	8.2	10	20.8	20.3	14.4	14.5	35.4	33.7
	<i>Possible anxiety case</i>	20.7	22.4	37.3	35.3	32.3	28.2	60.2	51.8
HAD-D	<i>Sub-clinical depression</i>	7.1	6.2	17.4	17.2	11.4	9.8	29.7	25.3
	<i>Possible depression case</i>	18.7	15.8	31.4	30.1	29.0	21.6	52.7	38.6

It seems the FEAT sample shows substantially higher rates of clinical and sub-clinical anxiety and depression at registration than the sample of Dutch working age population. However the gap is progressively narrowed at T2 and T3, as the FEAT sample seems to converge on the working age sample. Some individuals crossed a clinical threshold at time 2 and then back again at time 3, in the reverse direction: see table 23.

Table 23: Improvement and deterioration in HADS caseness

Scale	T1 - T2 n=47		T1 - T3 n=26	
	<i>improvement</i>	<i>deterioration</i>	<i>improvement</i>	<i>deterioration</i>
HAD Anxiety				
Number crossing the threshold Score of 8	4	2	5	1
Number crossing the threshold score of 11	7	1	3	3
HAD Depression				
Number crossing the threshold Score of 8	7	3	3	5
Number crossing the threshold score of 11	3	3	4	1

Unlike the HAD, the WEMWBS has no pre-determined clinical cut-off points, so alternative approaches need to be considered. Johnson *et al.* (2006) explore the use of measures of clinical significance in rehabilitation research. They see it as a way to bridge clinical research to rehabilitation outcome focused research. One of the two approaches they recommend, the Reliable Change Index (RCI), was applied to the WEMWBS scale. The Zahra & Hedge (2010) method for calculating and interpreting the RCI was adopted. This requires calculating the index for each case and identifying if a change is significant. An RCI of 1.96 or greater (positive or negative) is significant at the $p < .05$ level. They provide two methods for calculating a clinical threshold score to separate clinical from non-clinical cases. Both methods gave a score between 45 and 46, roughly half a standard deviation below the general population mean. Any cases below 45.5 at T1 moving above it by T2 or T3 can be considered as a clinically significant improvement. Table 24 reports the outcome of this analysis.

Table 24: RCI caseness in the WEMWBS scores

	Direction of change	Number of cases with RCI above 1.96 = Significant at p< .05 level.	Number of cases both significant and crossing 45.5 clinical threshold
T1 – T2 (n= 47 cases)	<i>Positive change</i>	11	6
	<i>Negative change</i>	5	2
T1 – T3 (n = 26 cases)	<i>Positive change</i>	9	4 (= 3 identified at T2; plus 1 additional case)
	<i>Negative change</i>	2	1 (not measured at T2)

Taking together the changes at T1 – T2 and T1 – T3, it appears that 7 participants made improvements that could be described as clinically significant during the period of study; whilst 3 deteriorated significantly.

6.5 Multivariate analysis

We can now explore inter-relationships between the scale scores. This is best done by looking at T1, where the sample is largest. In table 25 the inter-correlations are presented, and it becomes apparent that there are very strong relationships between the different scales.

Table 25: Intercorrelations between well-being and psychological distress measures at T1

		WEMWBS	SWEMWBS	HAD Anxiety	HAD Depression	Vitamin Scale 12 item	Vitamin scale 9 item
WEMWBS	Pearson Correlation	1	.909**	-.648**	-.752**	-.749**	-.746**
	Significance		.000	.000	.000	.000	.000
	N		113	113	113	110	113
SWEMWBS	Pearson Correlation		1	-.597**	-.686**	.704**	.716**
	Significance			.000	.000	.000	.000
	N			113	113	109	113
HAD Anxiety	Pearson Correlation			1	.669**	-.604**	-.577**
	Significance				.000	.000	.000
	N				114	110	114
HAD Depression	Pearson Correlation				1	-.686**	-.652**
	Significance					.000	.000
	N					110	114
Vitamin scale 12 item	Pearson Correlation					1	.966**
	Significance						.000
	N						110
Vitamin scale 9 item	Pearson Correlation						1
	Significance						
	N						

A number of observations can be made. Firstly, the 7 item SWEMWBS score is very highly correlated indeed to the full 14 item WEMWBS. This suggests that it is not picking up on eudaimonic well-being as a separate construct; rather that it represents (as the authors intend) an effective short form measuring the same construct of general well-being. Secondly excluding three items from the Vitamin scale, on the ground they may be questionable makes no meaningful

difference to the final scale scores: the 9 and 12 item versions are highly correlated.

Anxiety is known to be strongly correlated with depression. Crawford *et al.* (2001) found highly significant correlation of .53 between the HADS anxiety and depression scales in their large UK sample study. In an international review, Bjelland *et al.* (2002) found correlations between .40 and .74. So it is unsurprising to see the HADS scales correlating in this sample.

All the instruments are producing scores that are highly inter-correlated. Every relationship is highly significant and in a predictable direction. Measures of positive well-being are positively related to each other and negatively related to measures of psychological distress. Whilst the direction of relationship is not surprising, it could also be suggestive of a variety of measures that are not measuring separate independent constructs; rather they may be picking up on the same underlying variance. This possibility can be assessed by use of factor analysis.

A Principal Components Analysis (basic, with no rotation), confirms that this is indeed very likely to be the case. The single factor identified accounts for 76.092% of the variance in the data at registration T1. The meaning of this factor can be deduced from looking at how it correlates to each of the scales in this component matrix: see table 26.

Table 26: Principal components analysis

Scale	Loading onto component 1
WEMWBS	.921
SWEMWBS	.883
HAD Anxiety	-.776
HAD Depression	-.846
Vitamin scale 12 item	.905
Vitamin scale 9 item	.895

It seems that the underlying factor is a feeling positive versus feeling negative construct that is very similar indeed to the WEMWBS construct. To put it another way, the other scales are adding relatively little extra information to the analysis, above and beyond that contributed by the WEMWBS. This is suggestive that the Vitamin scale is not detecting the psycho-social precursors of well-being; merely reflecting a global negative or positive outlook.

Had the indications for the vitamin scale been more encouraging, this would have facilitated an additional approach to analysis. Each of the 12 factors could be considered as a potential mediator variable. Structural equation modelling could be used to explore the influence of each factor on well-being outcomes. Drawing causal inferences from analysis of concurrent data might be questionable, but the existence of three measurement points would facilitate capturing a change in perception of psycho-social factors as a precursor to change in well-being. A further difficulty is that any analysis rooted in correlation-based techniques may be inadequate to fully reveal effects given that Warr (2007) is clear that the vitamins have a non-linear relationship to well-being (factor 1-6 are curvilinear; factors 7-12 have constant effects above a threshold). In any case such an analysis has not been attempted here as it would not be meaningful given the question marks over the construct validity of the vitamin scale.

6.6 Regression analysis

Regression analysis was used in an attempt to identify factors among the demographic, baseline and intervention variables that may be associated with subjective and objective outcomes for FEAT service users. This proved to be problematic due to data quality on the administrative database. Steps were taken to ensure the number of independent variables was not excessive in relation to the sample size. In particular, barriers to employment were represented as a single aggregate variable. However, it is the effects of the intervention variables on well-being and psychological distress that are of most interest, but proved elusive.

Levels of contact with FEAT EAs were not recorded, so it was only possible to discern if there had been contact. As the self-report questionnaires were administered by EAs at T2 and T3, this effectively reduces this variable to a constant: no comparison can be drawn with the minority who did not see EAs. Similarly, the great majority of service users in sample participated in confidence building workshops, making it unlikely that effects can be detected. More generally, scrutiny of the database and feedback from FEAT staff both suggest that those with the greatest difficulties tend to engage with the service for longer periods, and use more interventions. Thus levels of intervention usage are unlikely to be related to outcome variables, severely limiting the value of this kind of analysis.

An unsuccessful attempt was made to identify variables related to subjective well-being (WEMWBS) outcomes for the 47 participants at T2 (6 months) using multiple regression analysis. The regression model produced was not significant ($F= 1.334$ $p = 0.251$) and predicted only 31.4% of the variance; no significant associations between WEMWBS and demographic, baseline or intervention variables emerged. It seems that the quantitative data cannot provide direct linkages between interventions and well-being outcomes, that might give clues as to the active ingredients.

Repeating the multiple regression using the HADS scales as dependent variables produced similar results, except that one association was detected: those with a common mental health condition tend to have lower HADS scores at T2. This is of little interest as this effect is also present at T1, and reflects conceptual overlap rather than causality: those diagnosed with anxiety and depression would be expected to score higher on scales designed to screen for these conditions.

Although peripheral to the focus of this study, data for employment outcomes is available, so can also be considered. Binary logistic regression analysis was used to identify factors associated with achievement of a job outcome. This method has some advantages as it requires fewer assumptions than some alternative analytic approaches. Job outcome was represented as a dichotomous dependent variable as inadequate data was available to separate full and part-time work. Cases with missing data were excluded, leaving 514 cases in the analysis. The model generated correctly predicted outcomes in 77% of cases. Three variables emerged as significant: see table 27.

One factor emerges as strongly significant: a shorter period unemployed is very clearly associated with achieving an employment outcome. Presence of a severe or enduring condition, identified at initial assessment, is not a significant factor. These findings are consistent with both the VR literature, and the informal observations of FEAT employees.

Table 27: Binary logistical regression - seeking variables associated with an employment outcome

	B	S.E.	Wald	df	Sig	Exp(B)
<u>Demographic/socioeconomic variables</u>						
Gender	-.248	.234	1.124	1	.289	.781
Age	.004	.010	.182	1	.670	1.004
White Scottish ethnicity	-.273	.306	.797	1	.372	.761
Scottish Index of Multiple Deprivation (SIMD)	.040	.044	.817	1	.366	1.041
<u>Baseline indicators</u>						
Total number of perceived barriers to work	-.121	.048	6.237	1	.013*	.886
Length of time unemployed	-.399	.072	30.826	1	.000**	.671
Severe & enduring condition	-.322	.318	1.027	1	.311	.725
Common condition (anxiety or depression)	.339	.319	1.133	1	.287	1.404
<u>Intervention variables</u>						
Individual EA support	1.262	.786	2.573	1	.109	3.531
Attended STARS or STEPS Confidence building workshops	-.199	.350	.325	1	.569	.819
Number of job seeking workshops attended	-.023	.082	.077	1	.782	.978
Work placement	.589	.270	4.734	1	.030*	1.801

*significant at the $p < .05$ level; **significant $p < .01$; volunteering and rare interventions were excluded.

Unsurprisingly, more barriers to work are associated with reduced employment outcomes. It is unclear to what extent this reflects negative perceptions, and perhaps a defeatist approach, or that the practical obstacles reported have real effect in frustrating job seeking activity.

Regarding interventions, participation in a work placement is significantly associated with achievement of an employment outcome. This seems intuitively correct. Although not significant in this analysis, individual EA support appears to be strongly associated with job outcomes; but this is less likely to be meaningful. Employment outcomes are more likely to be recorded for those

individuals the EAs have maintained contact with, so this may be an administrative effect.

The analysis was repeated replacing job outcome as dependent variable, with a dichotomous variable capturing any kind of recorded outcome (open employment; education or training; volunteering; informal learning) as opposed to no recorded outcome (as a proxy for unemployment). The results were broadly similar, with length of time unemployed emerging as the only highly significant factor. However, the number of barriers to employment, and participation in work experience disappeared as significant predictors. This may be because alternative outcomes such as education are less inhibited by barriers to employment, and less facilitated by work experience.

This use of regression analysis in relation to employment outcomes is exploratory, and not directly related to the research question, so a predictive model was not developed further.

6.7 Linking results to the research question

The evidence presented in this chapter relates to research sub-question 2: *To what extent do service users report experiencing changes in their well-being during and after guidance interventions?* It seems that individuals contributing to the data set have reported positive changes in their well-being in the six month period during which they are in receipt of a service, and continuing improvement at follow up stage a further six months later. The magnitude of these changes is equivalent to moving from levels consistent with a clinical sample towards that of a mainstream unemployed population. Clinical significant improvement is twice as common as deterioration in the sample. The absence of a control group and substantial attrition rates mean that extrapolating from this observation to attribute change to the effects of interventions is problematic.

6.8 Summary

- At the point of registration with FEAT, participants had an average level of well-being, anxiety and depression approximately one standard deviation worse than that of the general UK population.
- Participants who continue to engage with the FEAT service over time show increased levels of well-being and decreased levels of anxiety and depression over time. Causal inferences cannot be made from this observation.
- Subject attrition was a very important factor reducing the confidence in these findings. However the available evidence suggests that systematic bias introduced by attrition was not a powerful factor.
- The high degree of consistency of the findings across all measuring instruments is striking, and increases confidence in the pattern observed.
- Use of published population norms goes some way towards compensating for the lack of counterfactuals. The resulting comparisons suggest that the sample progressively converged on levels of well-being and distress expected for the mainstream unemployed population over the period of time they were engaged with the service.
- Considering the rate of clinical 'caseness' in the sample this also shows modest improvement over time, against a background of fluctuating levels of symptoms that might be expected in a sample with mental health conditions. Roughly twice as many individuals improved to move above a clinical threshold as deteriorated below it.
- Participants' perceptions of their access to the psycho-social precursors of well-being also increase over time, and this effect is consistent across all the factors identified in the vitamin scale. Improved access to psycho-social precursors of well-being may explain the improvement. However, the

consistency in the data implies a more likely explanation is that participants' assessments of their psycho-social environment become more positive as their well-being improves.

- The pattern of results is highly suggestive of different measuring instruments picking up on common variance in the data. There is evidence of an underlying positive versus negative well-being dimension explaining most of the results. It seems that the WEMWBS was the best measure for identifying this, and that the other instruments used added little additional information.
- Only one variable emerges strongly as a predictor of outcomes. This is the length of time unemployed, which is negatively related to employment outcomes and positively related to continued unemployment after FEAT intervention. For the most part, engagement with interventions did not predict positive outcomes, partly because those furthest from the labour market may require or engage with more support.

Chapter 7: Qualitative results

7.1 Overview

Ten individuals took part in semi-structured research interviews approximately six months after registering with FEAT. Of these six attended a follow up interview approximately one year after registration. A balance of gender and geographical locations was achieved in this sample. This chapter reports the relevant findings from these interviews.

The themes emerging from IPA analysis are identified, discussed and illustrated with quotations from participants. This approach is explicitly interpretive. The themes are discussed in relation to the relevant literature.

Not all the findings derived from the interviews are reported here. This is because a large body of data was generated. Several participants spoke at length about their personal experiences of unemployment and having mental health conditions. This material was valuable for contextualising the data, but is not of direct relevance to the research question. As a result it is summarised only briefly in this chapter. The results reported in detail here are those most pertinent to the research question, most particularly sub-questions 2 and 3:

To what extent do service users report experiencing changes in their subjective well-being, during and after guidance interventions?

To what extent do service users attribute changes to the effects of guidance interventions?

7.1.1 Brief summary of progress at 6 and 12 months.

IPA analysis involves an initial stage of analysing each individual in isolation as a case study, followed by a stage in which these analyses are integrated to identify shared themes. Consistent with the IPA method, it is the thematic analysis that is reported in this chapter; this is not a case study approach to reporting. This has the drawback that a sense of individual's holistic experience is lost. For this reason a brief overview of the ten cases is provided in table 28, to underpin the thematic analysis with a sense of individuals encountering a service and experiences changes.

Table 28: Research interview participants - summary of progress

Participant	Key issues reported about FEAT interventions and their impact	Progress at 6 months	Follow up i/v?	Progress at 12 months
A	Attended STARS. Work experience had a big impact on confidence	Well-being improved rapidly; anti climax/set back after work experience ended	No	Found work
B	STEPS/STARS was high impact experience – re-evaluated self. Offered mentoring role but not taken up yet.	Well-being improved Job hunting; studying part-time to enhance employability	No	Not known
C	STARS helped build confidence. EA emotional support valued. Volunteering built social confidence and influenced occupational interests.	Well-being improved Volunteering, studying, caring for family & job seeking,	Yes	Well-being stabilised. Pursuing multiple activities and considering HE study/ retraining.
D	STARS helped to see self as normal, and valued exercises/ cognitive tools for managing thinking. EA recommends experimenting with work environments. Leads to work experience – hopes it will lead to a job.	Well-being improved. Able to be in social situations again. Missed STARS course after it finished	Yes	Well-being stabilised. Physical health variable. Not participating in work or learning; set back after work experience ended without job offer.

Participant	Key issues reported about FEAT interventions and their impact	Progress at 6 months	Follow up i/v?	Progress at 12 months
E	Valued open discussion of mental health issues on STARS, and some cognitive tools for managing thinking. EA support also.	No impact attributed to FEAT, other than optimism about the service. Progress seems to be made in previous years.	No	Unknown. Believed to be seeking to overturn psychiatric diagnosis
F	STARS helped to put problems in perspective EA had big impact; rebuilt confidence and revamped CV which led directly to job offer.	Found seasonal/temp work Well-being improved	Yes	Found new job; Well-being stabilised, but not yet returned to pre-event levels.
G	STARS improved self-esteem and rekindled passion for learning. EA motivating 'positive kick' Positive anticipation of work experience.	Well-being improved rapidly. Studying in FE.	Yes	Fully recovered & feeling positive. Full-time student, volunteering & working part-time. No need for employment advice.
H	STARS helped stabilise emotions. Subsequent gap in contact from FEAT associated with relapse. EA contact valued, again stabilised emotions, but frustrated it's not leading to job or work experience.	Well-being improvements interspersed with relapses e.g. when STARS finished.	Yes	Volunteering & mentoring. Seeks P/T work. Mental well-being varies dramatically with level of FEAT contact
I	STEPS/STARS moderately positive. EA support to become active. Found the offer of a mentoring role too much pressure.	Modest improvement in well-being. Job seeking; exploring but not committing to volunteering. Reduced use of GP	Yes	Well-being slightly improved over year. Moving on from fixation on unsuitable occupation. Exploring courses but anxiety is a barrier.
J	EA did not reject when failed to attend appointments. Gave encouragement 'push'. CV support.	Well-being improved. Job seeking & considering FE study	No	Found work

A systematic IPA approach was adopted, and involves taking the analysis through a series of steps. This required analysing each individual interview in isolation, effectively as an individual case study. Subsequently individual case analyses were integrated to identify the common emergent themes across the sample. This analysis process is outlined in detail in Appendix 3C. As noted there, with experience some streamlining of this very detailed process was possible.

As recommended in IPA practice, a small number of rather broad themes provide the structure for the analysis of the interviews. Each broad thematic area is further divided into sub-themes as outlined in full in appendix 3E. The broad themes are listed below:

1. Life events
2. Experience of unemployment and mental health issues
3. Recovery from, and adjustment to a mental health condition
4. Work orientation
5. The role of FEAT and the impact of guidance in recovery
6. Other issues emerging from the follow-up interview

The background material in themes 1 and 2 is summarised briefly. Material directly related to the research question is reported in full in this chapter.

7.2 Participant experiences that are background to the study

Some of the material generated in the interviews was contextual and biographical. These are not reported in full here, but key themes emerging from this material are briefly summarised below:

7.2.1 Life events

Some participants' contextualised their experience in terms of stressful or traumatic early life experiences, such as bereavement or troubled adolescence. More proximal events were identified by some as triggers for the onset of their mental health condition, such as the pressures of caring for sick relatives, and bullying, difficult relationships, or noxious environments at work. These events can be understood in terms of developmental and life event perspectives on stress and mental health (e.g. Holmes & Rahe, 1967; Cooper, Cooper & Eaker, 1988; Friis *et al.*, 2002; Monroe & Harkness, 2005). The career impact of traumatic events is not well understood, but there is some evidence of negative impact on developmental measures of career adjustment (Strauser *et al.*, 2006).

7.2.2 Experience of unemployment and mental health issues

Although reasons for becoming unemployed were sometimes associated with the onset of a mental or physical health condition, in most instances leaving work was voluntary. Redundancy where it did feature in biographies was mostly a temporary state. This is consistent with Kemp & Davidson (2007) and Shuttleworth, Green and Lloyd (2008) who found that choosing to leave work for health reasons was the main reason for unemployment in IB claimants. Even voluntary job loss can be a major blow (Bodman *et al.*, 2003), although life transitions that bring chronic stressors to an end may be positive (Wheaton, 1990).

Those participants with the most extensive work experience found it difficult to adjust to an economic environment in which finding a job was problematic, as

this defied their expectations and they lacked job seeking skills. Others felt very distant from the labour market, and acutely aware of the potential threat to income via their benefit status that might result from making a move towards work.

Many, but not all, participants spoke of their experience of psychiatric symptoms. For some this meant isolation, fear of going out, psychological distress, and difficulty with concentration and memory. Some reported contemplating suicide. For some the intangible nature of their health condition was a source of frustration, as they were unable to validate the reality of their experience to others. Some participants put their experience in a socio-political context and discussed issues of mental health related stigma in wider society, and discrimination by employers in particular. A minority in the sample felt very frustrated with Government agencies in relation to benefits and assessment of fitness for work. One individual expressed mistrust of the psychiatric profession and mental health system, with particular reference to the effects of medication.

Some participants expressed some ambivalence towards being identified as having a mental health condition whilst being unemployed. On the one hand it conveyed advantages in terms of access to incapacity related benefits, validated their experience of levels of distress that were beyond normal experience, and reduced demands from others. On the other hand the labelling limited their chances of reintegrating to the workplace and affected their self-esteem. Pilgrim & Rogers' (2005) exploration of the sociology of mental health includes a discussion of labelling theory which focuses on the far reaching negative consequences of identification of mental health conditions. However, they point out that labelling can be seen not just as route to discrimination, but also as a human right, because it facilitates access to compassionate treatment and care. Walker & Fincham's (2011) qualitative study of workers with mental health conditions suggests difficulties around the negotiation of identity with occasional use of the 'sick role' in acts of defiance against employers' control of illness discourse. Although the context is different, this also suggests some ambivalence to labelling.

7.3 Participant experiences relevant to the research question

This section reports in full the themes emerging from analysis that are foreground to the thesis, as they relate to the research question.

7.3.1 Recovery from, and adjustment to a mental health condition

The experience of participants can be understood in terms of a recovery model of mental health and rehabilitation (e.g. Bradstreet; Berzins, 2004; Provencher & Keyes, 2011; Shepherd, Boardman & Slade, 2008). This takes a biographical, subjective and holistic perspective, moving away from concepts of medical cure towards a focus on healthy functioning and re-engagement with the community even if symptoms of a mental health condition are ongoing. The concept of recovery goes beyond that of coping. Patton & Donohue's (1998) qualitative study of the long-term unemployed suggests that coping strategies that involved meaningful activities (as opposed to filling time and comforting behaviour) were more successful in promoting well-being. Recovery seems to be associated with steps towards personally meaningful thinking and behaviours.

Level of functioning (including emotional state)

The majority of participants reported an improvement in their mood and level of functioning in the period since they had registered with FEAT. In some cases this was a modest improvement, in others a dramatic one. Several still experienced low moods, but pointed to the qualitative distinction between depression and feeling unhappy; their new downs were normal, everyday or proportionate to their situation.

...I suppose the more I have done the less I have felt depressed because each little achievement makes me feel better, it improves my self-esteem which

reflects on my depression and, yeah, so I have felt less and less depressed....and I've become much more open and much more friendly, much, much less cynical, because depression brings excruciating cynicism [laughs] ...that's pretty much gone and even though I've had negative times and stuff and people have said to me; how are you doing, and I've said; well I little bit down, and they say; oh really, and they'll start, and I say; look, I'm not depressed, I'm just a bit down because I'm fed up I'm not back in work yet... three times I felt a bit down but feeling down is part of normal life...[Participant A: female].

Much less, much less anxious... And definitely within the last six months... I do, I feel stronger, stronger in a lot of ways... [Participant C: female]

I'm not happy yet...Yeah, I feel a bit happier, and a bit less frustrated as well. I mean you don't have as much time to sit and brood. If you're stuck in the house, you've got too much time, and then you think what have I done, what have I done wrong? And then you think it's just bad luck or whatever. But you easily blame yourself, do you know what I mean? You put a lot of pressure on yourself thinking you're an idiot, you're useless, and it's all negatives...Yeah, I'm a bit more positive about things now...Yeah, I'm not as depressed as I was, that's for sure! ... You feel like your spirits have lifted a wee bit, and like more things are going your way instead of everything against you. It's like you feel there's more of a flow, and it's just all-round happier. There isn't all the negatives and I'm getting enough help now, and somebody cares! [Participant D: male].

D also described greater resilience to stress, and beginning to feel able to assist or show compassion for others. Participant G also spoke enthusiastically about her improvement:

I definitely can't say I'm depressed any more, I think that's a good thing...well of course it's ups and downs, everybody have, but it's not such, not so important, like because you see end of result and today's ups and downs is just today's ups and downs... And yes, I look forward to study another year...I feel little bit more and I'm happy. It's unbelievable. [Participant G: female].

For Participant F, progress was modest and directly related to returning to employment, specifically the latent benefit of time structure. He felt that he was still not able to enjoy all his former habits and leisure interests, and now had a more subdued personality:

Well everybody seems to say I'm a lot quieter now and a lot more reserved...Although I was never like the life and soul of the party... I'm still not hundred percent... And my concentration's still very kind of poor. Memory, better. But, as I say, being back in, like, daily working routine, I do feel a lot better within myself as well obviously....just fortunately being in work is the main thing... being back in, like, daily working routine, I do feel a lot better within myself...It was the start of me getting back into a daily routine, I think, and getting something to get up for... [Participant F: male].

Three participants with enduring mental health conditions were more equivocal about whether their level of functioning or mood had improved recently. One suggested his mood had been more or less level for a long period of time, but that he at least was now able to focus on his financial needs rather than purely health ones:

Yes, I'm not focussing on my illness now, I'm more focussed on trying to dig myself out of the hole that I'm in. [Participant I: male].

Another described experiencing fluctuating emotions, and undertaking ongoing work on sleep and relaxation since joining FEAT, with both progress and substantial setbacks.

Yeah, I've been getting actually better...they're linked together, physical and mental, but first of all my mental well-being to me means... that I'm able to function and just do the tasks people normally take for...getting up, for a start, making my breakfast, being able to get out my front door and interact with people in social situations or whatever like this, two months ago would have been impossible I couldn't even speak to my family or friends because I was in such a really terrible, down situation, I thought I might have to be hospitalised...[Participant H: male].

For another participant, learning to live with a mental health condition was a long term adjustment, and that disturbed emotions and to some extent grip on reality was a constant feature requiring substantial effort to manage. Most of the progress in self-insight and building a lifestyle had been made prior to registering with FEAT and that frustration about not having a job to keep him occupied and to achieve a decent income was a continuing feature:

...I have been given the opportunity, I've moved out of the homeless place, I have a flat, I've got a partner...my girlfriend now we're going on four and a half, five years, I am a shining example of somebody with mental illness and I'm having a good time... I can't accept my circumstances and I refuse to do that because I want to do things, I can't sit and do what I'm doing forever, there's only so much DIY in the wee flat I can do, it's...I'm quite happy, I don't want for anything but I need to do something, I need to occupy myself, I can't live on benefits my whole life, it's driving me, if anything, crazy...I don't just want to sit on bloody incapacity benefit for the rest of my life ...

[Participant E: male]

This participant's passionate account clearly shows a desire to work. He also expressed a preference for hard physical work and disdain for some of the options offered to him. This seems consistent with the evidence provided by Nixon (2010) that working class male social identity with its emphasis on standing up for oneself, is difficult to reconcile with the restructuring of the workforce with the increasing prevalence of (servile) service sector roles.

Medical recovery

For most participants improvement in their mental health condition was not closely related to their medical status. This resonates with the accounts provided by the recovery movement (e.g. Bradstreet, 2004; McCormack, 2007; Shepherd, Boardman & Slade, 2008) of improvement as a social process within which medical considerations are only one small part. Some had taken medication for a while and then stopped, but neither taking medication, nor moving on from it seemed to be connected closely to the experience of recovery in their minds.

But I gave up using any kind of medication years ago because I felt it was pricking my mind and then making me feel I was better and also I was sleeping at all sorts of times and things. So the cognitive behavioural therapy was better in that sense, again I don't know if it helped me...[Participant I: male].

As previously mentioned, Participant E had negative experiences of psychiatric medication. Whilst acknowledging the practical benefits that a psychiatric diagnosis had brought him and at some level accepting it, he nonetheless felt ambivalent about it. He was aware that the categorisation of his pattern of symptoms had been problematic and had reason to believe that his diagnosis could be 'overturned'.

Well I've got a psychologist, I'm no longer under psychiatric care because they know that I'm not typical of any symptoms that you might associate with somebody diagnosed as [specific disorder]...I could probably campaign because I mean the nature of the way the diagnosis was made is questionable...that's my barrier, I just don't like being pigeonholed...
[Interviewer: *Because a diagnosis helps with other... practicalities of life?...*]
Of course it does ...I have been given the opportunity, I've moved out of the homeless place, I have a flat...and I could get the diagnosis overturned but the truth of the matter is, I'll still have [specific disorder]... [Participant E: male].

So in this instance medical status seemed to have more significance for social identity than for the experience of feeling well or ill. The reliability of diagnoses has been a focus of the critics of psychiatric practice for some time (e.g. Townsend, 1982), and is clearly an issue here.

Reinterpretation of earlier events

Some participants made comments that suggested that they were re-evaluating experiences in their past, and sometimes re-labelling them in a way that they found helpful. This process of reflection and re-evaluation could be thought of as part of recovery. Some found it helpful to retrospectively label difficulties they had experienced earlier in life as arising from a mental health condition:

Though saying that, you know, I have had episodes, you know, any major trauma in my life, you know, they have often knocked me back, you know, family bereavements or when I was younger and married, I had really quite difficult problems trying to have a family and getting pregnant and staying pregnant, lots of, sort of, events like that, I was most definitely depressed at that time...But, I don't think at that point I recognised it as that. [Participant C: female].

This example also shows moving towards balanced evaluation in the reassessment of the past:

So, yeah, there have been times in my life where I have been hilariously happy...But you forget sometimes. So, yeah, I recognise now that...there have been times when I've been happy. [Participant C: female].

One participant found it constructive to reassess her problem of underemployment as temporary and arising from her difficulties with English as a second language, rather than arising from the deficits in her intellect or merit:

It's nothing to do with my mental abilities. It's language... But I get gradually back where I belong, yes. [Participant G: female].

Another seemed to have adopted an explanation offered to him by a health professional based on a metaphor of mourning, reminiscent of the Kübler-Ross (1969) model of loss as applied to redundancy. This seemed to help make sense of an unexpected and bewildering episode:

Well I had a couple of sub-sessions with a psychiatric nurse...they come to the conclusion I was grieving for my old job...[Participant F: male]

Social network participation/social capital

As might be expected for some, the experience of their mental health condition was associated with social isolation. If social networks are seen as providing 'buffering' against the effects of psychological distress (e.g. Argyle, 2001), this could leave them more vulnerable to the consequences of their condition. However, most participants described some level of involvement with family or friends throughout the duration of their condition. For some it seemed that practical problems caused isolation, which contributed to the mental health condition, rather than isolation being a consequence of feeling depressed or anxious:

Well I live in Kirkcaldy and my family, my daughter and her partner and their daughter, and another baby on the way, and all my brothers and sisters, they're all through in Glenrothes, which is only seven or eight miles away, but it's expensive to get through on the bus, so I can only probably do that once a fortnight. [Participant C: female].

... it maybe language because... your ability to understand is very limited. And because of that it doesn't go so much out and doesn't get so much like interesting contacts. And your contacts is kind of limited with 'Hi' and 'Bye' and smile and food shopping and everyday things, and it doesn't improve anything. [Participant G: female].

Family and friends could be a source of peer group expectations. This could be gentle and supportive:

Yes...everybody around me was really positive about me, there's a place for me...One friend said, I knew you could do this and I've been nagging you for the last couple of years, I told you...you can do something, you've got a lot to give, you've got a lot to offer, you're just a waste not doing anything...As I say, most of the people that I know are employed, I've got one friend who's unemployed, that's it...[Participant A: female].

Reflecting O'Donovan & Hughes (2006) point that social networks and social support are not necessarily a positive influence on health, family influence could also be neutral or negative:

But because I've never had any praise off my family or any encouragement or support, I've always been put down by them, I'm getting put down even further because I'm weak because I've got a mental health problem. But the main reason is because I'm not working, I'm not contributing to society or paying my taxes or whatever and my family, my friends, it's yak, yak, yak, that kind of way all the time, get a job, get a job, get a job... And that's a huge pressure on me as well and that drains me and it's like keep having to put your guard up, like being in a boxing ring deflecting the punches and things and it really gets wearing...
[Participant H: male]

This individual had also found it very difficult to move on from a mental health treatment unit, because on completion of his treatment all the social support that was associated with it, such as participation in a men's group, was withdrawn.

Several participants described improvements in their social involvement. Two participants made contacts or friends on the STARS course which have continued. Others described engaging in volunteering or returning to socialising:

Socialising, I've actually been out a couple of times now, go to pubs, gigs. Whereas I wouldn't have went out before, I would've thought, no I can't, can't go out the door... Probably the last month or two month. [Participant D: male].

Blustein (2006) argues for the importance of wider social networks reaching beyond the family. Certainly in this instance they were, as the individual was persuaded to return to his regular poker nights by a supportive friend:

... I was always coming up with an excuse every time ken that I couldn't make it ken and I did, I have started going back the last two times they've played, ken

but I still, it's still no the same, ken, I'm still no getting the...the enjoyment that I used to. Ken but at least I'm going now...[Participant F: male].

Involvement in family for several participants, both men and women, meant caring roles. In one case feeling better meant being able to rise to this challenge:

...and it was not easy, you know, just dealing with things, dealing with my nephew's illness, you know, I'm the one that the family are coming to and relying on for support...so they individually come to me and share their fears ...and I just thought, well, my granddaughter and this new baby that's coming, you know, I want to be able to...I want to show them that I'm, that I can cope in adversity. [Participant C: female].

In general, discussion of family ties and informal social networks did not feature as much as might be expected, and yet it seems unlikely that this is not an important area. It may reflect the nature of the research interview structure, which did not require participants to discuss family, intimate relationships or friendships, but allowed them to do so if they took the conversation in that direction. Personal questioning was avoided to prevent intrusiveness and to give participants a right to protect their privacy. It may be that some participants had less to say on the subject as they had relatively few social contacts or felt ashamed of their social or relationship status: mental health service users are more likely to live alone, to see fewer people and to be dissatisfied with the numbers of people that they see (SAMH, 2006).

There are gender differences in social networks, and this has implications for mental health (Silk, 2008). In the sample this was more evident in relation to family caring roles, which male respondents seem to describe primarily as a burden, whereas female respondents described both pressures and a positive sense of identity emerging from being an effective carer. Blustein (2006) points to gender differences in the meaning placed on caring roles, and notes they can reinforce social connections, enable the caregiver to express motivations related to family goals, and provide legitimate power through taking responsibility for the well-being and development of another. Social support

may often be conceived as having a buffering effect on well-being, but support is not uni-directional and its meaning can be very situation specific (Stansfeld, 2006).

Learning journey

Two participants used the metaphor of a journey to describe their experience of having a mental health condition, unemployment and recovery. Use of this metaphor was also reported by Bodman *et al.* (2003), in the context of job loss as a 'painful journey' and one with uncertain travel through 'unchartered territory'. Here the metaphor captured both this arduous experience and also a sense of at least partial progress:

I was very ill for quite a long time, and it took me a long time for to come back. It's like you're on a journey...Before I went there [FEAT] it was a hard, hard journey. [Participant B: female].

Yeah, and it is a journey, you know, the...depression is a journey but also the job search is a journey as well, so it's...it's just getting everything, getting all your ducks in a row. [Participant C: female].

Others who did not use the metaphor nonetheless described a long hard process towards understanding of their experience and coping better with it. Recovery was not necessarily complete or irreversible. This individual described it as a partial experience:

... in recovery not recovered that's... how I look at it and I could be in recovery for the rest of my life... if I can ever be comfortable at, you know, in my life and say well stop pushing yourself because if I, if I'm setting this bar to high I'm going to go back the way again, sort of... [Participant H: male].

Improved self-insight did seem to be a common theme in the learning process:

What I'm trying to say is now I seem to be much more informed about what I'm doing or I understand myself better than I would do say five years ago, when I

just seemed to be doing something maybe for the sake of it. I don't know.
[Participant I: male].

But really the overall thing I've learnt about myself or I've got out of the journey I've been on is just to be kind to myself and be sort of positive, you can do this. Mental illness, depression, anxiety, whatever has always been a negative on me and people have always said; oh, you're always down on yourself, you're down on everything, [H]. And something has clicked fairly recently that I can retrain my brain, before I never believed that until I started to go to these courses... [Participant H: male].

Factors that initiate or promote recovery

- i) Intangible progress and small steps

Medical intervention did not seem to be described as the trigger for recovery for most participants, but it was often not clear what was, or even at what point in time:

But the actual catalyst for the turnaround, I don't know...at some point in time I feel that I must have just thought, this is my life, it is a mess, but if I don't sort it it's just going to be a bigger mess, so let's just regroup... financially I was in a really bad situation, but I dealt with that and it was not easy...But again, trying to identify the triggers or, you know, the mile stones, I don't know why it's so difficult to identify the why's and the how's or the changes, but I can recognise now on reflection that there most definitely have been. [Participant C: female].

For some it seemed to be an accumulation of small actions that made a difference:

Small steps, maybe most basic step is get out of bed every day and really do your 'to do' list that you have, not like I say, oh well today is really not a very good day, today I won't go out... [Participant G: female].

It was not clear that intervention from agencies such as FEAT acted as a trigger for recovery, but there were hints that once the recovery had begun, they were involved with the healthy processes underway:

[Interviewer: *Is it that case that you got over feeling depressed and then you started using these services, or is it the case that these services have helped you to get over being depressed?*]

Both, because depression is not just a yea or nae thing it's a degree...I was recovering from my depression and then I started dealing with these organisations they helped as well because they boosted...because my self-esteem was boosted... Yeah, they've accelerated it, I think. [Participant A: female].

ii) Identity

Bodman *et al.* (2003) suggests that job loss can have far reaching effects on identity for people with mental health conditions. Amundson (1994) suggests that negotiating identity is a central concept in counselling the unemployed. In the FEAT sample, as the recovery literature would suggest (e.g. Bradstreet, 2004; Shepherd, Boardman & Slade, 2008), getting better did not necessarily mean a return to a former self, but could mean construction of a new one. Participant's B's testimony was interesting in this respect. A loss of an earlier personality, a rebuilding of a new one and the key role of learning experiences in the form of courses (initially STARS, and subsequently an FE course) featured strongly:

I'm not joking it gave me the confidence that I've never had for about nine years, because I didn't recognise myself really, but with the programme that they went through it made you see yourself in a different form. I think what had happened to me was I forgot who I was, because it's a long time that you're just sort of under the influence of different drugs and what have you for to calm your brain, or whatever they professional doctors get to be doing with you... and then I'm not saying it was a magic wand they had, it certainly wasn't, but whatever that, what goes in that course, whoever had put that together has gave it great thought and it allowed people just to come together and grow

again...It's like a part of you dies actually...So it was just like a wee wakening thing... [Participant B: female].

This individual had been a FEAT client on two separate occasions. Most recently she had repeated the activities, such as exercising, and registering with FEAT, that had successfully helped her recover on a previous occasion. The sense that personality could be both lost and reconstructed was echoed by other participants:

I was aware that I'd lost so much personality I used to want to get back to my old personality, get my old personality back, but then I discovered well that's never going to really happen and I realised that...I was worried I was going to stay with a non personality, I was worried that no personality was going to come back to me because I couldn't see it coming back. And then I realised that my personality was going to evolve anyway and change...[Participant A: female].

Another participant had a less fluid sense of identity, and wanted to regain his former sense of self. For him, returning to work was a necessary precondition for this:

...although I know I still am not back to normal yet, getting there I would say, getting there now...I'd like to get back to how I was...But I know it's no going to happen. I always knew getting a job would... make me feel better, ken...So, but as I say, there was a, gradually I was getting better anyway, ken...But there was, it was only to a certain extent and as I say I knew if I didn't get a job I was never going to get back to...[Participant F: male].

This next individual felt abnormal and ashamed to go out in public, prior to getting support with FEAT. The STARS course experience helped him to normalise his own experience and realised that many people on the street looked unhappy:

So before it was like if somebody looked at you, you freaked and you thought there's something wrong here, but you couldn't figure out what. And I always thought it's me, there's something wrong with me, and I just blamed myself for everything. Anything that went wrong it was like...that's like born to lose syndrome or something... Yeah, and they said just look at people in the eye as

you're walking down, and see who's happy and see who's not and you notice right away...And it makes you feel better, it totally made you feel better. You just realise you're not alone, you're not the only one. And again it boosted you, made you feel good. I think that's what it is, making you realise that you're not so useless that you can't help yourself, and that's what they get into your head. It is a lift, definitely. [Participant D: male].

For two female participants, identity was linked to caring. For participant B, this related to her values and work identity. Participant C seemed to measure herself by how effective a support she was for her family. Recovery meant beginning to do a better job of it:

So, I, sort of, feel, I suppose, disappointed in myself that I've not been able to be more of a support, that I've not been as freely able to, you know, if I had access to transport and fuel and everything was...I would be through every day offering what practical and emotional support that I can, but I just feel because I'm surviving on job seekers allowance... I do feel disappointed in myself that that's the best that I can manage, but that's just me being too tough on myself, perhaps...I do, I feel stronger, stronger in a lot of ways...And supporting my family, I think when [nephew] was diagnosed, I was just holding everybody up and that was, you know, seven years ago when my brother in law died, I tried, you know, I made the effort to but I just couldn't, but this time, you know, some things in life you've just got no other choice but to deal with them and this is just one of those situations, it's hellish but...[Participant C: female].

iii) Personal responsibility

Taking responsibility for oneself was an issue raised by some participants.

I'm quite happy to sit on incapacity benefit for the rest of my life like the government want me to do, there's not anyone in the world that can say any different because the medical profession says you're ill, I can sit and do that till I die, I don't want to, I've had to work on barriers myself and, you know, it's hard like, it's hard... that's how I do it, you know. Yeah, take responsibility, understanding myself... [Participant E: male].

Taking responsibility seemed to be central to the turnaround experienced by one participant:

...Well, I think, to an extent, it was important for me to take that control and responsibility back for just having positive things in my life and not just expecting someone to knock at your door and bring positivity to you. Just...I just can't imagine what an empty life would be like without having these interests and things to occupy me, I really...yeah, I think that just would be too challenging not to have a reason to get up in the morning. So, I just felt that it was incumbent upon me to fill the void...[Participant C: female].

There is a relationship between personal responsibility and a sense of agency or identity, but it is a distinct concept. Nelson-Jones (1984) identifies responsibility as a central integrative theme in counselling for mainstream client groups. He sees it as an inner process rather than a state, linked to making choices, which subsequently help to define the self. He suggests it is a concept that is implicit in many psychological approaches, but one that does not require esoteric knowledge to appreciate. He distinguishes personal responsibility from externally imposed responsibilities; it comes from within, but does not mean self-blame. He suggests change is often associated with taking responsibility, and this was certainly an important factor for participant C. Unlike some of the other themes in this section, responsibility does not feature prominently in the literature; an exception is Dickson & Gough's (2008) review of recovery based approaches to supporting adults with mental health conditions into work.

iv) Agency

Several participants reported a growing sense of being able to initiate activity with the expectation of positive outcome. At least three had begun studying on their own initiative, in this case directly aimed at improving employability:

I also went and did some courses off my own back because I looked at applications for the kind of work that I want to do, the criteria and things like that, there were certain things that sometimes they look for. So I decided to go

off and do a first aid course, and so I did a first aid for project persons at work, it was at Perth College, that was a one day thing. I did a food and hygiene certificate as well...I was looking at jobs where you work with people that are mentally disabled and working in the community, which is something that I will do at some point, I do want to go and do that because I think I'll be good at it [laughs]...[Participant A: female].

Unsurprisingly, feeling able to take action was interlinked with energy levels, sense of coping and moving towards desired outcomes:

I always think if you're out there then you're more socially active and you're out in the workplace, you've got more chance of getting a job if you're already in a job, or you're on a placement, they can see at least you're trying. Whereas a lot of people just sit there and do nothing and refuse to do anything. I'd rather get out and do things, it leads to other things. So I think there is a positive energy, that when you go out with a goal, then that's how you want to go, and you're going to get it... Yeah, I'm not as depressed as I was, that's for sure! I suppose the frustration's went down a bit as well, 'cos I always felt enormous frustration at not being able to do what I want, and now it's like I feel I can cope with things better, I can cope with stress a bit better, and not just giving into things, giving it a better fight...[Participant D: male].

For one participant, becoming active again had meant initiating a range of activities, and the whole was greater than the sum of the parts:

So I don't know how I ever managed to fit in a full-time job before! Between studying and volunteering and, you know, really actively job hunting... [Participant C: female].

There seems to be strong resonance here between participants growing sense of agency, and the literature suggesting a linkage between self-efficacy and well-being in the work and learning domains (e.g. Lent & Brown, 2008). Similarly the importance placed on mastery, a concept incorporating job search self-efficacy, in the MPRC job search program (Price, van Ryn & Vinokur, 1992; Vinokur & Schul, 1997) suggests this is a key area.

v) Goal setting & future focus

There is a strong body of research linking positive well-being outcomes to goal focused processes (Pomaki & Maes, 2002; Walsh, 2003), particularly where they are approach (rather than avoid) goals and are set autonomously, not imposed. Some evidence to support this position was found. Learning goals were important for some participants, and in some cases this was to enhance employability or respond to skills deficits (as in the example of A above), and here also:

And this is what my aim is just now. At the moment I'm going to the college to learn computing...Because I felt at the bank it wasn't a case that I couldn't do the job, but I was trying to learn this new job, sitting in front of a computer that I had never done in my life before...and I thought dear that is just too much for me to bite...Whereas if I can get my computing skills into order and pass the exams that I'm hoping for to be passing I feel well I won't be frightened to go and chap back at this bank's door... [Participant B: female].

Participant C seemed to have become particularly focused and goal directed:

And then I moved from there thinking, you know, this is what I'm going to need to do, this is where I'm going to have to look to find a job, it's not going to come looking for me and I can remember one night sitting and writing a list of where these jobs might be...But then, in this period of unemployment, I contacted the Open University again and asked if my, you know, the credits that I got a way back in 1986 and '87, were there still, on the register, did they still count and they did. So, I thought, well that's what I'm going to do, I'm just going to dash on and use that time and so I picked up that again and all being well, I'll have a BA by 2011...the financial problems, well, the major financial problems, they're pretty much resolved, I mean, I'm still surviving on job seekers allowance, which is a challenge, but the major, you know, threat of repossession of things, they're now resolved... [Participant C: female].

One participant seemed to find his goals as a source of stability or resilience:

And when bad things come back to haunt you, you can deflect them, and you've got that power to just wave it off and still feel good, feel positive and think, does it matter, am going to cope where I'm going. And they always said, 'set yourself a goal, 'cos once you've got that goal that's where you're going, you've got that direction and you've got that focus to go there.' I think that's one of the major things about it, is to say, 'where do you want to go and how are you going to get there,' and you are going to get there 'cos you want it. [Participant D: male].

For another goal setting seemed to be central to her experience of recovery and coping:

... I think you can't be depressed if you know how to reach your goal, you can't be depressed, you get depression when you're stuck and you think anything, it doesn't matter what you do it won't work out anyway that come from desperation, but if you know how to get there, it's going to be hard but I'll get there eventually, because you look forward to tomorrow and depression and look forward doesn't work together, depression disappear... I think, oh well I won't go tomorrow, maybe I don't need to this just now, I'm really tired and busy, but to get your goal, you have to do all this things and I have my 'to do' list out for every day and yes when I don't want to go out of bed I get my 'to do' list and I get out of bed and I do it because no other way how I going to reach my goal? [Participant G: female].

These experiences seem to provide strong support to the linkage between goal-oriented behaviour and well-being suggested by Walsh (2003) and Lent & Brown (2008), and are closely related to the notion of self-efficacy. Counter evidence is provided in just one case, where goals seemed to be part of the problem. This participant seemed to describe repeatedly setting himself goals involving learning or volunteering opportunities, but feeling unable to commit fully to them. Anxiety was too strong a force to get over the initial hurdles in participation, in spite of multiple attempts:

So I didn't go to that course and I enquired at other colleges but they were the same, there's not a demand for the basic bookkeeping course... I don't know if I've got the courage to go for it...it was the same when I was due to do

placements in school, on the teacher education course...I don't seem to realise until it comes to the crunch that I can't go through with it. [Participant I: male].

Griffiths & Ryan (2008) suggest a link between lifelong learning and recovery and indeed for some participants it did seem to play a key role.

7.3.2 Work orientation

Historic work orientation

All participants had previous work experience to a greater or lesser extent. It was striking that several spoke positively about their occupational skills and attitudes, but that this confidence was compartmentalised to their past. They seemed to have faith in their narrowly defined vocational competence, but not in their ability to get a job, or to cope in the social context of a new work environment.

Before I became ill ...I was a full-time carer. I worked with all types of clients, all kinds of patients... and it was basically going out and seeing their needs and fulfilling them and delivering the care that was required to keep them health and safely in the community and I enjoyed that very much...it was interesting and it seemed to charge me up... but I did have a very big impact on the people that I, you know, I cared for. [Participant B: female].

Yeah, and I was always very good on the phone and polite and listened to what people say and I won a lot of customer services accolades and things like that, and I was always getting told from my superiors I was a really good advisor. [Participant H: male].

Faith in core vocational skills and potential was tempered by some concern expressed about lack of skills or qualifications needed to get a job.

...I done tremendously well in the British Army... I was a good recruit and I was a top recruit... I mean I got into the [elite unit] man, that is sorted, I don't know if you know anything about the forces, you can ask anybody about the forces,

that's very hard, I mean the selection process for that is unbelievable, I mean it's like...it's arguably like the hardest infantry on earth man it's very hard and I got in that... the bottom-line is I'm 32 year old, I don't have the skills, nobody's going to employ me. [Participant E: male].

I never, I left school at 16 and I never went to my exams when I was 16 because I just thought other stuff were more important than that at the time. I obviously regretted it later on. I never done any further education or anything like that. [Participant J: female].

Whilst some individuals tried a variety of occupations, sometimes for short periods, in other cases work histories were very extensive and consistent over decades rather than years. Some had management or supervisory roles, and demonstrated loyalty to their employer.

Well when I was sixteen my first job was working in a warehouse in Kirkcaldy...that's basically about thirty years experience working in stores and warehouses...[Participant F: male].

Yeah, well I left school nineteen eighty four, I went straight into the travel business, I was on a youth training scheme back then for a year... and then basically I enjoyed it and I was in travel until two thousand and five, so twenty one years, I moved up the career ladder... I was a sales person, just dealing with the public, selling holidays, that kind of thing, then I was ambitious, a job came up actually as assistant manager in that branch so I was assistant manager. Then I was moved around the company because they wanted to try and get me a managerial position so I worked in Perth for a few months and Inverness and quite a few places in Scotland. Eventually I got a manager's job...[Participant H: male].

I joined the civil service...and was there for about ten years with a break in between... [Participant I: male].

These extensive work histories did not seem to transfer to a confidence in capacity to work in the future, at least without intervention.

Occupational choice and identifying suitable work in the light of a health condition

Some participants discussed their choice of occupation in the context of their career history. Some had made adaptive changes in the light of events:

So I had countless [catering] jobs from then up until 1999 when I was made redundant from a small factory, I was the cook in the staff canteen, and they, overnight, had to half their staff numbers so it didn't justify keeping me on. So, in 2000 I did a course with Fife Council, the SVQ level 2 admin, and from that I got work right away. So since then, I've been in, sort of, clerical, administration roles. [Participant C: female].

Events could lead to being forced into a change of occupation and, as suggested by Hogarth *et al.* (2009), 'trading down' the job market. This participant had to do this after moving to Scotland from Eastern Europe:

I'm able to do manager work, but if you can't speak the language only production is yours and it was the hardest part, because you feel like I can do much much more, why do I have to do that and you have to check this with reality, like look at you change country your language is not good enough, you have to do it. [Participant G: female].

Underemployment seems to be associated with negative mental health consequences (e.g. Dooley, 2003, 2004; Dooley, Prause & Ham-Rowbottom, 2000; Broom *et al.* 2006). Underemployment seems to be common amongst migrant workers, for example Weishaar (2008) found stress issues in a qualitative study of Polish migrant workers in Scotland.

One participant's account of occupational choice was unique in that he had repeatedly tried and failed to train to be a mathematics teacher. He was continuing to apply for teacher training ten years after his first attempt, and experiencing recent rejections. He accepted this was a kind of fixation and that

while he may have the numerical skills, he lacked the social confidence or emotional resilience needed:

...I seem to have great difficulty letting go of this idea of being a teacher, I mean I know it's not for me now but I just keep trying... I had sort of said to myself, that's going to be my last attempt and of course I really just felt, you know, I'm flogging a dead horse now, I'm too old to do all this, you know, I couldn't cope with all the adjustment needed... when you try to think of something else you can't quite...it's almost not been what I'd call an obsession, but it's been there for 25 years... [Participant I: male].

Another participant was finding particular difficulties in identifying suitable work in the light of his health conditions. He was disappointed at the lack of advice offered by the JCP Disability Employment Adviser (DEA) on this, and seems to have an unmet need for a specialist vocational assessment service:

That was a bit of a struggle, try identify what you want to do...It's like there's so many jobs I can't do any labouring or stuff, I can't do nothing physical, anything where I'm bending a lot, I can't do that either. So it's like it reduces your job market right down... But as for them trying to tell you what environment you can work in, they're struggling as well, 'cos they don't know how fit you are, they don't know what you're capable of doing. And I'm in the same boat, because I don't know either. And you're expecting them to give you a better guidance to what jobs you can do, and they're like, 'well we don't know what you can do.' There's a stupid thing in-between, and then they're like, 'well we can send you on a placement, or you can volunteer to do whatever.' But even when I said, 'right I'm up for volunteering to do anything,' they're like, 'no, we don't know where to put you.' I was like, 'well you're not helping me...' [Participant D: male].

Another wanted to find a new occupation that would reflect his desire to be supportive and nurturing, but feared an environment that might be stressful and trigger deterioration in his mental health condition. He had confidence in his customer care skills, but was attracted to sports. He was frustrated by the difficulty in finding a suitable opportunity, but this was balanced by a recognition

that he was setting quite narrow and specific requirements, leaving him uncertain what to do.

I've always through my life loved to help people and encourage people and it's just trying to bring those components together into what can I do as a job sort of thing...But I'm completely unclear what I want to do in the future because I keep throwing ideas at [FEAT EA] saying, well sport was my passion and I wanted to be a PE teacher but I had so much pressure when I was seventeen from my family to say get the first job that comes along...But I've got fire in my belly again for something, but I really feel frustrated because I don't quite know what...[Participant H: male].

Work orientation after the FEAT intervention

Within the sample, there were different perceptions of their own employability. In this case time spent unemployed as a carer for an elderly relative had led to a recognition of a potential for caring work:

I was looking at jobs where you work with people that are mentally disabled and working in the community...Quite simply I think I'll be good at it...I feel for them, I feel for that sense of loss of their identity and the disorientation that they feel and the fear, people that have dementia are aware of it...I also used to take care of, and still do although to a slightly lesser degree, my ex mother in law, she's elderly. And it's probably primarily through taking care of her, which I've done for quite a few years on and off, and then taking care of my father that I discovered I had an awful lot of patience with people...[Participant A: female].

In this next example, a growing sense of employability came with recognition of intact intellectual abilities, in spite of adverse events. Lack of confidence in the specific area of interview performance persisted, however:

I suppose now I feel that I'm job ready, whereas, I definitely wasn't job ready before... if I can just get through the interview...after the bullying at my previous job, I come away from that knowing that I had a brain, you know, despite this

person's attempt to just undermine any confidence and my own intelligence so, I mean, she didn't quite manage to...[Participant C: female].

The outlook was not optimistic in every case. This participant wanted to work but did not believe he was employable, and attributed the problem to length of unemployment, skills atrophy and to employers' attitudes, not to his intrinsic potential or motivation:

...I know what I would like to do, I'd like to get a job working for the council, that's what I want to do because I want to get paid man, I want to be able to earn, I like going to work and coming home fucked and going to sleep after my dinner, I love it and I've not done that for a long time... No, I'm not applying for jobs just now because it's not a realistic option, I can't go to an employer, I'm not employable, that's been proved and it's a fact, I'm not employable because how the hell would... I've limited skills, right, limited skills and I've been on the sick for the best part of ten year, that's the bottom-line... the way I sound, the way my voice sounds, the way I am, the way I move, I act, you know, and then people get to know my mind, I often find people who have made presumptions about me and I'm getting that all the time so I know I'm not going to get a job, what are they going to give me a job for? [Participant E: male].

As might be expected there were shades of grey in self-perceptions of employability. Whilst most participants saw work as their goal, consistent with the reports from VR sources (e.g. Grove 2001; Secker, Grove & Seebohm, 2001) and also findings from qualitative research with similar groups (e.g. Arthur *et al.*, 2008; Bodman *et al.*, 2003). Several were proactively job seeking, as in this next example. With an extensive work history, he doubted his potential to return to full-time work, but saw part-time work or volunteering as realistic possibilities. His comments seem to be in line with the qualitative evidence reported by Lee (2010), concerning a sample of incapacity benefit claimants using volunteering as a substitute source of psycho-social benefits of work, or as of intrinsic value in its own right (Bodman *et al.*, 2003). As Lee suggests, it is less clear that volunteering is a route to enhanced employability:

I'm kind of rudderless as well because I don't know where, where I'll finish up with it sort of thing, whether I'll just end up having to still volunteer or whether I can, if there's any jobs out there, if I, it's like me thinking well if I serve my apprenticeship as a volunteer is there going to be something at the end of it that I can latch on to, i.e. a part-time job or whatever...oh god I really need to earn money but on the other side I'm thinking can I take some more short-term pain for long-term gain, if I can keep my volunteering going and enjoying that and building myself up mentally and all the rest of it to then see if it takes me a step somewhere else where eventually I might be able to get a job out of what I'm doing so I'm split down the middle and I have this conflict every single day...

[Participant H: male].

In this case job seeking was complicated by doubts about the likely effectiveness of trying to boost employability through learning:

I want the quickest and shortest possible route to being given an opportunity where I can prove myself and get, you know, the trust, I'm looking to be employed...and I don't think it is an appropriate course of action for me to go to college and develop my skills so I can work in a supporting environment, it's just not going to happen... I want to get a job, I don't want to be fannying around on courses for the rest of my life...I want a course which can help me...[Participant E: male].

In this case, although the individual was more concerned about her role as a supportive family member, she felt job ready and was job-hunting independently and rationally, with minimal support:

No, in both cases they were jobs that I found...So, yeah, off, pretty much, on my own back, so credit to me there, I suppose!.. I must have just sat down and thought, well where are jobs advertised? And then taken my lead from my advisor at the Job Centre and then consequently from FEAT in the same way they get their information about job vacancies... [Participant C: female].

In both the following examples, a disconnect between confidence in job skills and confidence in job hunting is apparent. In one case written applications

were the focus of the concern, in the other interview skills, so the perceived weakness was sometimes very specific.

[Interviewer: it sounds almost as if you're more confident about your ability to do a job than you are about your ability to get a job.]

Yes, absolutely, absolutely, you hit the nail on the head [laughs]... I feel more confident in person than I do on paper because I...yeah, I don't know why that is but I think I've got really bad handwriting as well, oh God, and I'd have to write down things like how long have you been unemployed and what you did in between and all that kind of stuff...[Participant A: female]

Well, when I'm thinking about two job interviews coming up next week, my confidence, I wish it was a bit stronger, but, you know, that's maybe just a natural dislike of the interview situation...The interview process though, you know, I think it's just a natural fear of interviews...you know, she's offered to help me more with the application forms, though she...the fact that I'm getting interviews, suggests to her that that's maybe not an area that I'm needing too much support on...[Participant C: female]

Frustration was a feature of the job search experience:

I've had maybe ten interviews... Well that's why you've just got to hang on, the fact that you get to interview stage and in this climate that's remarkable...I really went through a phase, maybe about three weeks ago, of just utter frustration, you know, well what else can I be doing...[Participant C: female].

Media reports of the recession affected some participants:

But my overall, overall ride and experience...of looking for a job is fear ...I hate looking at the news because it keeps saying the number of people out of jobs, blah, blah, blah, and you listen to the radio and Fife Kingdom FM and say there's another two thousand added to...I'm thinking; God, that's all competition. But apart from that my biggest fear is when I've been putting away application forms is having a gap in my employment history...[Participant H: male].

7.3.3 The role of FEAT and the impact of guidance in recovery

FEAT in the context of other helping agencies

Most participants used more than one helping or employability agency either sequentially or concurrently. These included JCP, Skills Development Scotland (SDS), Fife Opportunity Centres, Working Links, Next Step, and Momentum. Some participants seemed to refer to more than one agency when making statements. This suggested that to the extent they were perceived as providing broadly similar services, they were experienced as all part of the same process. Although one participant had used only FEAT, and another complained of inconsistency in advice relating to CV writing from different sources, some seemed very comfortable using multiple agencies.

In most cases the JCP service was referred to as ineffectual, over-focused on monitoring job search behaviour or benefit compliance, and neglecting helping the actual job search itself:

The JobCentre, that usual, they just put you in a box and don't really help you, it's more about making sure you've filled this form in properly and that form out properly. I mean okay, you've got your rules, but circumstance should come into play. [Participant D: male].

But the JobCentre was a complete waste of time for me because I went there and saw a disability rights advisor and he went; oh, er, oh, er, I think what you're doing is great, lots of people just sit on their hands and they're not looking to do anything, just take the benefits, he says; you're clearly not stuck in a benefit trap. I says; I'm not because I'm struggling financially and I'm looking to get back to doing something. So, anyway, I left him and he just gave me his card and that was it, he says; what you're doing through FEAT is what I would have been recommending to you. [Participant H: male].

Other sources identify (different) concerns with JCP services. Dean (2003) conducted qualitative research with a small group of claimants with complex needs and found that although their (mostly New Deal) personal advisers were

generally experienced as helpful, a number of problems emerged. These included ambivalence towards the help offered by the establishment which could be perceived as interference, and promoting self-blame, and the use of 'confessional' CVs. The system was experienced as offering little choice and unsuitable to support their unsettled lifestyles, fragile health and fragmented employment histories. People preferred to do things for themselves, which sometimes meant using private employment agencies to access low paid work.

Some FEAT participants also commented on their experience of using services provided by DWP contractor agencies:

...there's certain government agencies...they have like people within their offices that deal with incapacity and stuff and I know what they are doing is they're going to fuck me off into a training provider and it's not going to do a damn thing for me and it's going to destroy what I'm trying to do for myself and I've had experience with these a few times, you know. [Participant E: male].

This latter opinion was shaped in part by observing the promotion of qualifications perceived to be low value or tokenistic, and also by media stories concerning DWP contractor agencies. Conversely, an exceptional view was this individual who missed the mandatory job search help she received from a DWP contractor, when the service was withdrawn:

ESA aha. Which I thought as well it was a really really good benefit as well because it wasnae like you were on incapacity and you werenae getting help, and they were actually helping you and I thought it was a really really good thing, but I mean the conditions were you had to go to [agency] and things like that and if you didnae your benefit would get stopped, but what had happened basically I used to go in front of a panel and I never received a letter and because I missed it I did get the benefits, got all that stopped which I wasnae very happy about. [Participant J: female].

Initial contact/referral to FEAT

Keyes & Lopez (2002) suggest there is a thread in the counselling literature that conceptualises clients as active agents rather than passive recipients of therapy. Presenting for help is proactive behaviour. Several participants were proactive and self-referred to FEAT. Two participants spotted advertising in the local council jobs bulletin, and acted on it:

...and it was while I was like applying for a job on-line with Fife Council that I noticed a bit of the, it must have been the end of the application sort of form an advertisement for FEAT. Because I think they maybe do something with the Council, or whatever...and it said ken if you've suffered from mental health problems, ken, we can sort of help sort of thing...so I gave them a phone and I don't know who it was I spoke to anyway, but they arranged a meeting for me...
[Participant F: male].

Recognition of, or insight into their situation precipitated this for some, as they became receptive to assistance. This individual seemed to proactively initiate a number of things, including study and volunteering, at the same time as approaching FEAT on the recommendation of her JCP adviser:

Yeah, aha, and I recognised by that stage that I was in a state of depression and I suppose lost...it was hard to focus on... the most beneficial way of getting work, when I was just lost in this fog...And I knew that I had to move through that and any straw that I could grasp on to, I was definitely open to help...[Participant C: female].

In this case the participant recognised the need for a specialist service, and had planned long in advance of the time when she was free to access such a service. She was eventually referred to FEAT after contacting two DWP contractors:

...I knew because I'd been out of work for such a long time...the transitional period is, as everyone knows, is a problem, I knew I was going to need some help, I knew I couldn't just go, go to the JobCentre, phone a job and get a job,

because I didn't have the confidence to do it either...so I knew I needed an organisation that was going to help me bridge that gap... oh probably a couple of years ago I heard about an organisation... that helps people back into work if they've been out of work for a long time basically, but at that time...I ended up caring for my father who had Alzheimer's so I wasn't able to go back into work even though I kind of wanted to. And I kept a leaflet for, I think, probably two years and then eventually...my father died last year and my depression had got much better, I was not as ill and I got in touch...[Participant A: female]

These accounts of self-referral, suggest taking responsibility, being realistic about the situation and future planning or setting intermediate goals, in the latter case over long term period. This suggests the roots of recovery can pre-date engagement with the helping agency. Two participants had come across FEAT at a jobs fair/open day in Glenrothes, and had been impressed by what they heard. In one case it seems that the recognition of her state of depression came at that point:

Originally well they spoke very well, it was when I filled in the form it was a saying and it was true, at this time definite, I was really, really depressed. But I think they are more like meant to be for really, you know, deep problems and maybe my depression wasn't very deep, but it was kind enough to help me. [Participant G: female].

Expectations of the FEAT service seem to have been modest, and not too specific beyond thinking that the service would be attuned to the needs of people experiencing mental health conditions:

But my expectation of it was...well, I don't think any concrete, I had no...I didn't think they were going to have a big file of jobs that they could offer me, I did think that they would have tools, though, to enable me to be able to do that myself...But in my head I had no idea what... [Participant C: female].

I just mean that to start with my expectations were really low, I didn't think that they would be that good, so they'd gone up a little bit with the experience...I thought it would be less personable...everybody's dealt with me as a whole

person not just well you need to get a job, we need to get you into work...[Participant A: female, referring to FEAT and other agencies].

The helping relationship

Accounts of the helping relationship established with the participants, both individually and in groups, were overwhelmingly positive. All of the classic ingredients of a person centred relationship (Rogers, 1951) were identified: genuineness, unconditional positive regard, and empathy. Other generic valuable helping attributes such as consistency, positive attitude and supportiveness also feature here. In some cases accounts of the relationship established with FEAT staff merge with discussion of the experience of relating to fellow service users in a group context, or to staff from other agencies:

And people were very understanding and all the people that I've dealt with...in these organisations have been completely non judgemental and really positive as well...it's not just been the work that I've done with them, it's actually been the people as well, the people have all been really positive. [Participant A: female].

I don't know what else, what kind of else training they do, but I think so far they are there, what is, they are very positive people. All these people who I saw during the day or when I spoke with them, they are kind of positive and they really, really, wanted to help you and you catch a little bit of their attitude and I think, well yes, they get paid, I hope so, but they do a job that they really want to do or you get a feeling like it's not just the job that they do, they really want to do this for you... and you doesn't get this feeling very often any more, like if people have time for you and people put in effort, maybe some extra effort, because of you. You get this extra effort from your friends or from your relatives, but not from strangers generally, and that's very nice to get this help. [Participant G: female].

And I felt in FEAT they gave everybody an equal chance... It's been well looked into and they take their time and they just allow you to come on gently...It's no forcefully. And also I think they were very good at making everybody feel at, at ease... [Participant B: female, referring mostly to a group context].

Bordin's (1979) concept of the working alliance is a key way to think about the helping relationship. Lustig *et al.* (2002) represents a rare attempt to consider this in a vocational rehabilitation context. They found evidence of an association between a strong alliance and positive employment outcomes and perceptions of future prospects. Similarly, Masdonati, Massoudi & Rossier (2009) in a Swiss study found that a strong working alliance in career counselling was associated, not just with improved satisfaction with the counselling, and reduced career decision making difficulties, but also with a higher level of life satisfaction, a key well-being variable. However causality is hard to attribute in these studies, and context matters. Weinrach (2003) suggests that Carl Roger's core conditions are compromised when applied in American welfare-to-work programmes, a context in which benefit sanction may be applied. He proposes a less romantic, more pragmatic approach to helping may be more appropriate - sometimes directive, sometimes foregoing counselling in favour of other kinds of practical support. Clayton *et al.* (2011) similarly found that the relationship of trust between claimants and personal advisers in DWP settings was important, but this could be undermined by lack of time (when handling those with more complex needs), or by role conflict when the adviser was potentially involved in benefit sanctions. Hasluck & Green (2007) in their broader but less systematic literature review on DWP initiatives for the unemployed, conclude that the relationship with the adviser is important, and that mandatory participation tends to be less successful than voluntary participation.

FEAT's work is not driven by welfare-to-work targets or benefit sanctions, and participation is voluntary, so the helping relationship is not compromised. This point did not escape one participant who linked FEAT's ability to be client focused to its funding model:

...FEAT seemed to have a...I don't think they're in a financial climate where they have had to struggle for survival in a sense that some of these other services have, that's maybe got something to do with it, so they don't have to please as many people maybe. That, you know, the resources are not getting forced.

[Interviewer: Oh that's an interesting point; they've got a Big Lottery grant haven't they?]

Yeah, they're not fighting for survival so they're not pouring a lot of their time into their profile. That's true, a lot of services who are fighting for funding and because funding is an issue, they're going to put a lot of their resources into their image, their PR, you know...[Participant E: male].

Another individual had experienced withdrawal of service by another agency due to her failure to attend appointments. FEAT staff seemed to understand non-attendance as a feature of mental health conditions to be expected, and attendance was not linked to benefits or service entitlements. This was particularly valued by this individual, and paradoxically led to an improvement in attendance at appointments:

...they are always on the other end of the phone if you need them or basically talk for any guidance that you need so it is, a support basically that's there and it's good to know that. And I mean they have never let me down ... you can basically rely on them whereas the like before well I had better not miss an appointment and things like that or that this will get taken away from me and having said that, you dinnae have to, you are no constantly worrying about it, it's I mean the first obviously after the first few times I missed appointments I did start going and that because I didnae work myself up saying what are they are gonna think of me and things like that. Whereas I have done that before, it was like basically you want they would phone and say do you want to meet up next week and you would be like aye, phone up. There was nae hard feelings there of you never came to the last meeting and things like that. You could feel relaxed.

[Interviewer: That was different from what you had experienced at other agencies then?]

Definitely yeah...[Participant J: female].

There were very few comments about the relationship with FEAT that were not explicitly positive. One individual felt frustrated that he had not yet found a suitable opportunity through FEAT, and perhaps an uncertainty whether to attribute responsibility for that to FEAT or to his own passivity and narrow

occupational preferences. Perhaps allocation of responsibility had not been explicitly negotiated:

... and I've not discussed this with my employment advisor at FEAT but I think that's where they need to, now I've got a focus what I'd kind of like to do whereas I never had that before, I've narrowed things down, I think FEAT need to sort of say right well although they are a voluntary organisation and it's like me sitting back and letting someone else do all the work...but part of me thinks they're not doing their job but the other part of me thinks is that me just being lazy and I'm no, I could go on the computer myself and do that...

[Participant H]

Some commented at follow up interview on their ongoing contact with the service or awareness of service rationing:

I think FEAT have a limited time or hours or whatever how you call it, how long they can deal with one person. [Participant G: female].

But I believe my year's up now with FEAT, I can't continue with them. Only get a year or so. So I had a letter... 'I'm just writing to you to tell you about closing down your file,' and it's the first time I'd known about it [laughs], so a wee bit a lack of communication there. [Participant I: male].

FEAT interventions

It appears that different elements of FEAT intervention were important for different people. This is consistent with Berzins' (2004) argument that different things help different people, and that what is helpful at one stage of the recovery process may not be helpful at another.

i) Role of the Employment Adviser (EA)

Provision of a FEAT EA is both a service in itself, and the client contact mechanism through which other elements of the service are mediated. As such it is central to the helping process. Participants were overwhelmingly positive

about this service. Support was both practical and emotional. Several participants valued the practical help they received to revamp their CV, or that the FEAT Employment Adviser proactively found suitable job vacancies and forwarded them. In this example CV support turned round a pattern of failed applications, and speculative distribution of the redesigned CV led indirectly to a job offer. In fact he attributed both his success in finding work and his improvement in confidence and mood to his employment adviser's intervention:

Well, aye, so, employment advisor, so as I say my confidence was still really zero basically... when I did have meetings with [FEAT EA] I mean it did like gave me more hope for the future...she not only like gave me confidence, revamped my CV and that, she also went to the bother of actually posting me jobs that had been, that I'd maybe missed in the JobCentre... I actually sent the CV's to people I started getting, ken, acknowledgement about it, and I got a couple of interviews... But just actually having a job again...does give you a bit of a boost obviously...I got my first pay packet the day [laughter]... [Participant F: male].

The EA initiating contact seemed to be highly valued. This was not just for vacancy notification, although that was also welcome. This contact provided evidence that someone cared, and was taking an interest in their journey.

...my FEAT advisor, she'll phone me up to ask how I'm getting on, have I sent any, have I heard from any applications that I'd sent away and...knowing there's somebody there cares about your journey and is taking an interest, you know, in your job search and your immediate plans for the future, somebody is there to...not check up on you but just to support you and to say that you're not on your own...[Participant C: female].

One participant, who lacked supportive friends and family, appeared to suggest that contact from the EA and the associated focus on job seeking helped to stabilise his emotions:

And I didn't start to get emotionally a wee bit more stable until about three months ago when [FEAT EA] got in touch and I got my teeth into doing some applications forms...even filling in an application form I feel I'm doing

something...It fed my self esteem and I felt emotionally, again, yeah, I'm fine, I didn't have a lot of bad thoughts coming out of my mind and stuff...

[Participant H: male].

Emotional support was reported in relation to confidence building, optimism that finding work was possible, or gently challenging negative thinking. The overall effect was motivational:

...they sort of helped me in understanding that there is other places out there that will take folk on that's no worked for that amount of time... It's gave me that push to go out... they are always on the other end of the phone if you need them or basically talk for any guidance that you need so it is, a support basically that's there and it's good to know that... [Participant J: female].

There were some observations of the EA service that were unique to individuals. These included:

- encouraging use of other support services
- providing an opportunity to discuss fears about job hunting
- finding a pragmatic solution to difficulty in knowing what kind of work was suitable, by suggesting safe experimentation through work placements
- offering to accompany the participant to interview for a volunteering opportunity
- the support got so far but could go no further because job hunting was replaced by studying as the main focus.

ii) STARS/STEPS course

With one exception, the entire sample had taken part in the STARS confidence building course. Two participants seemed to have participated in both the STARS and also the STEPS course, during an earlier period of registration with FEAT. They are broadly similar in content. The courses were described positively, in some cases very positively:

*... I've went on the STARS course, I thought that was a tremendous course ...
No, they're taking them [issues] head on which is refreshing, it's really nice...*
[Participant E: male].

*It's allowed me to challenge my thinking...in a more positive manner and also
allow me to deal with my illness as effectively as I could on the day or the time
when it's happening...Without it...I would have still been in this black hole...I
would not be here sitting speaking to you today if I hadn't went on they
courses... During the course at FEAT it taught you how to say no...it gave me
the inspiration to find myself. It also gave me the motivation to get up there and
when I went into that room that people as the same as you felt at one, and I
could speak openly, clearly, confident...it's like your battery, your car, the
battery was flat with me, when I went to FEAT it charged it up...Yes it was, what
was it, that was the Bible I called it actually. The STEP course...It is truly
amazing...That was the gateway for me to see myself. That was the trigger I
would say...It's allowed me to challenge my thinking...in a more positive
manner and also allow me to deal with my illness as effectively as I could...*
[Participant B: female].

The second example above suggests that the course had a central catalytic effect in the recovery process. This participant attributed her gains to the STEPS and STARS courses, which she had participated in during two separate periods of unemployment. They had represented key milestones to recovery, with impacts on managing thinking, assertiveness, mood, energy levels, sense of self-identity and community. More specifically several participants suggested that being with a peer group that shared their issues was very helpful:

*So the fact that I was meeting up with people in a similar situation...And there
was people who'd been out of work for a very long time, there was a guy that
had been an alcoholic, everybody was on the same kind of...we were all out of
work. And people were very understanding...Yeah, and really positive attention
as well, really positive.* [Participant A: female].

*...and, I mean, it was a nice group, everybody gelled and, you know, nobody
was disruptive or, you know, they just entered the programme for what it was
and were able to then just get the benefits...Mmhmm, yeah, oh it definitely has,*

being part of a group again and working together towards a goal, I mean, that's, you know, it's not like work but it's...I enjoyed being back in a situation like that with people, so, yeah. [Participant C: female].

Even attending in the first place could be challenging, as it involved coping with a social situation. This participant overcame a reluctance to leave the house and began to have social contact again through the STARS course. He began to socialise with friends again after participating in the course and concurrently with undertaking a work placement. He began to see himself as normal again, and to use goal setting as a technique:

I was petrified, I was totally petrified. I was frightened, really shaking when I went out the door, the first time I went...It was just total nerves. I mean I got in there and I was sweating buckets, and the BO was bad. Aye, it's like you smell fear, and that's what it was like. I don't know what they thought the first time they saw me, but that's what it felt like, total fear. It felt like I went to a boxing match or something...Yeah eventually I calmed down a bit, because I got used to going to that place and meeting with the same people and that, I started to calm down, each week got a wee bit better. The first two or three weeks it was hard going. It was just that whole thing about going out...It was like you so used to just being in your house and not communicating with anybody... it was a positive influence, no doubt about it. It definitely picked you up, brought your motivation back, and set your focus on something else instead of everyday stress, do you know what I mean? And if you look ahead, you're not dwelling on stuff too much... You always have a goal, and that's the main thing I learnt, I always have a focus somewhere out there. [Participant D: male].

One participant almost dropped out because of finding it difficult to cope with another service user whose behaviour was in a manic phase. More generally there was some self-consciousness in relation to participants comparing themselves to others on the course. One found it normalising; two felt that others on the course had more problems than they did, which helped to put their own issues into perspective. This next example is reminiscent of Warr's (2006) observation that well-being is influenced by comparison against three kinds of benchmark, with other situations, with other time periods, and in this case, with other people:

Yeah, you just realise eventually that there's people a lot worse off than yourself, even people who were on that course were a lot...they were still, like, basically getting treated probably and they were still on their medication and that. And, as I say, by that time I'd obviously come off mine, but...I wasn't like probably as seriously affected as some of them were. They were from all walks of life, skilled as well. I mean there was a doctor, an architect, yeah, and I mean... But, as I say, I mean it did give a bit of a boost to your self- esteem again, gave me a bit more confidence...And it sort of brought me out my shell again a wee bit, yeah. So it certainly helped, aye...So, without the STARS course and [FEAT EA] I doubt if I would have been ken looked so positively for about being able to get a job again...I know that the days that I've had a session with [FEAT EA], or if I've been at the STARS, the five sessions that the STARS courses lasted, ken, you did feel...a bit uplifted once you'd came out... [Participant F: male].

The example above also shows attribution of positive mood to attending the STARS programme. For several participants, activities or learning exercises focused on managing thoughts and building self-esteem were highly valued:

Yeah, I mean they do build you up and make you feel good. Even the tiny wee things, some of the exercises that you're doing, and just the wee exercises that they do gave me a lift, silly wee things. Even like praising people and just saying 'thank you' if someone says, 'well done.' And I got a wee piece of paper with a wee note on it one day, and just felt great and I took the note with me, I said, 'I'm taking this with me,' [laughter] 'cos I could just take it out of my wallet and look at it and go right, I'm okay now, sort of thing. Whereas before I would never have thought of that...[Participant D: male].

This example shows attribution of some modest improvements in social confidence and motivation since attending a STARS course:

Well the first thing was doing the STARS course in May, I've also been more able, I think, to consider looking for jobs...if I was successful doing that job, actually working in it, and it was because of that statement that I found about FEAT, that they would give you support in the early stages of a job, that's

what's keeping me going... And that was a positive experience and it gave me the feeling, well yes, I can get on with other people, right... [Participant I: male].

Whilst the effects of STARS and STEPS seemed to be overwhelmingly positive, there were some suggestions that participants missed the course when it was finished. This example suggests that STARS had a lot of impact, but the gains were lost when the course ended:

...I still felt emotionally like a wreck and I was fearful and everything for about a couple of months. Then I went on the STARS course and my emotions became quite stable and I felt whatever normal is, I felt ready to give something back, I wasn't down or I didn't feel depressed or anything like that or even anxious, I felt good. But then the course finished and I had like a mourning period, as I say, where I missed it and I missed the structure and I got down again and tearful and I could be out walking the dog and bursting into tears, all that kind of thing and a black cloud over me and I just couldn't see any way out of it, no positive thoughts, all negative stuff...[Participant H: male].

This individual reported not feeling better until contacted by their FEAT EA three months later. These reports of post-course deterioration seem to suggest that participation offers temporary access to psycho-social factors that boost well-being. This is analogous to reports that occupational training offers only short term benefits to well-being that do not endure beyond the end of the programme (e.g. Creed, Hicks & Machin, 1998; Donovan *et al.*; Machin & Creed, 2003; Stafford, 1982; Vouri & Vesalainen, 1999). However, the evidence found here that improvements in health can result from confidence building courses in vocational settings, is consistent with the literature (e.g. Creed, Machin & Hicks, 1999; Harry & Tiggemann, 1992; Muller, 1992).

iii) Work experience

Only a minority of the sample had undertaken work experience placements arranged by FEAT. Some were waiting for a placement to be arranged. One had lost a placement because anxieties about travelling had led to non-attendance. Another individual waiting for a placement described the

anticipation as a very positive experience in itself: this spilled over into making daily routine activities easier to fulfil.

If you really, really, want something, like I really, really, really, want to go to library, I think it wasn't easy to find this place, but yes when you found this place and when she eventually phoned me back and told me, look I found you this place, I thought I really was dreaming, because I was happy...Optimism and like a wheel is spinning all the time, it's not like, oh can't be bothered, it's tomorrow is better and there is plenty things out there and you kind of more see things, or you find more outlet, or you are more open and you are more like energetic and you have more time and power to do it and even when schedule it's really, really, busy you still find something to squeeze in, it's good for you. [Participant G: female].

Another individual was pleasantly surprised by his placement, and then disappointed it did not turn into a job:

...I did a placement, printing designs on t-shirts, that was supposed to turn into a job until we had this economic hole...and then there's no trade...Yeah, folk didn't have the money to get their t-shirts done. He's struggling himself now actually. I don't know where the future's pointing; it doesn't look very good at all... [Participant D: male].

For one individual a placement, in this case arranged through FEAT referral to another agency, was a high impact experience. It boosted confidence and self-esteem, made relaxing in the evening easier, and helped with relationships with others:

I actually enjoyed it, I enjoyed it, I find it really rewarding and it boosted my self-esteem, even though...unpaid work and it was voluntary and it wasn't necessarily going to go anywhere, it still boosted my self-esteem because I got up in the morning, early mornings as well which if you've been unemployed for a long time you tend not to get up every morning, you don't have a purpose to get up in the morning, yeah?... I feel much more positive, I feel much more confident in my own ability to actually go out and earn some money, work and be a respected tax payer [laughs] a contributory member of society and all that,

yeah, yeah...I enjoyed my fun even more...I enjoyed that kind of coming home from work feeling a bit tired and I liked to curl up on the sofa with a nice, massive mug of tea...and say; oh, what films are on this week, and things like that...And it felt so much better to do it, it felt so much better to do that because I felt I deserved it...it's not been plain sailing, it has been a bit up and down, like I said, everybody said, absolutely everybody around me said that when I was doing the work placement I was changed, I was a completely different person...[Participant A: female].

At the end of this placement she retained some gains in confidence, apparently because there was now objective evidence of her ability to perform well in a work environment. But the end of the placement did mean returning to prior patterns of behaviour, and increased social pressure to find work:

...after the six weeks once it stopped I was a little bit down, well at first it was fine, but then after a few weeks and I was still hoping that they would take me on and they said there were no positions...So it was great and then after a few weeks of being out, not working again that's kind of a little bit down, a little bit depressed because it's just a bit of an anticlimax really and...everybody knew about it and everybody said; have you got a job yet, have you got a job yet, have you got a job yet, have you got a job yet, or how are you getting on, and stuff, so it's...I'm constantly aware of that. Whereas before the work placement nobody was asking me; have you got a job yet, have you got a job yet, all the time sort of thing, but now everybody's expecting that. [Participant A: female].

This observation is not a trivial one. Bodman *et al.* (2003) reports that service users experience the question 'what do you do' as very painful and difficult. Social situations where people with mental health conditions have to account for their continuing unemployment may be a source of significant distress. It seems that even a short lived activity like work experience has potential implications for social identity, an important element in recovery.

iv) Volunteering and mentoring

Several participants had been involved in volunteering, although some used the term in a way that blurred the distinction with (FEAT arranged) unpaid work

experience placements. FEAT involvement in participants' volunteering varied: sometimes it was limited to encouragement, in other cases referral to volunteer bureau, or taking people to interview. In some instances, activity may have been self-initiated.

It was clear it could have both practical benefits and contribute to building vocational and social confidence:

It's good. It's good to have. First it's reference, but another is you do something and after that you think you've done it you feel, yes, I can do it.
[Participant G: female].

Well that's right, yeah, so that's helped, you know, that's been a benefit as well, able to see... Yeah, well I get my travel expenses back... So I was able to go and visit my sister and see my nephew last night and had my tea there and it was, you know, so it's got that wee bit of a benefit that I've had a nice day at the office and then it finishes off, you know, catching up with the family and otherwise, I just would have been at home, probably just with my Open University books but, you know, I wouldn't have spoken to anybody, I would have been isolated... And the social contact is important, I mean, I think it would be quite hard to work your way through a depression on any level, you know, any degree of depression without social contact... just sitting, you know, talking about Britain's Got Talent or, you know, yeah, just... it's, sort of, like, being part of the real world again... [Participant C: female].

This individual was also volunteering in a hospice and this had led to a broadening of her occupational preferences:

... the volunteering at the hospice... from day one, I've just felt so at home and, I mean, it's challenging, some days are just desperately sad... So I think just seeing the work that the staff do there has maybe awoken me but just... maybe the need to do something real with my life... but I love it... I thought that I would enjoy it but it's been a hundred times more enjoyable than I imagined... I feel, I'm told that I've done a lot for the patients but, you know, I probably come away they've probably done more for me and that's not a bad thing, I think.
[Participant C: female].

Coutts (2007) suggests that volunteering is valuable in recovery because it was less pressurised than paid employment, and involved flexibility and choice. Not all participants welcomed it, however. Two had explored volunteering but not felt the need to pursue it as they had found paid employment; another two were reluctant to participate.

Several participants had been invited to be mentors i.e. taking a one day course as preparation to contributing to group discussions on the STARS programme to support groups of new FEAT service users. In general this offer seemed to be well received, interpreted as very positive feedback. The anticipation of taking on this role was a positive one, even if the activity did not come to pass:

...after it [STARS] they had says to me, [B] how about being the mentor this time. I says oh the second time, I says well that'll be super, and I felt within myself, hurray, imagine you are getting the second opportunity. So I got myself quite excited, but here, hold and below, I was going on holiday ...So, of course, they had to give it to someone else, it was only fair...[Participant B: female].

This individual felt honoured by the offer of a role as a mentor and looked forward to it eagerly:

And I'm really looking to get my teeth into that because I want to give something back to FEAT as well for all the support and help they've given me so far and are continuing to give me. [Participant H: male].

He contributed to several STARS events, but it was sufficiently important to him that he found it hard when there were long gaps between courses, and his services were not needed.

Only recently I'm in a better place because through the winter I was really, really down and depressed...a part of it I tribute to, there was a huge big long gap with me and FEAT either not having any contact or I wasn't offered any mentoring work cause I did a, a mentoring workshop in October and then there was nothing till March basically this year so the more time I've got on my hands

the more time I've got to think and the more to analyse and that's when I tend to go, can go downhill, whereas when I'm occupied or I've got x amount to do in a week and to look forward to...FEAT had given me a boost and phoned me up and said you've got terrific skills, you'll make a great mentor and we've got courses now for you to get involved in and that was a real big sort of self-esteem boost to me which I've got my self-esteem generally is, you know, on the floor so that, that's helped me...[Participant H: male].

More recently he has enthusiastically pursued a volunteer role befriending people with mental health conditions, providing the support that he felt he had lacked at key points.

Global assessment of FEAT

The overall impression of FEAT as a service was an overwhelmingly positive one. Bodman *et al.* (2003) similarly found that service users welcome help for the most part. It is clear that the most participants, with one exception, did attribute change to their involvement with FEAT. Christie & Marshall (2008) found a similar response: health improvements were rapid and dramatic and all of their participants had positive things to say about their CMP practitioners.

The aspect of the service that was perceived to bring about change varied between participants. This individual attributed positive outcomes to the service as a whole, and in particular both hedonic and eudaimonic well-being benefits of work experience placement. FEAT intervention had 'boosted' or 'accelerated' her recovery rather than initiated it:

...So, yeah, it gave me access to all the services and that's been really good...I can't say there's been anything negative about it at all...I have gained so much through...my dealing with FEAT and [agency], it's helped me ten times more than I thought it would... I feel much more positive, I feel much more confident in my own ability to actually go out and earn some money, work and be a respected tax payer [laughs] a contributory member of society and all that, yeah, yeah. [Participant A: female]

This next participant felt she had recovered a lost sense of self through FEAT intervention. The supportive helping relationship was important in this, but the STARS course also played a key role both through teaching positive thinking skills and in rekindling a general interest in attending courses and studying. Positive anticipation of activities facilitated by FEAT contributed to a sense of optimism. In addition volunteering and work placements provided practical benefits of experience, evidence of competence and access to employment references. She describes a full recovery from depression:

...I used to know who I was and I think I kind of lost myself with this years when I came here and I think FEAT gave me an escape and I found myself again and I'm pretty independent, I know what I want and where I ended up, I just needed this somebody who remind me you can do it and because you change country and because blaa, blaa, blaa, you still can do it and I'm now focused...I think FEAT gave me kind of kick, like a positive kick to chose trainings or find trainings or keep my eye more open... I definitely can't say I'm depressed any more, I think that's a good thing ...and getting out of that stage, is really great, honest. That's something that I definitely should thank FEAT... they gave me lots of courage to really try new things or really keep trying, even when things doesn't work out straight away...it's like your battery, your car, the battery was flat with me, when I went to FEAT it charged it up...[Participant G: female]

But no, it was a positive influence, no doubt about it. It definitely picked you up, brought your motivation back, and set your focus on something else instead of everyday stress, do you know what I mean? And if you look ahead, you're not dwelling on stuff too much...[Participant D: male].

...maybe I wasn't entitled really for FEAT help, but they helped me and they made a huge change for me, because really they more for really big problems, but they made a huge change for me and I appreciate it. Glad they exist. [Participant G: female].

This individual explicitly linked his participation in the research to his gratitude to FEAT for helping him.

As I say, FEAT were a tremendous help to me, I thought...so if there's anyway I could help get more funding for their next, whatever, ken I think they deserve it anyway, ken. I mean so that's why I like agreed to...come and blether today, ken...Aye I mean they helped me so...I'd like to help them if I could.
[Participant F: male].

Another individual said that her confidence had improved and that she was proactively job seeking, and now felt work ready. Encouragement or 'push' from her FEAT Employment Adviser, combined with a positive anticipation generated by the expectation of a work placement and a college course, seemed to be making the difference:

I've started looking for jobs a lot more, sending my CV out whereas before I think it was always in my head to do but I never actually done it. Actually I could feel my confidence been a lot more as well within, what I was basically I'm going out and I'm making appointments now whereas before I would phone up and cancel them and what not, but it's sort of gave me a push that I needed ...I'm just basically just looking forward to the next step and hopefully that's going into some kind of work placement or even starting the college course in January... Oh definitely, that's it I mean if there wasnae all these things going on, I don't think I'd probably be where I was months and months ago and I'm just glad that somebody is pushing me forward and basically said there is this out there, there's that out there and given that push to go and do it and believe in myself and get my confidence back up so. [Participant J: female].

Three participants were more measured or balanced in their praise, but still broadly positive nonetheless.

So I would say FEAT's been as good a supporter as they could have been... the only thing I can say is they're pushing me for the mentoring when I really had no belief in it at all but I had to go along with it, but that wasn't an intention on FEAT's part...[Participant I: male].

This one felt that he had not yet gained anything concrete from his FEAT experience to date but felt hopeful about it:

Thus far it's been promising, I've enjoyed it, I think...it was fresh in the kind of things that they've actually involved themselves with and put in front of me, which have been basically highlighting real issues and that's nice to see...
[Participant E: male].

This next example provides the most nuanced view. He felt FEAT was a very good service, and had gained from the volunteering opportunities in particular. However he felt his expectations were high and had not all been met: he had not accessed a work placement or part-time work through FEAT. He felt disappointed that another service user he knew made rapid progress through obtaining a work placement. He came to rely heavily on FEAT at times, and found it difficult when there were long gaps between being contacted by the service. However he balanced this critique with recognition of his own responsibility to initiate contact with the service, his restricted choice of occupation, and the resource limits faced by the service:

...their website's really good and telling you what they can deliver and stuff, but I had this idealistic picture that I was going to be either in some kind of volunteering position within two or three months or work experience, that's what I was looking to gain out of this was I thought that FEAT put you into employers who were very sensitive to people who had mental health issues, they took you in, had a look at you, you could have a look at them and if nothing transpired at least you had a wee bit of work experience under your belt... But the only downside is still, without being terrible about them or negative about them and speaking behind their backs, is I just wish there was more...I really thought they had a whole big gamut or list of employers...mental health is a big journey and it starts with the individual, but you do need a lot of support behind you, family's important, friends are important, but if you really want to get back into college or into work then having an umbrella like the Fife Employment Access Trust is...if it goes away it would be a disaster, in my opinion... so moving on the FEAT thing has been my prop, prop up, sort of, getting me back to doing bits of contribution like my mentoring and I've started to do some befriending through a different firm...[Participant H: male].

As previously discussed, there were some suggestions that the period after an intervention could be associated with partial loss of the gains made, that

interventions were missed when they were over, or that more or ongoing social contact would have been welcomed:

So it was great and then after a few weeks of being out, not working again that's kind of a little bit down, a little bit depressed because it's just a bit of an anticlimax really and I was quite...so I'm still in that kind of situation at the moment really... I haven't really gone back to where I was before though...Because I've maintained and boosted my self-esteem and things like that...[Participant A: female].

[In relation to STARS course] *Although, maybe I'm selfish in saying that, but I just feel I wish there was another one that you can go, but then you can't keep going to their things...[Participant B: female].*

Evidence of post-intervention deterioration can also be found in the quantitative research literature exploring impact of vocational training on well-being. This does not mean that temporary relief is of no value; it may provide a window for action to promote reengagement; at the very least it may demonstrate that distress need not be permanent. Conversely, it may mean that there are risks to self-confidence from participation in employment support initiatives if job outcomes do not follow on, or support is short term. This is a concern that service users are well aware of, even where services overall tend to promote confidence (Joyce *et al.*, 2010).

Some participants suggested that services such as FEAT should be better marketed, or more widely known as there was a huge need for them in the community, and not just for those with diagnosed mental health conditions:

But people that are in my situation, whether it'll be through depression or alcoholism or mothers that have stayed at home with their kids or what, people that have been out of work for a long time, people that are in my position need help with that transition, they're not aware of the services, they're so not aware, and the services have been so good for me and most of the people that I've come across as well in the same situation. It's a tragic waste...[Participant A: female].

Some global comments about FEAT linked, or compared the service to medical services:

And I never...because there was, like, nobody helping me, as far as I was...apart from FEAT. They were probably the best actual medical, well not medical help, but I got the best help I actually got... As I say I mean it was better, better help than I got from my doctor anyway, ken. [Participant F: male].

Similar comparisons are reported by Christie & Marshall (2008) in qualitative research with IB claimants on Pathways to Work. Some felt that their CMP practitioner belatedly gave them the one-to-one support that they had not received from their GP. This next participant explicitly linked his FEAT involvement to a reduced level of usage of primary care services:

There was something else came into my head there... oh yes, I've not found I need to go to my doctor as much, in fact, at all since I joined FEAT...because I'm feeling I'm being helped.

[This was reiterated at follow up interview]:

... I'll follow something up on that that's happened since, not with that specific opportunity. But it's important because it's related to FEAT. Yes, you've mentioned impact to FEAT. Fewer GP visits, yes. I went to visit my doctor for the first time in about a year in February, just to update him ...[Participant I: male].

This last example is intriguing not just because of the implication that reduced need for visits to the GP suggests less perceived distress; it is an important metric for health economists. It provides a very tentative support for Mayston's (2002) suggestion that reduced health costs may be an economic outcome of effective guidance. It is consistent with Seebohm, Grove & Secker's (2002) suggestion that there are strong links between meaningful occupation, clinical improvement and levels of service use. Although very interesting it remains an isolated example; no other participants reported this effect. Aylward & James (2002) do report instances of people identifying improvements to both their physical and mental health resulting from learning advisers' interventions in a primary care setting. In most cases this is an indirect effect arising from

participation in learning, but in at least one example they report an attribution of a direct effect.

7.3.4 Other issues emerging from the follow-up interview

Accuracy of first interview analyses

One of the purposes of the follow interviews was participant validation of the analysis. Before turning to this it is worth noting that in the initial interviews there were some responses to suggest agreement with researcher interpretations, sometimes with an apparent intention to be encouraging, or perhaps a supportive response to the researcher's tentative attempts at checking. This example is a response to summarisation, from a participant who did not attend a follow up interview:

Hmm mm... You're definitely paying attention. [Participant A: female]

The six participants in the follow up interviews were unanimously of the opinion that the account of their views fed back to them was a broadly accurate one. This was expressed both by numerous minor agreements or non-verbal approval throughout the interviews as specific topics were summarised. More persuasive were overview statements, when asked to react to the accuracy of the interpretation as a whole:

Oh, I would say so, yeah... I think it represents it quite accurately. I can't think of any major omissions or anything anyway so. [Participant C: female].

No, I think it was quite accurate. [Participant D: male].

No. I don't think you missed. I think you did pretty well. I think you should be proud of yourself. [Participant G: female].

That's sounds a very, very good summary, you know... in the gist of what, it's bringing obviously a lot of things back to me what I had said and whatever and I

obviously said a lot [laughing]... But I agree with it all... I don't think anything really has been missed. [Participant H: male].

Yes, I would say it's quite accurate, very accurate, that is...[Participant I: male].

Only one participant offered corrections to biographical details; interpretations were not disputed. One participant seemed taken aback by the accuracy, scope and detail of the summary offered, and expressed surprise that he had shared so much in the first interview.

Changes experienced between first and second interviews

The six participants who attended the follow up interviews did seem to have experienced an improvement in their well-being since their initial registration with FEAT. However most of these gains were made in the early stages of their contact with the service; gains between the first interview (at T1: six months) and the second interview (at T2: twelve months) were modest, or negligible. With the exception of one individual whose mood had fluctuated dramatically, gains made had been retained, but not in every case at the higher level associated with initial participation in FEAT activities and interventions, where these had not led to a job.

But yes, I feel going...even to a year ago, I'm much stronger still. [Participant I: male].

Basically, I'm still on the hamster wheel I feel. I finished a placement, it didn't happen; basically the guy couldn't get enough trade, so that never really came to anything...

[Interviewer: *So it'd be fair to say, towards the end of last year, you made, in terms of mental well-being, you made quite a significant improvement, but it's levelled off now.*]

Yeah...But at least I have the knowledge to deal with it now, which is a lot better, because you can recognise a lot of the symptoms, do you know what I mean? Alright, you're feeling depressed, I can alter my thinking I guess. So it's recognising it I think, and making you aware of it, that's what should be getting

taught now to people, how to recognise the pressure and deal with it before it gets too much. Because when you do get to that, it can spiral out of control. You're not yourself, you're definitely not yourself, and you start getting deep, dark thoughts about just running off a bridge. And that's crossed my mind a few times, but that's because of the situation I'm in, do you know what I mean? I wouldn't be thinking about that if I had a job, I'd be too busy getting on with things. But because you're left out of the loop, you just think what's the point? Do you know what I mean?

[Interviewer: *So it will be reasonable to say it's not like you've completely recovered from depression or anxiety, but you've got quite solid skills in managing now, that those skills are there permanently, so you can keep it under control.*]

Just keep a check on it. [Participant D: male]

The relative stability of the participants' position between the two interview periods was striking. It seemed that the first six months of engaging with the FEAT service was an eventful period in terms of experiencing interventions and changes to well-being. The subsequent six months contained relatively fewer events of such impact, and seemed to reflect consolidation of their position. Warrener, Graham & Arthur (2009) in a qualitative study of the CMP on PtW programme suggest that gains in self-esteem were hard to sustain in the long term where no progress was made towards finding work; however where techniques for managing stress in everyday situations had been learnt, then sustained positive impacts were possible. This is consistent with the FEAT evidence: changes of thinking brought about by the STARS or STEPS psycho-educational programmes could be enduring.

7.4 Summary

Ten participants were interviewed six months after registering with FEAT. Of these six participated in a follow up interview at twelve months after registration. Six broad themes emerged from the IPA analysis of the interviews:

- Participants reported challenging life events that had significance for them in the development of their distress. While often these were historic, more recent events were also reported that had played a role in the triggering of their recent episodes of distress, and leaving work.
- Participants gave moving accounts of their experience of unemployment and symptoms of psychological distress. Leaving work was a voluntary or consensual process, but this did not mean there was no distress. Social stigma associated with mental illness, unemployment and claiming benefits was a live issue for them. A minority expressed frustration at their experience as claimants, and assessments of fitness to work.
- Recovery from, and adjustment to a mental health condition seemed to be a complex process that could not be reduced to medical treatment. For some, recovery was a long and arduous journey, and the process was idiosyncratic and sometimes intangible. Rebuilding social identity, taking responsibility, developing a sense of agency, and setting goals all played a part.
- Participants had worked previously, and in some cases had an extensive employment history. Whilst several had confidence in their narrowly defined vocational skills, this did not transfer to confidence in their ability to secure or sustain work into the future.
- Participants had an almost unanimously positive view of the role of FEAT in their lives and the impact of guidance in recovery. Although there was a wider context to recovery, they unambiguously attributed some of their progress to FEAT input. Different elements of the service worked for different individuals. For some the supportive attention of an EA was

important, for others the skills in managing thinking taught on the STEPS or STARS course, for others it was the evidence of their ability to cope on work experience that made a difference.

- At the follow-up interview participant expressed agreement with the interpretations offered of the initial interview. There were few gains in well-being between six and twelve months after registration. Instead they reported some deterioration after interventions were complete. However participants did not regress to the levels of distress experienced prior to the intervention, and some consolidated their gains.

Chapter 8: Discussion

8.1 Overview

This chapter integrates the empirical findings with the literature review. As a starting point, the qualitative and quantitative findings are summarised separately. Then they are integrated: the four elements of the research question are used as a structure for this part of the discussion. The next step is to consider the inferences that can be drawn from these findings.

Three key themes are highlighted and addressed in the light of the integrated evidence. This provides an opportunity to review the potential mechanisms for guidance to impact on well-being so as to assess which channels seem most promising, and to consider the wider implications of the argument.

1. The potential for guidance interventions to have direct effects on well-being. This requires a consideration of the relationship between therapeutic and career counselling.
2. The potential for indirect benefits resulting from guidance interventions as a result of facilitating participation in work or other comparable activities.
3. A discussion of the wider implications for policy and the potential for considering career guidance to be a public mental health intervention.

8.2 Interpreting the findings

8.2.1 Quantitative evidence

As a result of the substantial limitations noted in the methodology, in particular sample attrition, data quality issues, and the absence of a control group, only very limited inferences can be drawn from the quantitative data.

Firstly, looking at objective outcomes, the length of time unemployed is the single predictor that emerges unambiguously from the regression analysis. This variable predicts no outcome being recorded on the FEAT database (which is likely to mean continued unemployment), and it is inversely related to the likelihood of achieving a job outcome. This is consistent with the vocational rehabilitation literature (e.g. O'Flynn, 2001; Davis and Rinaldi, 2004), which suggests that employment history is a more robust predictor of outcome than diagnostic categories. Anecdotal reports from FEAT staff are also consistent with this observation. The number of perceived barriers to work is also inversely related to achievement of work outcomes, but disappears as a predictor variable when unemployment is treated as an outcome. This is understandable if the barriers that prevent employment present less of an obstacle to participation in education and volunteering: those who are prevented from working may often be finding alternative activities.

Secondly, regarding subjective outcomes, there appears to be positive change in well-being in the sample at least while engaged with the service. This pattern was very consistent across the three measuring instruments used, increasing confidence in the observation. In a sense, measures of anxiety, depression and perceptions of psycho-social environmental conditions added no additional useful information to this picture, other than confirming the direction of change of well-being. Arguably the use of $p < 0.05$ level in a repeated measures design with a small sample leads to an over-conservative judgement of significance. With the effects detected on the different measuring instruments at (or in some

cases close to) this level of significance, and strong inter-correlations between them, it seems reasonable to claim that there was a positive change in the sample. Mean changes conceal considerable individual variation in patterns of response. Such fluctuation in mental health conditions are to be expected; measures of clinical significance suggest that there was a modest improvement in the sample.

Assuming the effect is present as measured, it remains impossible to draw any causal inferences from the quantitative data. Multiple regression analysis found no significant relationship between well-being related outcomes and intervention input variables. It is a modest but positive effect on well-being, consistent with the small effect sizes observed for other guidance outcome variables (Kidd & Killeen, 1992; Whiston & Rahardja, 2008). However, it could also be explained by:

- a broader trajectory of recovery which begins prior to registering with FEAT and continues unaffected by interventions
- adaptation or adjustment to unemployment
- an artefact of re-measurement as suggested by Paul & Moser (2009).

Quantitative data concerning interventions cannot be meaningfully linked to either objective or subjective outcomes, in part because of limitations in the recording of data, and also because the level of service, or 'dose size', offered to those more distant from the labour market may be higher.

8.2.2 Qualitative evidence

Notwithstanding the idiosyncratic nature of personal accounts, here the evidence speaks more clearly. In the majority of the sample, there were clear reports of improvement in well-being. In a small minority of cases reports of change in well-being were equivocal, involved fluctuation over time, or other pre-occupations. Causal attributions of positive effects on well-being arising

from FEAT interventions were made in the majority of cases; no attributions of negative effects were made.

Participants understood the role of FEAT in their lives as part of a wider journey of recovery. There were examples of specific FEAT interventions having a powerful catalytic effect, but in other instances the factors that brought about positive change could not be isolated and recalled, perhaps because they were gradual and incremental. Different FEAT services were impactful for different people. For some participation in a confidence building course was a powerful way to rebuild self-concept, and learn skills to manage negative thoughts. For others, EA contact provided practical and emotional support, and evidence that someone cared. For others, a work placement provided rapid positive impact on self-esteem and social confidence.

One caveat to this positive picture is that some participants reported experiencing deterioration in well-being after the end of an intervention. The reasons for this were not always the same. Reduced social contact was a factor, as was false hope of employment being raised leading to unfulfilled expectations (in self or others). Deterioration experienced was in most cases not a return to the pre-registration levels of distress; most of the relevant participants were clear that they did not regress to the baseline. Acquiring thought management skills, and improved self-esteem seemed to give a permanent baseline for well-being at a level slightly higher than their pre-registration levels. All this happened within 6 months of registering with FEAT; no further change was reported in the follow up interviews. It seems that the biggest positive gains to well-being were achieved relatively quickly.

The concept of validity is routinely rejected by qualitative researchers in favour of more diverse approaches to research quality, such as the concept of 'trustworthiness' advocated by Lincoln & Gruba (1989). More specific to IPA, Smith, Flowers & Larkin (2009) recommend use of criteria developed by Yardley for assessing quality of qualitative research, which can be applied here:

- *Sensitivity to context:* Context is reported at a variety of levels here, including policy, economic and local factors. Consistent with the recommendation of Smith, Flowers & Larkin (2009) substantive verbatim reporting has been used to support interpretations. This reporting has sought to be empathetic to the circumstances and perceptions of participants. The impact of FEAT services is understood in a wider context of recovery.
- *Commitment and rigour:* Research quality is underpinned by consistency between ontology, epistemology, methodology and analysis. It is supported by a systematic, thorough and auditable approach to analysis, and confirmatory analysis of one interview by an experienced IPA researcher. The use of follow up interviews provides strong confirmatory evidence to increase confidence in the interpretations made of participant's subjective understandings.
- *Transparency and coherence:* Appendix 3 provides much of the detail recommended by Smith, Flowers & Larkin (2009) to demonstrate transparency in all stages of analysis, including the interview schedule, and analysis protocol, with an exemplar.
- *Impact and importance:* This is explored later in this chapter, most notably in the discussion of key theme 3.

8.2.3 Integrating, and drawing inferences from the findings

Use of triangulation between qualitative and quantitative approaches in a mixed methods design can be approached in more than one way (Erzberger & Kelle, 2003). Amongst other possibilities, findings that are convergent or in agreement could be seen as mutually validating or confirmatory. Alternatively, evidence from different sources could be viewed as complementary or supplementary. Here the findings are linked to the relevant elements of the research question.

Research question 1

Is there a sound rationale for suggesting that career guidance may enhance subjective well-being?

It is unambiguously clear that a rationale can be offered to link guidance interventions to well-being outcomes. Indeed, the application of theory to this question suggests that multiple rationales can be generated. Empirical evidence shows a strong relationship between current career status and health outcomes, and in addition strong longitudinal linkages between lifespan career events and subsequent health outcomes. Studies with robust designs show that group interventions to support job seekers can have positive health impacts, and diverse quantitative and qualitative evidence shows that individual guidance interventions can impact on well-being related variables, most notably confidence or self-efficacy. The evidence generated in the study of FEAT can be taken to offer support to this position, as both quantitative and qualitative evidence points to improvements in well-being in the sample, concurrent with engagement with the service. Taken together theory and empirical evidence suggest that the proposition of a link between guidance and well-being is a defensible position.

Research question 2

To what extent do service users report experiencing changes in their subjective well-being, during and after guidance interventions?

The quantitative data provides evidence of a modest positive change in well-being for FEAT service users over periods of 6 and 12 months. Although consistent across measuring instruments, no causal inferences of any kind can be made from this finding. The qualitative evidence provides confirmatory evidence of improvement in well-being in the sample. It also suggests that the observed changes may not be linear over time; rapid initial improvement, followed by a post-intervention deterioration is a possibility. This was not detected in the quantitative study, but the timing of measurements and participant attrition could obscure it. This finding has resonance with the literature from a variety of sources including the MPRC studies. Evidence from studies of occupational training also raises an issue of deterioration after initial

improvement.

Research question 3

To what extent do service users attribute changes to the effects of guidance interventions?

Here, the qualitative data provides clear evidence that service users attribute the cause of the change in their well-being, at least in part, to the guidance interventions they have received. The nature and extent of the impact, and the active ingredient in the interventions seems to vary between individuals. The impact of the intervention needs to be understood in a wider context of a recovery process that may begin prior to registration and involve other agencies.

Research question 4

Can potential causal mechanisms linking guidance interventions and well-being outcomes be identified?

Drawing on theory, potential causal mechanisms were generated in chapter 2, and expanded in appendix 4. Indeed multiple causal mechanisms, both direct and indirect were identified. Whilst this implies deep linkages between guidance interventions and health outcomes, it means that identifying causal pathways is potentially difficult as there are many contenders to eliminate. A review of the evidence for the main groups of causal mechanisms is provided in this chapter in sections 8.3 and 8.4.

Transferability

A key issue is that of generalisability (in the language of quantitative positivism) or transferability (in the language of qualitative interpretivism). In the spirit of critical realism, the approach here is to transcend this dichotomy by use of the concept of inference transferability. This term is suggested by Teddlie & Tashakkori (2003) who stress the distinction between results and the inferences based on them. They suggest the inferences from multi-method research can be stronger. Transferability can be ecological (across contexts), population

(across groups), temporal (across time), or operational (across measuring methods).

The empirical study conducted in this thesis is specific in its population, geography and time frame. However claims for transferability of inferences can be made. A strong case can be made that unemployed adults with common mental health conditions are not a distinct population from the wider workless community. The rationales and causal mechanisms linking guidance to well-being explored here are not unique to sub-clinical populations. Taken together with the existing empirical literature it is reasonable to claim that this study provides incremental evidence to support the notion that guidance can impact on mental well-being.

The argument is developed further now, by further integrating the findings with the literature such that three key themes can be explored in depth.

8.3 Key theme one: The direct effects of guidance

This section focuses on the potential for career guidance interventions to have direct therapeutic effects on service users. It begins with a review of the direct causal mechanisms suggested in chapter 2. The discussion is then expanded to encompass the literature concerning the relationship between career and therapeutic counselling. A critique of this literature is offered.

8.3.1 Direct causal mechanisms

The impact of a supportive helping relationship

Common factors represent an obvious place to look for active ingredients: if they apply in counselling more generally, it is a small step of logic to suggest they might apply in guidance, or indeed might explain why some approaches work better than others, but there remains a lack of research in this area (Whiston *et al.*, 2005). Among the common factors, the extensively studied concept of the therapeutic alliance represents the most obvious target for research. However Bedi (2004), building on the theoretical work of Meara & Patton (1994), found very few empirical studies specific to career counselling that addressed the impact of the therapeutic alliance on outcomes. In a recent UK qualitative study of five therapeutic counsellors working with young people, the importance of the quality of the relationship, and creating a 'safe space', were among the issues they identified as important. This evidence is used to explicitly suggest that there are commonalities with the work of career advisers (Westergaard, 2012). Similarly, reviews of DWP initiatives (e.g. Hasluck and Green, 2007) suggest that the client's relationship with their personal adviser is important.

In the FEAT sample, the helping relationship clearly emerged as a factor, with the supportive, consistent client centred approach being valued by service

users. Aspects of the helping relationship that were potent varied between participants but included:

- EAs proactively maintaining contact, which was proof that they cared
- a non-judgemental approach
- being positive, encouraging and providing a 'kick'.

Assisting in the management of distress

FEAT service user reports clearly indicate emotional improvement in the first six months. Whilst improvement had a context that was wider than engagement with FEAT, some of it could clearly be attributed to reassurance and encouragement from the EA, or encountering positive opportunities like work experience. However, it was the STARS and STEPS courses, that seemed to be the most potent in this respect, with positive impact on several participants, and dramatic effect on a minority. This is unsurprising as these elements were specifically designed to teach thinking skills and alleviate distress; they were not directly career related.

It seems an employment focused agency can be a viable location for the delivery of a psycho-educational input. There is resonance here with the literature relating to pre-vocational interventions (e.g. Muller, 1992; Harry & Tiggeman, 1992) and use of CBT in CMP contexts (e.g. Kellett *et al.* 2011).

Promoting a sense of personal agency

Here the empirical literature speaks clearly: there is a substantive evidence base for the impact of guidance interventions on self-efficacy (e.g. Gainor, 2006). With some definitions of well-being focusing on functioning and responding to environmental challenges, the perceived capacity to act must be a necessary element of, or precursor to healthy coping in the work domain (Lent & Brown, 2008).

In the sample there were several examples of individuals becoming more proactive while engaged with the service. In some cases these developments

seemed to be in parallel with using the service, perhaps, but not necessarily as a result of it. For a minority, taking responsibility for resolving their own circumstances was a necessary first step to doing this. Some expressed confidence in one aspect of their functioning, such as core vocational skills and motivation. This confidence did not transfer to applying to jobs or coping with their social demands. In this sample, self-efficacy was very domain specific. FEAT input clearly helped restore a sense of agency that was specific to job applications for some, more general for others.

Promoting a focus on the future and external goals

The literature concerning goals is also convincing (e.g. Pomaki & Maes, 2002; Walsh, 2003). Evidence linking goal focused thinking and behaviour with well-being outcomes has emerged from positive psychology, from studies of self-efficacy, and also from the lifespan development literature where the effects of achievement of life goals have been explored in longitudinal studies. Taken together this is persuasive.

For several FEAT participants the setting of goals was a central element in their recovery process, explicitly identified in their testimony. This operated at different levels, from that of a daily 'to do' list, up to long terms plans such as setting educational goals with a view to enhancing employability.

Promoting constructive re-evaluation of past experience

In spite of its strong roots in psychodynamic and narrative counselling, this is not an effect that is systematically explored in the career related empirical literature. Two isolated exceptions are worth noting. McGregor, McAdams & Little (2006) found that higher levels of happiness were related to having personal goals that were consistent with personality traits and linked in a meaningful way to the life stories individuals construct. Cannon (1997) presents qualitative evidence that people often hold distorted interpretations of failures or setbacks. He suggests that such experiences are ubiquitous and aggravated by modern workplace cultures. He goes on to propose that career advisers and counsellors have a role in reviewing past life experience, and helping clients to reinterpret failure experiences.

In the FEAT evidence some participants reported a re-evaluation of either their early experiences (of trauma or experiences that in retrospect could be seen as episodes of mental illness), or of recent triggering events. These seemed to suggest that events were put into perspective and given meaning, in a way that allowed moving forward. However, there is little evidence that these processes were directly resulting from engagement with FEAT; it seemed that this aspect of recovery had happened independently of interventions.

Strengthening identity and self-concept

The centrality of self-concept emerges clearly in both the developmental and also the recovery literature. More specifically, evidence for the impact of guidance on vocational identity is strong, so there are reasons to be confident that this will be an important mechanism (Hirschi, 2011; Whiston & Rahardja, 2008). In the FEAT data, distress could be related to frustrated identity as a worker, or to the meaning of unemployment in a local social context. Issues of self-esteem were raised frequently by participants and were clear that interventions were supporting them in this respect. One key channel seemed to be that feedback from social contacts influenced self-evaluations, which in turn influenced levels of positive or negative affect. For example, one participant's mood was affected by interactions with supportive friends positively when engaged with work experience, and negatively when she had to admit the work experience had finished with no job secured.

One interesting account of recovery began with low skill work in a quasi-industrial setting experienced as depressing and undermining to self-esteem. Support from FEAT to develop life goals and engage in education enabled her to redefine her identity as a student, and the job was relegated to a secondary role to get her through college. As the job became peripheral, it was no longer the measure of her worth, and ceased to be a cause of depression.

It seems clear that interventions can impact on well-being via definition of identity, but that this impact mechanism is often indirect rather than direct: it

involves adopting valued social identity or role. As Price, Friedland & Vinokur (1998) pointed out, an important pathway between work and well-being is its symbolic meaning as a source of life roles and status from which the self is constructed.

8.3.2 The relationship between career and therapeutic counselling

Any consideration of the direct effects of career guidance on well-being outcomes must involve viewing it as a potentially therapeutic intervention. In doing so it is impossible to ignore a long running debate in the literature concerning the nature of the relationship between career counselling and the wider practice of counselling for non-career problems. The debate is one sided, with most contributors arguing for the integration of career and personal counselling. Few argue against this, although a minority of voices suggest that vocational psychology could lose its distinctive identity by getting too involved in the counselling psychology project (Hesketh, 2001; Vondracek, 2001; Heppner & Davidson, 2002). A key argument underpinning the case for holistic practice is that problems from career and personal domains of life overlap and interact with reciprocal effects (Herr, 1989; Krumboltz, 1993; Betz & Corning, 1993; Hinkelman & Luzzo, 2007⁴¹, Lenz *et al.*, 2010). Zunker (2008) stresses that mental health problems are pervasive and affect every domain of life, but it is also the case that work is central to an individual's life story and identity, hence their connectedness is inevitable.

There is empirical evidence that the concerns raised by career counselling clients encompass personal issues and heightened emotions, and are broadly similar in pattern to those presenting themselves for general counselling (Anderson & Niles, 1995; Fouad *et al.*, 2006; Gold & Scanlan, 1993; Lucas, 1992; Niles, Anderson & Cover, 2000; Phillips *et al.*, 1988). Several sources

⁴¹ Hinkelman & Luzzo (2007) also cite evidence from Pace & Quinn (2000) that there is overlap between people presenting for career and personal counselling in a university setting.

(e.g. Blustein, 1987; Burlew, 1996; Croteau & Thiel, 1993; Haverkamp & Moore, 1993; Imbibo, 1994; Lucas, 1993; Lenz *et al.*, 2010; Pope, Cheng & Leong, 1998; Super, 1993; Tolsma, 1993) present case studies demonstrating the entanglement of career with other life issues, together with narratives describing how careers counselling resolved them. Davidson & Gilbert (1993) use dual-career families as an exemplar of the inter-relation between career and the personal. In a feminist qualitative study, Lucas, Skokowski & Ancis (2000) identified the importance of relational issues in the career decision making of depressed female students: parents and significant others represented a key influence in decision-making and the main source of concern for the clients.

These arguments could be considered to be independently supported by evidence of the complex practical, social, economic, and psychological barriers to participation in work and learning experienced by disadvantaged groups (e.g. Harden *et al.*, 2001; Lee & Vinokur, 2007; McQuaid & Lindsay, 2002) which frequently arise in guidance or welfare-to work settings. It is also independently supported by an extensive literature on work-life balance which wrestles with the relations between work and personal domains, and its consequences for well-being (Greenhaus, Collins & Shaw, 2003). The argument that personal and psychological issues are entangled with career issues and need to be addressed together seems to be very sound. However this is evidence about presenting problems, not about the efficacy of interventions, so the therapeutic process must also be considered.

Hackett (1993) characterised the divide between personal and career counselling as a false dichotomy; Blustein (2006) sees it as an artefact of language. Richardson (1996) extends this line of thought by trying to unpack the discourse of separation between career and personal counselling. Seeking a deeper explanation, she attributes the divide to three 'false splits' within the discipline of psychology:

- A split between the normal and the pathological. Here she describes normal functioning as being typically viewed the domain of counselling, and pathological functioning as the domain of psychotherapy.
- Splitting the self. The vocational self is treated in counselling as separate from other aspects of self and identity, as if it can be split off and dealt with separately. This point is echoed by Burlew, 1996. Zunker (2008) also provides a discussion of these issues, emphasising the possibility for 'spillover' of issues between life domains
- A split between the public domain and the private domain. The former is dealt with by career counselling and the latter by personal counselling.

These distinctions are useful primarily because they point to ambiguities in the debate. The term personal counselling is often used, without clarity as to its meaning. It appears to conflate a focus on the domestic (family and relationships; or private rather than public domain), an implication of more intense emotional content, and a higher level of intrusiveness than career counselling. Blustein & Spengler (1995) argue that career *is* personal, whilst accepting that the two domains can also operate separately. Most authors in this debate focus on the career/personal boundary; few sources problematise the boundary between personal counselling and psychotherapeutic or mental health practice (notable exceptions include Persaud, 2001; Super, 1993). Some contributors to the debate explicitly argue that there is no meaningful distinction between career and mental health issues or their associated counselling practice (DeLucia *et al.*, 1989; Burlew, 1996; Lenz *et al.*, 2010). Buckley & Buckley (2006) addresses working at the boundary between normal and abnormal in a coaching psychology setting.

Various attempts to resolve the issue are suggested. One is a continuum of practices between career, personal and psychotherapeutic counselling, addressing a continuum of problems, implying multiple counsellors for multiple problems. Another is to import the continuum into career counselling practice by offering an intervention model with varying levels of therapeutic content (e.g. DeLucia *et al.*, 1989; Chopra, 2009). Others suggest a vocational focus for career counselling, with the capacity to broaden the intervention to cover other

domains. Blustein (1987) advocates concurrent but mutually supporting career and therapeutic interventions for people with substance use issues.

In parallel to the neglect of the personal by career counsellors, some suggest a neglect of work by counselling and psychotherapy (e.g. Blustein, 2006). The focus on inner thoughts and feelings distracts from the realities of social inequality. For example, Jones (1996) argues that the harsh and unethical work environment in the USA demands a political advocacy role for counsellors. A counselling perspective that focuses on the symptom manifestations of health issues risks a politically naïve neglect of the socio-economic roots that cause them:

“Whereas career counselling has seemed too much embedded in the social structure, counselling and psychotherapy, for the most part, are blind to these aspects of the social structure.” (Richardson, 1996: 356-7).

Counsellors' own attitudes or perceptions may be the cause of the career-personal divide (Imbibo, 1994). Some argue that career counsellors, notwithstanding a flirtation with psychodynamic theory, have avoided psychopathology or intra-psychic issues more generally, and prefer brief contact (Spokane, 1989; Burlew, 1996). This reluctance may be reinforced by clients presenting with career concerns resisting their counsellors' attempts to delve into personal or emotional issues (Corbishley & Yost, 1989). Conversely, it has been suggested that generic counsellors neglect career problems raised by their clients in favour of more personal issues, because the latter are viewed as more interesting, and attract better status and reward in the counselling profession (Spengler, Blustein & Strohmer, 1990), a phenomenon described as 'vocational overshadowing'. Subsequent research does not support this conjecture (Spengler, 2000; Magee & Whiston, 2010). Some observers do report student counsellors avoiding career-related options in their training as a result of their perceived lower status (e.g. Heppner *et al.*, 1996).

Issues of the competence of career counsellors to address personal or mental health concerns are raised frequently in this literature (e.g. Niles & Pate, 1989)

Inevitably there are issues of defining the boundaries to practice. Chopra pushes the boundaries of career counselling towards the therapy domain; Robitschek & DeBell (2002) argues for career counselling training to have a broader base, and encompass non-vocational issues, whilst also strengthening the vocational related content of counselling psychology training. Zunker (2008) seems to suggest that career and therapeutic counselling should meet in the middle to create a holistic practice.

Having summarised the career versus personal counselling debate, a number of problems are apparent, and what follows is a detailed critique of this literature. Firstly, the debate has been largely conducted by North American counselling or vocational psychologists. To some extent the discussion could be viewed as an attempt to defend professional status, identity, and boundaries, and is typical of the discourse to be found in many professions. Most contributors are based in university settings where career services sit alongside student counselling services, so some degree of integration is feasible. A few exceptions relate to university based counselling services for the local community used as training ground for student counsellors (e.g. Anderson & Niles, 1995; Niles, Anderson & Cover, 2000; Multon *et al*, 2001); or individuals in private practice (such as Chopra, 2009); both settings in which the integration of the career and the personal is viable. There has been little attempt to extend the argument to mass services for school leavers, or those for unemployed adults, arguably the two largest potential client groups. A Turkish source, Oskay (1997), is a rare exception for offering a throwaway conclusion that schools, hospitals, workplaces and labour exchanges should not be neglected as settings in which career counselling could enhance welfare and happiness. There has been no recognition that the extension of quasi-therapeutic guidance to other settings is potentially problematic. Therapy may not sit so comfortably alongside guidance in contexts that are culturally very different from university counselling centres.

Secondly, the discussion implicitly assumes that career interventions can be equated with career counselling. Even in the work of Blustein (e.g. 1987; 2008), where several elements of this thesis can be found, a quasi-clinical service

centred on the counsellor is assumed. This assumption would not normally be made in the UK, where counselling has more often been seen as just one of a number of activities carried out under the umbrella heading of career guidance (SCAGES, 1993). As Jayasinghe (2001) described, the UK policy environment has been hostile to a counselling conception of career guidance. Currently practice across the four home nations is tending towards remote, information led services, even in universities. Conceptualising careers work as counselling may not sit well in all policy and practice environments. More importantly, it could lead to a blinkered approach to promote well-being related benefits for clients: health promoting interventions do not need to be quasi-clinical or to resemble therapeutic counselling in order to be effective. For example, the MPRC interventions were explicitly employment, not health, focused. Furthermore, there may be issues in providing a holistic counselling approach to service the whole population. The experience in England of the Connexions service personal adviser role was not unproblematic (Watts, 2001).

Thirdly, the career versus personal counselling debate has not yet been fully informed by the growth of positive psychology. The distinction between positive well-being and psychological distress is not often made explicit. The focus is predominantly on the latter, although some sources hint at the former (e.g. Spokane, 1989), talking in terms of work adjustment, and asset rather than deficit based approaches. Loughhead, Black & DeLucia (1989) explicitly see life satisfaction as an outcome of career development work. However, the recent literature does bridge this gap. Savickas (2008) has suggested that vocational psychology was always strength focused and contributing to positive psychology. This is perhaps a post hoc revisionism, rather than historically accurate, but it is a fair point that vocational and positive psychology have pursued similar goals: promoting adjustment, pro-active problem solving, positive thoughts and behaviours.

Finally, and most seriously, the debate is primarily discursive, and lacks a strong empirical basis. Where evidence is presented it tends to be concerned with client needs or counsellor inputs, rather than therapeutic outcomes. It is often in the form of case studies, or surveys addressing the concerns presented

by clients, or the techniques used by counsellors. The research tends not to use the most robust field techniques available: for example, Anderson & Niles, 1995 used post hoc analysis of case notes; Whiston *et al.*, 2005 used role play with pseudo clients. Case studies and expert opinion are undoubtedly valuable, but have a low status in the hierarchy of evidence based practice (as adapted for guidance by Hughes & Gration, 2009a & b). Lack of consistent standards in the reporting of case studies weakens their value: for example Lucas (1993) presents fictitious case studies. The evidence of efficacy rests on counsellors' own testimony: for example Lucas, Skokowski & Ancis (2000) report that in 15 out of 18 cases considered the counsellor believed their client had made progress as a result of the intervention. There is an absence of an independent perspective. Also, the issue of causal mechanisms does not receive systematic attention in this literature.

This is not entirely an oversight. Some recent contributions argue for a new discourse adopting an interpretivist epistemology that rejects empiricism in favour of narrative (Blustein, Medvide & Kozan, 2012; Richardson, 2012).

This thesis attempts to address the empirical deficit by:

- Providing a service user perspective to complement the counsellor reports in the literature. Qualitative evidence generated shows service users attribute improvements in their well-being to the guidance service they have received.
- The data generated in this study also provides some quantitative evidence of improvements in well-being concurrent with receiving an employment related support service. This is supported by evidence from ALMP studies.

8.4 Key theme two: The indirect effects of guidance

This section focuses on the potential for career guidance interventions to have indirect effects on well-being via promoting participation in work or alternative activities that may provide access to health promoting psycho-social factors. It begins with a review of the evidence for the indirect causal mechanisms proposed in chapter 2. The discussion then expands to critically consider the chain of inference required to sustain the notion of indirect effects.

8.4.1 Indirect causal mechanisms

Promoting engaging activity

There is substantial evidence from diverse theoretical and empirical sources in the literature that constructive activity is beneficial to well-being. More caution is needed regarding the extent to which a good P-E fit maximises these benefits: the congruence literature suggests that effects are detectable but are relatively small (e.g. Arnold, 2004). P-E fit concepts are therefore of interest, but should not dominate this discussion.

The quantitative data clearly indicates a proportion of FEAT clients are achieving objective outcomes, but it is problematic to attribute them to the effects of interventions. In the interview sample it was clear that at least one participant got a job directly as a result of support from the EA: the routine and sense of purpose offered by paid employment had clear well-being benefits for him, apparently an example of the latent benefit of time structure. Other cases had gained places in education or volunteering through FEAT. There were too few FEAT participants interviewed who were working to see effects of P-E fit mechanisms in action. Conversely, there was evidence that, at least for male participants, identifying an appropriate choice of work particularly in the light of a medical condition presented a substantial problem. FEAT could go some way towards dealing with this, for example by suggesting use of work experience as

a trial. However the absence of a thorough and systematic vocational assessment seemed to disadvantage them.

This seems to indicate that services such as FEAT can be important in securing work, but the absence of effective assessment of suitable work can be a cause of frustration.

Promoting social participation

The notion that career guidance services promote social participation in general, and combat youth unemployment in particular, is nothing new. Indeed it can be clearly traced as a central theme in the history of guidance services in the UK since the early 20th Century (Peck, 2004). There has been little doubt expressed that this is for the benefit of service users, but the nature of the good has not usually been expressed in terms of health and well-being. The Labour Government (1997-2010) used the discourse of social exclusion and inclusion (Levitas, 1998) from the early days of the administration (e.g. Social Exclusion Unit, 1999) and made this cross-cutting concept the focus, most obviously for guidance services for youth in England. With some exceptions (e.g. Mayor of London, 2007), notions of health and social capital have at best been implicit in this thinking, but most often entirely absent.

There is empirical evidence that guidance interventions can combat isolation and build relationships (e.g. Joyce *et al.*, 2010). However the data generated with FEAT clients had surprisingly little to say about the contribution of social capital to well-being. The FEAT service makes no attempt to work with service users social networks, or to involve key family or friends, which may in part explain this. However methodological weaknesses are likely to be more important here. An attempt was made to quantitatively capture the perceptions of individuals of their psycho-social environments with a view to seeing how these may contribute to well-being. However this attempt appears to have been unsuccessful: it seems reasonable to suppose that the measurement was swamped by a more powerful global well-being factor.

The qualitative data performed only slightly better in this respect. As discussed above, it was clear that family and friendship networks had mixed effects on levels of distress, supplying both a support and a pressure. But it did not emerge as a central concern for all participants, as might be expected from the literature relating social participation to well-being. This may simply reflect limitations or inadequacies in the research process, in particular the researcher seeking to avoid unnecessarily intrusive questioning on a potentially sensitive topic. In one interesting instance, a participant reported re-engaging with his social life simultaneously to beginning his work experience. He did not suggest these two events were linked but the timing may not be co-incidental: perhaps the onset of work experience caused an improved mood which led to social re-engagement, which then made other benefits possible.

However the key issue here is that too few participants in the interview sample were participating in work or learning to form a clear picture. For those that were, social aspects of this experience were not prominent in their reports.

De Silva *et al.* (2005), in their systematic review of studies linking social capital and mental illness make it clear there are methodological and definitional problems to be overcome in this field. It seems likely that a research design needs to address these issues very specifically in order to be successful.

Promoting access to income

Although relatively downplayed in the work of Jahoda (1982) and Warr (2007), Fryer (1986; 1992; 1999) locates the disempowering effects of economic deprivation as the key source of psychological distress. Fryer & Fagan (2003) claim that it is what unemployed people consistently say is the problem. MPRC evidence (including Price, Friedland & Vinokur, 1998) also identifies it as a key pathway to psychological distress. The evidence indicates the relationship between income and health or happiness outcomes is non-linear and strongest for the poorest in society (Benzeval, 2011; Warr, 2007). This suggests those interventions which support the most financially disadvantaged are likely to

have the strongest health promoting effects, a suggestion that intuitively seems plausible.

Contoyannis, Jones & Rice (2004) in an analysis of the British Household Panel Survey (BHPS), found evidence of socioeconomic gradients in health, but also that long-term income was more important than short-term income in determining health outcomes. Similarly Clark, Knabe & Rätzel (2008) use German panel data to suggest that levels of labour market security affect the well-being of those in work. Arguably a career strategy which could lead to greater income over the long term may have measurable health benefits, greater than those associated with rapid placement into marginal work, or dependence on a single employer. This is speculative; Lakey, Mukherjee & White (2001) suggest that panel data sources such as the BHPS are inadequate to study the health impacts of unemployment in general, and the effects of ALMPs in particular.

More directly pertinent is the evidence of the MPRC studies (e.g. Van Ryn & Vinokur, 1992; Vinokur *et al.*, 1991) which suggest that some element of the gains from their interventions could be attributed to the benefits of employment, including income, but by no means all.

In the quantitative FEAT evidence, an item in the vitamin scale asked for the level of agreement with the statement: *I've had enough money to get by*. This item did seem to behave anomalously compared to other items. This may suggest that the issue of income needs to be treated separately, but there is inadequate evidence to interpret this. The interviews were more informative. Two participants talked explicitly about financial problems, another implicitly by reference to concerns about benefit eligibility and subsequent satisfaction at getting a pay packet following FEAT support to find work.

In order to explain the non-equivalent well-being outcomes of different exit routes from unemployment, Strandh (2000) stresses an aspect of Fryer's agency deprivation theory. The frustration of agency caused by poverty has consequences for how life is viewed long-term into the future, making it more

uncertain and less under the control of the individual. Those exits from unemployment that are associated with secure income or improved long term career prospects seem to offer greater improvements in well-being. This also suggests that career guidance with a long term focus may be more beneficial than rapid placement into employment irrespective of job quality. This is consistent with Warr (2007) who identifies career outlook as a factor in well-being, a notion with a future focus.

This is also consistent with the view of Lindsay, McQuaid & Dutton (2007) who argue that the dominance of 'work-first' welfare-to-work approaches needs to be balanced with approaches that include 'human capital development' involving holistic coping and enabling services: the notion of an individual developing a long term sense of direction that reinforces their subject sense of employability adds an extra dimension to their position. Recent evidence from Green (2010) could be taken to support this view. Using Australian household panel data he demonstrated that an individual's perception of their employability is a powerful moderator variable, with the potential to substantially reduce the detrimental effects of unemployment or job insecurity on life satisfaction and mental health.

Facilitating adjustment to current role

An implication of an inter-relationship between careers guidance and well-being is that the vocational adjustment of workers becomes a topic of stronger interest, as support prior to entering the labour market is not the only way to promote well-being. This is not unproblematic as there may be boundary issues with other professions.

There is no relevant evidence from FEAT to draw on here, so it is necessary to turn to the literature. Relevant material can be found in vocational psychology (e.g. Lent and Brown, 2008), vocational rehabilitation (e.g. Hatt & Edmunds, 2010), P-E fit (Dawis & Lofquist, 1984; Furnham & Schaeffer, 1984), coaching psychology (e.g. Palmer & Whybrow, 2007; Fillery-Travis & Lane, 2007; Kauffman & Scoular, 2004), and occupational health psychology (e.g. Baruch, 2009).

There is little professional literature specifically addressing the role of career guidance practitioners in promoting the adjustment of workers in organisational settings. Brown & Brooks' (1985) contribution stands out as they explicitly suggest there is a role for career counselling in the workplace as a mental health intervention. They point out it is different in focus from individual interventions aimed at building worker's capacity to handle stress, or organisational interventions reducing stressors in the environment. Career counselling can address issues such as the role of work in a person's life, perhaps leaving the job entirely, or acting on the job or work setting to make it better fit the person's requirements. As such it may complement traditional stress interventions, and promote adjustment.

8.4.2 Indirect effects: the underpinning chain of inference

If it can be demonstrated that guidance does tend to encourage social participation in work or substitute activities, and that these activities are good for well-being, it could be argued that it does not matter which causal mechanisms are at play. There is ample evidence of the relative benefits of work over unemployment (see chapter 3). There is good reason to believe that guidance interventions can improve participation in work and learning, as service evaluations often demonstrate this (e.g. Scottish Executive, 2005b). Indeed many services have an embedded employment agency function, and their funding is linked to placements into work.

There is also evidence relating to people of working age with health conditions. A systematic review of the effect of welfare-to-work interventions in the UK for people with a disability or chronic illness found positive evidence of employment outcomes from these programmes in general, and vocational advice in particular (Bambra, Whitehead & Hamilton, 2005). Gabbay *et al.* (2011) in an evidence review for NICE of efforts to reduce long term sickness absence found that interventions with a workplace component, including vocational counselling, were more likely to have positive outcomes than those that did not. Regarding

the IPS supported employment intervention for people with severe and enduring mental health conditions, systematic evidence reviews have demonstrated effectiveness in achieving employment outcomes, even though evidence for its clinical impact is unclear (e.g. Crowther *et al.*, 2001a&b).

Two caveats should be noted. Underwood *et al.* (2007) found that there is a dearth of evidence relating to employment outcomes from interventions for people with common mental health condition; no firm conclusions could be drawn on their effectiveness, although there were some indications that proper treatment and management of mental health conditions improved employment outcomes.⁴² A methodological note of caution is sounded by Hämäläinen, Uusitalo & Vuori (2008): although the Työhön studies showed improved employment outcomes, experimental studies may over-estimate these effects. Nonetheless, it seems likely that guidance and employability related services tend to increase the probability of service users entering work.

This represents a pillar of the argument, but is not of itself sufficient. Even if guidance promotes work, and work promotes health, it does not automatically follow that a transition from unemployment into work (or learning) will result in a positive health outcome. The evidence certainly points to the effects of unemployment being largely reversible, but the quality of work remains an issue. Strandh (2000) represents a rare example of a study of the effect on mental health of different exit routes from unemployment. In a large Swedish longitudinal study he found that:

- Exit to employment improves mental well-being but the nature of the contract determines the effect: permanent employment meant larger improvements than short term contracts or self-employment.

⁴² This was an EPPI centre evidence review which found only six studies relating to work outcomes of interventions for people with common mental health conditions; of these only one related to the unemployed. This is most likely because as patients they are treated in primary care and do not access specialist services. The contrast with research into employment outcomes for severe and enduring mental health conditions is stark: they found no fewer than 135 studies, and seven systematic reviews into supported employment. This is in spite of the far greater prevalence of the common conditions.

- Exit to university education was associated with improvements in mental well-being, whereas exit to 'high school' level education offered no improvement.
- Exit to parental benefits improved well-being, exit to sickness benefits decreased well-being, and exit to retirement offered no substantive change.

Wanberg (1995) presents evidence consistent with this view: transitions from unemployment into satisfactory employment reported improved mental health; those moving into unsatisfactory work did not. She concludes that interventions should help people find work that suits their interests, skills and abilities.

This last point implies another leap of logic. If work is good for well-being, and transitions into work tend to improve well-being, and guidance tends to promote such transitions, then it would seem to make sense that guidance promotes well-being. This is a plausible chain of inference, but there is still a need for confirmatory empirical evidence evaluating the impact on well-being of guidance to encourage participation in work or learning. Effective guidance could also be informed by understanding what kinds of transitions into what kinds of opportunity tend to reinforce positive well-being, and an understanding of the processes involved.

8.5 Key theme three: A public mental health perspective

There are wider implications of following through the logic of the argument. If career guidance can be shown to improve well-being or reduce psychological distress, either directly or indirectly, then it can claim a place for itself as a health intervention. As career issues affect almost everyone, then the health impacts are potentially very widespread. The logical conclusion of this line of reasoning is that career guidance has the potential to be a public health intervention, if scaled up to be provided at a population level. Herr (1989) and Loughhead (1989) suggest both a preventive and a treatment role for career counselling, and the adoption of behavioural health approaches. Blustein (2008) explicitly suggests there are public policy implications of accepting the centrality of work and career in health. This line of reasoning has not been fully developed by these authors, or taken up by others. The policy implications have been neglected.

International sources stress the importance of mental health promotion and illness prevention. The World Health Organisation (e.g. WHO 2002; 2004a; 2004b), and the European Union (Jané-Llopis & Anderson, 2005) make it unambiguously clear that these areas should be priority areas for national health policy formation, and that an evidence-based approach should be adopted. The latter source and also the World Health Organisation (2000a) make explicit reference to mental health and the working age population. There is evidence that mental health promotion works (Jané-Llopis *et al.*, 2005). However, in the UK mental health is under-funded relative to the burden of disease it represents, and mental health promotion in particular is neglected (Curran *et al.*, 2007; Friedli & Parsonage, 2007). This is not an issue for the UK alone; the WHO (2005) identifies it as an international problem.

8.5.1 Community psychology and public health

Two movements in psychology have relevance to the concern for public mental health: community psychology and positive psychology. Community psychologists conceptualise mental health conditions as community phenomena with social causation (Fryer & Fagan, 2003) and therefore social solutions. This perspective is interesting, but limited by two factors.

Community psychology (informed by critical psychology) offers a radical critique of Government policy. These positions are consistent with what Watts (1999) would describe as a radical socio-political ideology applied to career guidance, although authors such as Fryer would likely reject this analysis. They are articulate in describing social disadvantage and convey moral authority, but their commentary is sometimes emotive. Walker & Fincham (2011) make a credible attempt at critical policy analysis, but their approach lacks the balance and empirical depth offered by those approaching work and unemployment from a public health perspective, notably Bambra (2011).

Community psychology does share with public health an interest in prevention, although with some scepticism as to how ideas translate from physical to social and mental health domains (Levine, Perkins & Perkins, 2005). The values-based adoption of an emancipatory communitarian approach (Nelson & Prilleltensky, 2005) has limited the community psychology to interventions on a small enough scale that local communities can play a key participatory role. The focus of interest is usually the local neighbourhood (Kelly, 2006) rather than the population level, in spite of the explicit concern with public mental health. This is a valuable perspective, but is not the focus of this discussion.

8.5.2 Positive psychology and public health

Positive psychologists on the other hand have enthusiastically embraced the idea of population level health, and constructive engagement with policy makers. Individualistic self-help interventions are prescribed by some, but Seligman & Csikszentmihalyi (2000) seek to distance themselves from such

approaches; it is at the population level that their contribution is at its strongest. Veenhoven (2004) concludes there is no theoretical or practical objection to the idea that happiness should be a goal of public policy, and proposes it should be more prominent in policy making. Pavot & Diener (2004b) agree, and argue that the SWB evidence base has advanced sufficiently to support this position.

Diener & Seligman (2004) point to the large scale of mental disorders in the population. The evidence suggests that mental health difficulties are more closely related to low levels of happiness and well-being than physical disorders. They go on to summarise evidence that conditions such as depression have been on the increase, in spite of historically rising prosperity, claiming this is a real effect and not an artefact of measurement.⁴³ This underpins the case that there has been an over-emphasis on economic indicators at all levels of leadership in society, and a false assumption that economic growth equates with improvements in well-being. Instead they argue strongly for systematic and consistent use of measurements of well-being by governments. Such measures could steer policy to improve people's lives more accurately than the use of economic measures, such as GDP alone, which is adrift from measuring societal success in developed nations.

This argument challenges fundamental assumption in economics concerning the nature of utility, and the use of monetary measures as a proxy for well-being, but it has had an impact on the discipline. The arrival of positive psychology was trumpeted by *The Economist* (2006). There has clearly been an impact on economists and policy makers, notably Layard (e.g.2004), who shares the concern that treatments identified as effective in ameliorating distress are not available in adequate supply to meet the level of need in the community. Policy commentators such as Marks & Shah (2005) and Delle Fave & Massimini (2005) have argued for the importation of positive psychology, including measurement of well-being, into policy making.

⁴³ This phenomenon is known as the Easterlin paradox. The observation of discrepancy between historically rising GDP and flatlining well-being in developed economies was first pointed out by Easterlin (1974) and has attracted considerable attention.

Tentative steps towards introducing well-being into Government begun by the Prime Minister's Strategy Unit under Tony Blair have been followed by unambiguous support from David Cameron for the idea of national measures of well-being (Donovan & Halpern, 2002; Halpern, 2010). In consequence there has been a recent review of well-being methodologies by the Office for National Statistics (ONS, 2011), and other contributions (e.g. Dolan, Layard & Metcalfe, 2011) with a view to selecting appropriate measures for the UK population. Such measures now form part of the Integrated Household Survey. This is a notable development because, as Halpern (2010) points out, that which is measured is important. UK developments need to be seen in a wider context; most notably Nicolas Sarkozy initiated the international Stiglitz Commission exploring the expansion of GDP measurement into measures of quality of life (Stiglitz, Sen & Fitoussi, 2009).

Bold claims have been made for the policy implications of positive psychology. Even its most bullish advocates do seem to suggest this might be premature (Kahneman, Diener & Schwartz, 1999, xi). Bok (2010) gives cautious support to the value of well-being research to policy, taking care to question the reliability of the evidence base. Halpern (2010) suggests that the well-being research agenda is less revolutionary than has been claimed, but its policy implications are more far reaching than its gurus have realised.

These developments are not uncontroversial. A recent collection of essays from the Institute of Economic Affairs (IEA) challenges the emerging well-being policy agenda (Booth, 2012). Here are arguments that forays of happiness science into economics are guilty of three main faults:

- The claim that economic growth has failed to produce improvements in happiness is based on methodological errors and a false claim that there is an excessive focus on GDP as an outcome measure. (Ormerod, 2012; Sacks, Stevenson & Wolfers, 2012)
- Adopting utilitarian philosophical assumptions, based on Jeremy Bentham's notion that the greatest happiness of the greatest number, would lead to well-being becoming the sole goal of policy (Schwartz, 2012)

- A focus on well-being by Government would inevitably result in a growth of the state, interventionist policy making and threats to individual liberty. (Schwartz, 2012; Bjørnskov, 2012).

It is certainly true that utilitarianism has influenced the well-being policy agenda, as it is explicit in Bok (2010), and Layard (2005). However the approaches to the measurement of well-being cannot be characterised as naïve. Diener *et al.* (2009) are emphatic that well-being measures should be just one consideration among many in policy making, and that interventionist responses do not necessarily follow.⁴⁴

Keyes' (2002) concept of a mental health continuum is useful in making the step from a tribal positive psychology position into a wider public mental health perspective. He suggests that mental well-being is normally distributed in the population as a whole. He places most people (54%) in a mid range of moderate mental health; just 11 % of people are in robustly good mental health, which he describes as 'flourishing'. At the other end of the continuum 18% of people have a mental health disorder, and 11% of people whilst not meeting the criteria for a diagnosed condition, are described as 'languishing'. Whilst the cut offs between these categories may be somewhat arbitrary, this macro-level way of viewing public mental health offers some important insights:

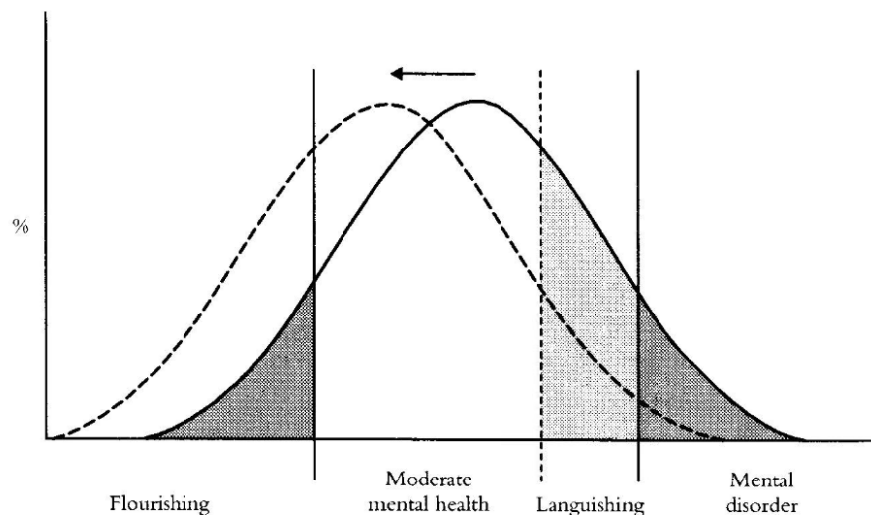
Firstly, interventions that help people with mental health disorders (effectively raising them up into the languishing sector) may not be effective at helping languishers move up into moderate mental health, or to help those with moderate health move up into flourishing. Different interventions may be required for different points on the continuum.⁴⁵

⁴⁴ The IEA critique is clearly from a neo-liberal perspective, and was swiftly rebutted by the left leaning New Economics Foundation (NEF, 2012).

⁴⁵ Butterworth *et al.* (2012) found that poor mental health predicts unemployment, and use this as a basis to argue for a policy of targeted interventions to support people with mental health conditions back into the workforce in Australia. This is consistent with Keyes' point.

Secondly, a small shift in the mean of the normal distribution causes a dramatic shift in the tails of the distribution. Thus a small improvement in population average mental health would substantially reduce the number of people with mental health disorders or languishers; it would also greatly increase the numbers of flourishers. This principle has underpinned public health interventions for physical disorders, such as the major reduction in injury as a result of shifting the safety behaviour of the whole population through wearing seat belts. Counter-intuitively, this suggests that interventions to improve mental health would be most effective if targeted at the whole population, rather than exclusively at those in distress. This approach is not of course the dominant one in the UK, with health resources predominantly going to the sickness focused NHS.

Figure 2: A shift in population mental health from Huppert (2005: 328) using Keyes' terminology



As demonstrated in figure 2, a small positive shift of the mean of population mental health results in a disproportionately large number of people crossing the threshold from mental disorder into languishing, and languishing into moderate mental health. Population level interventions have the greatest benefits for the least healthy. One implication of this is that even very modest effect sizes, such as those found in the congruence literature, could have major implications if they can be consistently produced across a population. This suggests that very small well-being gains from good P-E fit at work should not

be dismissed if they can be replicated on a large scale, as the population effect could be substantial. This observation has interesting resonance with two empirical observations:

- The gradient in the relationship between income and well-being is not linear; improved income has more dramatic positive effects for the poor
- Several MPRC and other vocational interventions have reported greater benefits for the most at risk sub-groups in the sample.

Like Keyes, Huppert (2004) adopts an epidemiological perspective. She draws on work by Rose that demonstrates the distribution of illness is related to prevalence of risk factors in the whole population, not just the sick. This applies also to mental health: it is distributed normally (not bi-modally) in the population. There is no clear boundary between general population and people diagnosed with anxiety & depression, in terms of symptomatology or the presence of risk factors. She suggests whole population interventions to raise well-being levels e.g. targeting schools or workplaces.

Huppert (2005) cites her own research work as providing evidence to support Keyes' thinking. Specifically there is evidence that the mean number of mental health symptoms in a population is related to the prevalence of clinical disorder:

“This implies that explanations for the differing prevalence rates of psychiatric morbidity must be sought in the characteristics of their parent populations; and control measures are unlikely to succeed if they do not involve population-wide changes.” (Huppert, 2005: 327).

8.5.3 Social interventions and public mental health

Having demonstrated there is ample evidence for the importance of social causation in psychological distress, Mirosky & Ross (2003) ask what can be done, and conclude:

“...strategies for preventing distress can be built on a few simple things: education, a fulfilling job, a supportive relationship, and a decent living are to mental health what exercise, diet and not smoking are to physical health.”

Mirosky & Ross, 2003:273-4.

With three out of four elements of their prescription relating to careers, it can be justified to explore the relevance of career interventions within a wider context of social interventions to promote mental health. There is a substantial evidence base demonstrating the impact of social and economic factors on mental health, however there is a relative paucity of evidence on the impact of social and economic policy initiatives on mental health, particularly in the field of employment (Candy *et al.*, 2007). Bambra *et al.* (2010) also point to the lack of evidence and reports they could find only three systematic reviews of the public health evidence related to unemployment and welfare.⁴⁶ Both Lakey, Mukherjee & White (2001) and Coutts (2010) specifically discuss this ‘evidence void’ relating to the health impacts of ALMPs.

Jané-Llopis *et al.* (2005) accept there are substantial gaps in the evidence base and some ineffective interventions, but claim that there is a growing theoretical base and body of empirical evidence for the effectiveness of public mental health measures, with the potential for lasting effects on well-being and additional socio-economic benefits. Social interventions are most likely to have indirect effects on health so there is not just a lack of evidence in relation to

⁴⁶ Crowther *et al.*, 2001a & b: supported employment for people with severe mental illness; Bambra *et al.*, 2005: UK welfare to work programmes for people with disability or chronic illness; Adams *et al.*, 2006: effects of welfare advice in healthcare settings.

their effectiveness, and a need to build the evidence base, but also substantial methodological challenges in attempting to do so.

In the terminology of health research, social interventions such as career guidance would be defined as *complex interventions* because they typically involve multiple components, combined in ways tailored to the individual, in the context of a complex system. Implementing rigorous clinical style randomised control trials can be impractical as Thomson *et al.* (2004) found in their attempt to evaluate the impacts of benefits advice on health outcomes. Similarly, NICE (1999) suggest that there is a strong *a priori* case to be made that there are social benefits of career guidance, but accept that evidence of such outcomes is hard to obtain.

It is problematic for social interventions to reach the whole population, in a similar way that fluoridation of water supplies could reduce tooth decay in the whole population. As a result the prime target for public mental health interventions is most often school pupils (Levine, Perkins & Perkins, 2005; Rothi, 2006) as they represent a large 'captive' target group, with near complete population coverage for an age cohort, and the potential that impacts may have long lasting or multiplying benefits. This is an obvious domain of activity for career guidance services. Another key population for public mental health intervention is employees in the workplace (Barry & Jenkins, 2007), also a potential domain for the delivery of guidance.

8.5.4 Employment policy and public mental health

A weakness of public health policy is that responsibility for it may be restricted to health bodies whose resources are dominated by disease management not prevention, and who lack authority over the areas of life where the root causes of illness can be found. The *Adelaide Statement on Health in All Policies* (WHO/Government of South Australia, 2010) represents an international recognition of the need for 'joined up' government, and that health needs to be addressed in other sectors of social policy. The interdependence of public policy requires a new approach to governance. This view now has a substantial scientific underpinning (e.g. Foresight Mental Capital and Wellbeing Project, 2008). Health prevention requires addressing causal factors and this cannot be done by treatment services:

“The drivers of health lie outside the health sector.” (Marmot 1999, cited by WHO, 2004b:55).

Marmot uses the phrase the 'the causes of the causes' to refer to the social inequalities that underpin biological causation. Bambra (2011) takes this further by her discussion of 'the causes of the causes of the causes'. She identifies employment as the key factor generating the social inequalities which subsequently lead to health inequalities:

“...paid work, or the lack of it, is the most important determinant of population health and health inequalities in advanced market democracies...” (Bambra, 2011: ix).

Reports commissioned by the UK Government and the departmental responses to them show sensitivity to the issues (Black, 2008; Department of Health, 2009; DWP, 2008; HM Government, 2005, 2011; Office of the Deputy Prime Minister, 2004; Perkins, Farmer & Lichfield, 2009). These demonstrate a move away from sole reliance on health and social services towards a broader based public health strategy that involves departments across government. It seeks to

address prevention across the lifespan, and encompasses the working age population.

Three concerns remain. Firstly evidence of effective impact of the work and health agenda is not yet apparent.⁴⁷ Secondly the effects of the economic downturn may undermine elements of the policy. Thirdly, the agenda ignores the potential of career guidance services to make a contribution.

8.5.5 Career guidance as a public health intervention

Policy discourse posits career guidance as a set of interventions with objectives relating to the promotion of economic development, lifelong learning and social equity. In recent years in the UK these have been channelled through a focus on social inclusion. The notion that career guidance could be conceptualised as having public health objectives does not seem to have been considered in the policy studies literature. However there are early signs that it may gain some purchase in the profession:

“...whilst the funding of careers guidance is commonly justified in terms of its contribution to creating and maintaining an efficiently functioning economy, it could equally be argued that it is justifiable in terms of contributing to the health and well-being of the nation.” (Bimrose, 2009:1).

This notion is not new, as it is hinted at by Herr (1989), and explicitly advocated by Blustein (2008), although his interpretivist stance may suggest a reluctance to produce the evidence base for practice in a form that is likely to influence policy makers. This is in contrast to the MPRC initiatives, which adopted an empirical public health focus from their inception (Price, House & Gordus, 1985; Price, 1997; Reiss & Price, 1996). They were not simply welfare-to-work

⁴⁷ Both Stoate & Jones (2010) and Bambra *et al.* (2011) point to the similarities between the Marmot review and the reports on health inequalities produced by Black (1980) and Acheson (1998). Their lack of impact on policy can be attributed to their timing in relation to the political context, and the failure to create structures to deliver the changes recommended, both within the Department of Health, and more importantly, across other departments.

programmes with economic drivers; the prevention of mental health conditions was the key goal. Price, Vinokur and colleagues see work as an important and neglected focus for the prevention of mental health conditions, and that work transitions are associated with risks to health. The MPRC and Työhön programmes are identified by Jané-Llopis *et al.* (2005) as rare exemplars of effective employment related public mental health initiatives for the unemployed. For all its strengths, the MPRC initiative excludes two ingredients that could potentially be potent: career counselling, and psycho-education.

Applying a classification used in public health provides a useful way of structuring this part of the discussion. Interventions could be considered to have three levels of objectives (Levine, Perkins & Perkins, 2005, attribute this categorisation to Caplan):

Primary prevention:

- to prevent the initial occurrence of a health condition

Secondary prevention:

- to limit the duration of the health condition
- to prevent or delay re-occurrence of the condition

Tertiary prevention:

- to ameliorate the severity of the condition

Primary prevention

Primary prevention is indisputably the most attractive option. The MPRC job search programme represents the best exemplar of this category. Any service targeted on unemployed groups could potentially have preventive effects. In addition, pre-redundancy interventions by career guidance agencies could help people to access opportunities, equip them with job hunting skills, and inoculate them against the negative psychological impact of unemployment, by reinforcing self-concept, self-efficacy and teaching strategies to stay socially engaged.

Given the evidence that the developmental effects of unemployment on mental health conditions are potentially serious and long lasting, this area must be of

particular interest as a target for primary prevention (Allen *et al.*, 2007; Monroe & Harkness, 2005). The increase in both the complexity of youth transitions, and the length of time taken to achieve independence, may raise exposure to health risks (Furlong, 2002). At least in Scotland, where a statutory provision remains in the form of SDS, career guidance services are particularly well placed as they potentially have access to the whole youth population in school and also have unique access to those who are NEET. It could be argued then that career guidance services for youth can make a major contribution to limiting the extent of unemployment by maximising access to opportunities. The MPRC interventions suggest it may be possible to 'inoculate' against threats to self-concept and self-efficacy presented by triggering events such as job rejection.

Career education could contribute to and integrate with health education, under the umbrella of personal, social and health education (PSHE), a point that has not gone unnoticed in the Black report:

“Many children already receive Personal, Health and Social Education at school. There is a great opportunity for the links between health, skills and work to be made clear as part of this curriculum...Schools and Further Education colleges should consider including the benefits of work in their health promotion for children and young people.” (Black, 2008: 105-106).

Stallard *et al.* (2010) describe the *Promise Project*, which is an investigation into the effectiveness of a CBT based intervention embedded in PSHE, with a view to reducing depression in at risk pupils. This example is directly not linked to work or career, but it does illustrate the point that this curriculum setting may be appropriate for preventive work. A role in PSHE could be one example of a wider role for guidance agencies in contributing to the work of schools in developing a protective healthy community. It is known that some communities resist the impact of poverty on health better than others; a phenomenon sometimes described using the metaphor of 'herd immunity'. This idea does not seem to have been tested in a school environment, but there is intriguing new

evidence that mental well-being is socially transmitted (Fowler & Christakis, 2008), at least in an adult population, so the notion is not entirely fanciful.⁴⁸

Career education could also be linked to health promotion for adults. A rare example of this is found in an unpublished MSc thesis (Chambers, 2010) describing an SDS career adviser's contribution to the *Island Health Road Shows*, conducted as part of a NHS/voluntary sector partnership health promotion programme on the islands of Colonsay, Coll and Tiree in 2009. Although not rigorously evaluated, positive feedback from participants is reported. This represents innovation by an individual practitioner; not organisational policy, and shows that a health promotion context for career interventions is conceivable.

In a university context, Smith, Myers & Hensley (2002) describe a career education programme for undergraduates incorporating a health promotion element within a broader life-career planning approach. This group based approach was explicitly influenced by calls for an integrated career and personal counselling, and the authors report it was well received by participants.

The issue of primary prevention is important. In spite of the large burden of disease represented by depression for example, relatively little is known about the effectiveness of early intervention. Evidence for the effectiveness of mental health promotion interventions with young people is inconclusive (Harden *et al.*, 2001). So this represents a key target for research effort: the potential value of knowledge in this area is great (Allen *et al.*, 2007; Gillham, Shatte & Freres, 2000). The DALYs impact of mental health conditions is magnified by their early onset. One longitudinal study concluded:

“The clinical implications of this research suggest that family, education and work-related events might be important domains for intervention for the primary and secondary prevention (relapse prevention) of MDD [major depressive disorder] among vulnerable youth.” (Friis *et al.*, 2002: 249).

⁴⁸ Further credence to this suggestion is lent by reports of local contagion effects which seem to operate in some instances of suicide, a phenomenon that has been observed in the UK (Bell & Blanchflower, 2004).

Secondary prevention

Evidence from the study of FEAT services suggests that it is at the very least plausible to postulate a role for guidance agencies in secondary treatment and prevention. Service users' accounts suggest that using an employability service as a platform for a psycho-educational intervention (STEPS/STARS workshop programmes) could be effective, in some cases highly effective. The evidence, albeit imperfect, suggests that well-being improves with contact with the service. Even though recovery was complex, subtle and idiosyncratic, it seemed that FEAT was involved in reinforcing the process. Evidence from the follow up interviews suggests that even in the absence of success in gaining work, there were gains in coping skills and emotional resilience that were reported, suggesting that full relapse was less likely as a result of FEAT intervention. Seen in the light of the quantitative evidence of employment outcomes from VR interventions such as IPS, and qualitative evidence emerging from the recovery movement (Coutts, 2007; Crowther *et al.*, 2001a&b; Seebohm, Grove & Secker, 2002) the evidence for secondary prevention, if not conclusive, is at least very promising.

Tertiary prevention

To some extent work-related tertiary prevention already exists in the form of the use of CMPs on work activation programmes, and the promotion of (usually part-time) employment for those with severe and enduring mental health conditions. These activities had tended to be the domain of specialist OH and VR services, the NHS, and DWP contractor agencies. Career guidance or employability agencies have not normally provided these services, although there may be a rationale for them doing so.

Career services as a platform for health interventions

An important point is that career guidance services could be a valuable platform for impacting on public health. There is currently a gap in provision:

“While there are structures for disseminating interventions for general health, physical health and mental health, there is currently no structure through which we can promote psychological health and well-being. Where do you develop a psychological health delivery system, especially for people who are unemployed? In other words, whose core business is it to address the psychological effects of unemployment?” (Rose & Harris, 2004: 301).

A pre-existing delivery infrastructure is good for cost effectiveness. More importantly, these services are uniquely placed for the delivery of psycho-social interventions to prevent the onset of mental health conditions in young people, by virtue of their role in providing both universal and targeted services to youth. Unlike schools they potentially have access to NEET groups and older teenagers/young adults around the likely age of onset of these conditions, so engage with all the key vulnerable groups. This makes a number of things possible beyond simple re-engagement in work or learning including early referral to health agencies for those at particular risk.

They could offer a platform that is not stigmatised by clinical associations. There is the potential for avoidance of stigma, and attracting service users groups that may disdain personal counselling but would accept alternative formats for help, such as men (Robertson & Fitzgerald, 1992).

Taken together the work of Keyes (2002) and Huppert (2004) represent an argument for both universal and targeted public mental health promotion. State career guidance agencies may be uniquely placed to contribute to this agenda because of their potential to access school pupils, NEETs and adult unemployed, the most important target groups for public mental health interventions.

8.5.6 Arguments linking the health and economic outcomes of guidance

Social policy in relation to career guidance has been driven by concerns of economic effectiveness (directly or indirectly via promotion of lifelong learning), and social equity. Few policy papers on the subject refer to health issues with the exception of Mayston (2002) and Gillie & Gillie Isenhour (2005) whose attempts to describe the macro-economic effects of guidance interventions include reduced costs associated with sickness absence and health care costs. The issue is mentioned in passing in a recent literature review (Hughes & Gration, 2009b).

Mayston (2002) conceptualises career guidance as adding value to human capital, essentially by increasing future earning potential. He identifies a number of economic benefits including reduced cost of unemployment benefits, reduced costs of crime, and increased tax yields to the exchequer of labour activation resulting from guidance interventions. He suggests that guidance may affect quality of life: a broad brush well-being concept which can be operationalised in health economics by DALYs. Even more directly relevant to health concerns is his suggestion that by enhancing income and quality of life, and reducing unemployment, there may be reduced costs on public funded health services (increased tax revenues could offset extra costs resulting from enhanced longevity). Unfortunately, this paper adopts very simplistic conception of the individual outcomes of guidance, perhaps reflecting an abstract level discussion.

A tantalising hint of evidence relevant to this claim emerged in the FEAT study. One participant stated that he had stopped going to the GP as a result of participating in FEAT services; at follow up he stated that he had been once, just to update the GP on his situation. Another participant described FEAT services as more effective than the GP, implying they served a replacement function. As GP attendance can be used as a metric both of sickness and of health economics, then perhaps Mayston's suggestion of cost savings on health services is worthy of testing. Booth (2006) adds credibility to this suggestion by

hinting that employment advice in GP surgeries might reduce the use of primary care services and that this is potentially important, given the strain on those services. The evidence from the *Prescriptions for learning* studies (e.g. Aylward & James, 2002; James, 2004) also suggests educational guidance may indirectly lead to improved health behaviours that could conceivably reduce the need for treatment.⁴⁹

This resonates with research into other employment support interventions for people with severe and enduring mental health conditions. Burns *et al.* (2007) report a European trial in which IPS was associated with reduced rates of psychiatric admission and shorter periods in hospital. Similarly, In the USA, Bush *et al.* (2009) found lower levels of mental health service use among those in steady employment compared to those who were not, a difference they describe as highly significant statistically, and suggestive of substantial cost savings to be gained from supported employment.

Vinokur *et al.* (1991), and Price, Vinokur & Friedland (2002) estimated the economic utility of the MPRC job search intervention. They make assumptions about long term gains based on estimated earnings projected to retirement age. This is unsafe given what we know about the fragmented career biographies of some marginal workers. More plausible are their calculations that the intervention not only impacted positively on the income of participants, but would pay for itself in two years as a result of reduced welfare payments and increased tax yields. They go on to address a key concern: whether supporting an individual into a job merely displaces another, generating no net gain to society. Accepting this as problematic, they argue that there are net economic gains due to the more rapid filling of vacancies and the improved match of individual skill sets to jobs.

⁴⁹ Adams *et al.* (2006) in their systematic review of the effects of benefits advice in healthcare setting concluded there was evidence of financial benefits but not health gains. There were reports of improvements in well-being reported in the studies they reviewed, such as reduced worry, but they judged the quality of that evidence insufficient to draw conclusions. Conceivably reduced healthcare needs might also result from financial guidance, but this is speculative.

This is a specific instance of a wider concern about guidance: whether it represents a private or a public good (Watts, 1996). To be more specific, this could represent a 'positional good'⁵⁰ i.e. of benefit to service recipients at the expense of non-recipients in accessing a finite range of opportunities in a social hierarchy. There are debates as to the extent to which education can be considered as a positional good (e.g. Hollis, 2006). This has resonance with studies of happiness which demonstrate that social comparison is an important factor (Warr, 2007). People seem to derive positive feelings from having relative advantage over others, and psychological distress is associated with low social status.

An alternative way of framing this thinking at a more macro level, would be to say that guidance services affect only the supply of labour; not the demand. Even if this is the case, it does not render guidance activity futile, as it may act upon social mobility, and the equitable distribution of life chances.⁵¹

8.5.7 Challenges to a public health rationale for career guidance

Whilst the thrust of this argument is to characterise career guidance interventions as potentially therapeutic or preventive, it should not be assumed that this position is unproblematic. It raises four difficult questions.

Firstly, advocates of a holistic approach that integrates career and therapeutic counselling have not articulated what that would mean in the context of mass services for school leavers or in a welfare-to-work context; i.e. those areas

⁵⁰ The notion of a positional good is attributed to the economist Fred Hirsch (1995), who contrasted the positional economic with the material economy: the former relates to scarce desirables which provoke status competition; the latter to goods and services that can increase in supply with public desire for them.

⁵¹ A more technical economic argument is alluded to by Korpi (1997) who cites Layard as a source. Reduced well-being due to unemployment may lead to reduced motivation, skills acquisition or performance at job interview, all of which lead to reduced chances of getting a job. Scaled up this means a stock of unemployed who are unable to compete in the labour market. This in turn reduces the supply of labour, drives up wage levels, and sets a higher equilibrium for unemployment. Conversely, ALMPs may, at least in theory, affect labour supply positively.

where state policies have most influence, and a public health role for guidance is most feasible. A key issue is: do these ideas scale up? The MPRC evidence suggests that they might: the scaling up of job search support is viable. Career guidance services don't have to be confined to small agencies; in some European states they are embedded in public employment services, although there can be role tensions where this is the case (Sultana & Watts, 2006).

Secondly, could career guidance interventions have iatrogenic effects? The guidance impact and evaluation literature shows a reluctance to consider the possibility of harm resulting from interventions, with the possibility mentioned only in passing by a few (e.g. Oliver, 1979). The more general possibility of perverse consequences of interventions is accepted by Hughes & Gration (2009b). These exceptions aside, the tendency is to assume benign ineffectiveness, where positive impacts are not detected. Any claims to assess health impacts via interventions should take the possibility of iatrogenic effects seriously. The most obvious risk is through raising expectations of employment that cannot be met, with possible consequences for income, self-esteem or depression. This is a risk that service users are very aware of (Joyce *et al.*, 2010). Even where expectations are met there is a possibility that the achievement of career goals may bring individuals into contact with a new group of people presenting a less favourable social comparison benchmark, with negative implications for well-being.

Thirdly, the guidance-health linkage could be taken to suggest an extension of therapy into previously non-therapeutic domains in education and work. This movement is not without its critics. The concept of education having a therapeutic function has been directly attacked by Ecclestone & Hayes (2008). They argue that the encroachment of psychotherapy into education and the workplace, supported by UK policy post 1997, has gone hand in hand with the development of a celebrity confessional culture in the media. The result is an introspective curriculum, a preoccupation with emotional literacy, a pathologising of everyday experience, and a construction of the self as damaged. Examples of concerns about emotional management practices can

also be found in the organisational behaviour literature, (e.g. Hochschild, 1983; Knopoff & Beckham, 2000; Warren, 2010).

Finally, if guidance services are to be a quasi-mental health service then sociological critiques of the mental health professions may become pertinent to guidance services (e.g. Pilgrim & Rodgers, 2005). As part of the state machinery to manage sickness and employment, they potentially become structures that contribute to the definition of self and identity for 'sick' workers and relocate them as functioning units in the economy (Walker & Fincham, 2011). A radical critique might argue that all guidance, VR, and welfare-to-work services are already a part of state machinery underpinned by neo-liberal ideology, so perhaps careers work embracing occupational health and well-being is a comparatively small extension of role.

8.6 Summary

A summary of the findings of the study, and the knowledge emerging is reserved for the conclusion chapter. This chapter sought to integrate the literature review with the new empirical evidence generated in the study. It provided a discussion of the following areas:

- a summary of the quantitative and qualitative evidence
- a review of evidence relating to the four elements of the research question
- inferences that can be drawn from the findings
- three key emerging themes were explored in depth
 - o the direct impact of guidance on well-being
 - o the indirect impact of guidance on well-being
 - o the implications of conceptualising guidance as a public health intervention

Chapter 9: Conclusion

9.1 Overview

This chapter seeks to integrate the diverse elements of the thesis into a coherent statement of the research outcomes. It is structured in the following way.

Firstly, a summary of the research is provided divided into two sections. The existing knowledge base derived from the published literature is summarised as 'what we already know'. The contribution of this thesis is summarised as 'what this study adds to knowledge'.

Secondly, the conclusions of the study are stated.

Finally, recommendations are made for researchers, theorists, policy makers and practitioners concerning the implications of locating well-being as a key outcome of career guidance interventions.

9.2 Summary of the thesis

9.2.1 What we know already

What we know about social causation, mental health and well-being

- Mental health conditions are commonplace, and have far reaching economic impact on society, in addition to the distress they cause. The associated symptoms and risk factors are normally distributed across the whole population.
- Co-morbidity is commonplace; mental health conditions frequently coexist with physical health conditions and substance abuse. Stress may be central to the mechanisms whereby social factors 'get under the skin'. Mental health conditions may be a key part of the process in the development of physical health conditions.
- Experience of mental health conditions in adolescence is associated with lifelong negative health outcomes. Health problems in young adulthood have long term negative consequences for employment, particularly for young people with lower educational attainment.
- Poverty and social disadvantage are key causal factors in mental health conditions. There are social and income gradients in mental and physical health, with low status and income associated with poor outcomes. A case can be made that the steeper the gradient, i.e. the more unequal the society, the poorer overall health outcomes for the society.
- Isolation and lack of social capital at an individual level, seems to be associated with poor mental health and well-being, but causality is not well understood.

What we know about work, worklessness, mental health and well-being

- Unemployment is associated with poor mental health. Although there may be some health selection effects, there is strong evidence that unemployment is a key causal factor in psychological distress, particularly depression.
- Work can provide access to psycho-social factors that promote good health; less often it can be a source of psycho-social health hazards. However the relationship is complex and inter-active: some workplaces may be harmful to health; some individuals may be vulnerable, so occasionally work may be detrimental.
- Youth unemployment has a scarring effect on individual's lifelong labour market prospects, with social and health consequences.
- Health outcomes are a consequence of causal factors that lie outside the health domain. A persuasive case can be made that employment factors underpin the differences in income and status that are key drivers of health inequality.

What we know about Government policy, work and public mental health/well-being

- UK Government publications demonstrate awareness of social causation of mental health conditions and the importance of joined up work and health policy making. However, mental health remains under resourced relative to its prevalence and in comparison to other major groups of health condition. Cross-departmental public mental health work remains underdeveloped.
- The current ambitious programme of welfare reform may be problematic to reconcile with a period of austerity, and a concentration of claimants with health conditions in areas of long term economic decline that are dependent on public sector employment. Like previous UK labour market policies it demonstrates a supply side bias in focus.

- The reification of work as a panacea for health and well-being has potential drawbacks: low paid, marginal or poor quality work is most accessible to the unemployed and yet may generate few benefits to well-being, risks exposure to psycho-social hazards, and can generate biographies of fragmented insecure employment with negative long-term consequences for health.
- The notion of well-being as a goal of public policy is gaining ground, but its value remains contested.

What we know about policy and provision relating to career guidance, VR & ALMPs

- Provision of career guidance and VR services in the UK is patchy and inconsistent, particularly in England.
- Labour market interventions typically focus on employment outcomes; health and well-being outcomes are rarely considered in either research or performance management.
- Career guidance has been linked to economic development, lifelong learning, educational attainment and social equity goals by policy makers, commentators and international bodies. It has not been seen as a tool to promote health and well-being by any of the key policy sources.
- Historically, career counselling has not been actively encouraged by UK career guidance policy; however counselling interventions have re-entered the employment policy domain via the promotion of the IAPT initiative by Layard.
- Career guidance services are ignored by the Government's work and well-being policy agenda. Equally, the guidance profession has ignored these developments.

What we know about the well-being impacts of career guidance and related employment interventions

- Expert opinion from psychologists in the USA points to the divide between therapeutic counselling and career counselling being artificial; the work and personal domains overlap and intertwine. This is supported by evidence of clients presenting to university counselling centres with inter-related career and personal problems causing psychological distress. It is further supported by case study narratives describing how interventions have successfully resolved these combined issues.
- Whilst expert sourced opinions and case studies are valuable, they are neither the most robust nor the most independent categories of evidence. There is a lack of empirical evidence to support these claims for impact (i.e. evidence of the presence of an effect, the effect size, and mechanisms of impact).
- Nonetheless the suggestion that career and personal (including mental health) problems are intertwined is supported by literature from other contexts. Studies of services for young people and adults who are unemployed or socially disadvantaged, frequently point to the complexity of the issues they face and the associated distress they experience. Studies of work-life balance show the importance of family factors in career.
- Studies of employees also point to career concerns as a source of stress in the workplace. Longitudinal studies suggest that early career experiences may have long term effects on well-being, and that gender and developmental factors may interact to affect well-being outcomes.
- Relatively little career guidance impact research has focused directly on psychological distress or well-being outcome variables. Some isolated studies suggest positive impacts of group interventions.
- However, there is empirical evidence to support the suggestion that career guidance interventions can impact on variables that are related to (or precursors of) well-being. An extensive research base demonstrates the impact of guidance on self-efficacy

(both career related and global). This is independently supported by qualitative studies of adult guidance which show that increased confidence is a frequently reported outcome of guidance, even when there has been no change in employment status.

- Studies of ALMPs usually rely solely on employment outcomes for evaluation. Some exceptions to this rule provide valuable direct measures of psychological distress as outcomes. These include three overlapping areas:
 - o The MPRC “Jobs” programme and its international replications provide robust quantitative evidence that brief group based job search support programmes can positively impact on both employment and reduce levels of distress, although the strength of this effect varies between contexts.
 - o Studies of brief pre-vocational training interventions provide some evidence of improvements in levels of psychological distress, but these may often be temporary, not enduring beyond the end of the programme.
 - o There is some evidence to support the use of CBT based interventions embedded in occupational training or used in condition management interventions alongside employment advice may help to reduce levels of distress and improve employment outcomes. This evidence is not conclusive.

- A plausible argument could be made that it is the most vulnerable groups who may reap the greatest well-being benefits from guidance interventions.

9.2.2 What this study adds to knowledge

- This study has sought to systematically explore the relation between career guidance and well-being. This has included a critique of the existing guidance literature for its failure:
 - o to produce robust evidence of impact on health outcomes
 - o to identify the causal mechanisms that underpin the proposed effects
 - o to recognise the wider significance for policy of producing such evidence.

- A consideration of relevant theories demonstrates that a rationale for linking guidance interventions to well-being outcomes can be developed, indeed multiple possible causal links can be postulated.
- The quantitative findings in this study show that participants in the sample demonstrated a tendency to small but measurable improvements in well-being for the period in which they are engaged with a specialist service. It is not possible to attribute this change to the guidance intervention, based on this data.
- The qualitative findings confirm the existence of the positive changes to well-being detected. They also show clearly that, at least within the sample, service users do attribute improvement in their well-being to the intervention.
- However different aspects of the service appeared to be of benefit to different individuals; multiple causal mechanisms were at work. These included a positive helping relationship, assisting the management of distress, promoting personal agency, future goal focus, and strengthening identity.
- Guidance was not solely responsible for recovery; rather it played a role in the process, perhaps reinforcing an existing trajectory of improvement. Also not all of the gains made were durable: there was evidence of partial post-intervention deterioration.
- The public health implications of guidance have been highlighted, specifically its potential :
 - o as both a universal and targeted social intervention
 - o as a platform for mental health prevention with key target groups
 - o as a preventive intervention with young people and the unemployed.
- The findings also provide evidence to confirm the well-established observation that the length of time unemployed is a better predictor of employment outcomes than mental health diagnosis in vocational rehabilitation.

9.3 Conclusions

The notion that career guidance may have an impact on mental health or well-being is not a new idea; it can be found in counselling sources from at least the 1980s onwards. But it is an idea that has remained peripheral, particularly in the UK, and one that to date has gained little currency in policy circles internationally.

There are reasons to move the concept of well-being to centre stage. There is a long running debate regarding the relationship between career and therapeutic counselling. To this we can now add a large and persuasive body of evidence linking mental health conditions to social, particularly employment disadvantage, and a growing impetus for public mental health measures to counter this. UK employment policy has acknowledged this development, even if the practical consequences of this are as yet limited. The growth of positive psychology as a policy influence reinforces these changes. The entry of CBT into the employment arena potentially opens the door for other counselling related interventions that are able to produce evidence of their efficacy. Each of these developments provides relevant arguments, but to date these literatures have been largely isolated. This thesis has sought to weave them together.

Well-being remains an ambiguous concept, and raises unresolved issues of definition. It may nonetheless prove a more useful banner than mental illness or psychological distress for the career guidance profession. It provides a focus for the study of the subjective outcomes of guidance. It is a concept that encompasses the whole population, and is more appropriate to the predominantly non-clinical settings that guidance operates. It is associated with strength rather than deficit focused practice. It is consistent with positive psychology and public health conceptions of interventions. It resonates with the recovery movement in mental health. It allows for the possibility of positive well-being being partially independent of mental illness, and its promotion also possible for those with enduring conditions. It is in step with the broad direction of travel of policy thinking.

This is not just a question of the profession being in tune with the zeitgeist. There are reasons to believe that career guidance agencies are well placed to impact on well-being. They could provide a good platform for public health interventions, where none currently exists. State guidance providers may potentially access the entire school population and,

unlike schools, also access vulnerable non-attendees. The biggest user groups of guidance: Young people and unemployed adults are also the groups most vulnerable to mental health conditions, and those most likely to benefit from prevention. There are also arguments for workplace career interventions, targeting another key population for public mental health promotion.

In order to realise the potential of these ideas it is necessary for the guidance practitioners to understand the profound connections between careers and health. This would enable the profession to begin a productive dialogue with policy makers. This can only be achieved if a strong evidence base assessing the impact of interventions on well-being outcomes can be developed. This study represents the beginning of such a research agenda: to enhance the guidance impact literature with a new line of enquiry.

This thesis demonstrates that the potential for career guidance to promote mental well-being must be systematically explored: there are theoretical, policy and empirical reasons to believe that this line of enquiry is highly promising. Bambra (2011) posits employment factors as the deep causes of the income and social status inequalities that drive negative health outcomes for disadvantaged groups. To the extent that a career guidance intervention impacts on the way an individual's working life unfolds, then it will also impact upon their health. The empirical evidence generated in this study provides some support to this conjecture.

9.4 Recommendations

9.4.1 Recommendations for researchers

Two technical weaknesses need to be rectified in guidance research. Consistent standards for recording the nature of interventions are desirable to generate evaluation evidence that is useful; this has been clearly lacking to date. Also, evidence hierarchies used in guidance should explicitly address the status of systematic reviews, meta-analyses, case studies and qualitative evidence.

The impact of guidance on well-being is under-researched. The arguments presented in this thesis would be strengthened by replication using a quantitative approach, ideally with a randomised control group design. Where this is not possible use of a comparison group, even if all factors cannot be controlled for, is better than none. More specific designs may be needed to understand the effectiveness of particular causal mechanisms, such as the building of social capital.

In terms of measuring instruments, the WEMWBS performed well as a tool, and appears to have the necessary sensitivity to detect change. Using a measure of psychological distress added no extra value in this instance. As guidance is not normally conducted in clinical settings, and its usual focus is strengths not pathology, then using a positive well-being measure seems most appropriate. In some settings it may be desirable to combine an affective measure such as the WEMWBS with a more cognitive construct such as life or career satisfaction, although these may be problematic for people in transition. Measures of global or career specific self-efficacy may avoid this problem, and their adoption could help to build an already promising evidence base. More generally, a case could be made for the evaluation of guidance interventions to routinely include measures of positive well-being. Including some shorter term measurement points e.g. 2 or 3 months, would be desirable to capture the dynamics of change in well-being.

An attempt to measure psycho-social precursors of well-being in this study appears to have been unsuccessful, so either the approach taken in this study needs further development, or alternative approaches should be considered (e.g. Muller *et al.* 2005).

Qualitative ‘replication’ with different sample populations would also be desirable, but would be better labelled as ‘iteration’. Reports in the guidance literature of enhanced confidence may be worth exploring as enquiry in this area could help to identify what is meant by confidence, and what elements of guidance help to promote and sustain it. Studies need not focus exclusively on service users with mental health conditions. The strength of the concept of well-being is its applicability to non-clinical populations. Any other client group of guidance services is appropriate. Those on the cusp between economic inactivity and social participation may be of particular interest, such as the ‘mainstream’ adult unemployed, or women returning to work after childcare.

Perhaps the area where evidence could have the greatest value would be to explore the potential for career guidance to act as a primary mental health prevention intervention for young people. The lack of knowledge about early prevention, and its potentially large impact on population health means this would be highly prized knowledge. This would require large scale longitudinal studies to explore. The growth of youth unemployment across Europe means this issue is of pressing importance.

9.4.2 Recommendations for theorists

Sociological approaches to careers that draw on structural explanations could be substantially strengthened by linking them to issues of health inequality. The potential for explanations positioning work as a root cause of the causes of health inequality means this avenue should be pursued. At a more abstract level, a critical realist perspective may help to reconcile the structure – agency tension that could arise from juxtaposition of structural theories with psychological approaches emphasising self-efficacy.

Social capital approaches to careers are under-developed. In the light of the potential for guidance to build social capital among excluded groups, and the links between social capital and health outcomes, suggest there may be gains from exploring it.

Conceptualisations of what guidance is trying to achieve could be informed by a consideration of well-being constructs, notably but not exclusively, the notion of

eudaimonia. Keyes (2006) model of well-being provides a good starting point for this work.

Models that suggest workers are affected more or less uniformly by specific job characteristics and work environments, and place less emphasis on occupation or individual differences, have been neglected by the guidance profession. However Kidd (2006) suggests these 'present status' models may be just as valid as P-E fit theory. Warr's vitamin model in particular may have value in helping to identify desirable characteristics of work environments that can be sought out or fostered by the clients of guidance services. This model may need some adaptation, to fully capture some key issues in thinking about careers beyond a single workplace, including the importance of personal finance, long term career security and personal agency.

Sen's (1993) notion of capability has not been adequately explored by career theorists, but there is reason to believe that his focus on valued goals and the capacity to act may provide a deeper philosophical underpinning to guidance practice. There is resonance with concepts of personal agency derived from social-cognitive theoretical approaches to careers, notably self-efficacy, but Sen's conception is much broader and includes a political or moral dimension. As Mulvey (2002) posits autonomy as the central ethical concern of the guidance profession, there is resonance with the values of the profession also.

9.4.3 Recommendations for policy

A powerful argument can be made that the promotion of well-being should take its place as a goal of guidance interventions, to sit alongside economic development, lifelong learning, educational attainment, and social equity. It is to the latter that it is most closely related, as inequality and exclusion have profound health consequences.

The UK Government's work and well-being policy agenda should take into account the potential role of career guidance agencies. Similarly, the devolved administrations in the home nations, and international bodies should be encouraged to consider that career interventions may have well-being outcomes.

Dialogue with policy makers is necessary to promote this vision for career guidance. It may be supported by arguments relating to the potential for economic gains from positive health outcomes in the working age population. This is provided evidence can be generated for gains from increased participation in employment, reduced dependence on welfare benefits, and reduced demand for health and social care services.

9.4.4 Recommendations for practitioners

Where practitioners are working with groups with mental health conditions then necessary steps may include clarification and management of the boundaries to practice; implementing mental health awareness training, and casework supervision; and closer liaison with health service providers. However, these issues arise only if we assume that guidance should resemble health interventions, or seek to target clinical populations with a view to addressing symptoms. The evidence seems to suggest that it may be possible for purely employment or education focused interventions to have beneficial health related consequences, even with unemployed groups with health conditions. It may be that subtle changes to provision could be effective:

- elements of mental health education could be incorporated in interventions
- outreach to locations attended by benefit claimants, or to health service premises.
- promoting long term career planning rather than short term placement into work irrespective of quality
- service evaluation and reporting to encompass measures of well-being
- practitioner research to encourage innovative practice in relation to well-being.

These issues are discussed in appendix 6. Practitioners and their managers must first make the step to recognise their work has health implications.

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Appendices

Appendix 1: Consent documentation

1A: Participant briefing sheet and consent form for well-being questionnaires

1B: Participant briefing sheet and consent form for research interviews

In collaboration with Fife Employment Access Trust (FEAT)

Guidance and Well-being Research Project

You are invited to take part in a research project.

What is the research about?

The project aims to find out how effective services like FEAT are at helping people. In particular we will be looking at whether FEAT is helping to improve the well being of its service users. We hope the project may give us some ideas about how to improve the service in future. The project is largely about the views and opinions of FEAT service users.

What does the research involve?

There are three parts to the research:

1. Looking at the computer records FEAT keeps, to see if they can give us any clues as to which FEAT services are most effective. All FEAT service users will be invited to take part in this part of the research. This would not require you to do anything at all, other than allow the researcher to use the information. If you are a current FEAT service user this may be the only thing you will be asked to do.
2. New service users will be asked to complete simple questionnaires. This will enable us to track of changes in well-being over time – because the questionnaires will be repeated after six and twelve months.
3. A very small number of service users will be invited to meet the researcher and take part in research interviews. These will look at the topic in more depth. This will involve volunteers only, and we will offer invitations nearer the time. Each volunteer will be asked to take part in two meetings, separated by a few months.

Will it be private and confidential?

Yes. Before information from the FEAT database is shared with the researcher, all names, phone numbers, dates of birth and the first two lines of addresses will be removed. For most of the research people will be identified only by a number (the number used on their FEAT records). With the research interviews, it would of course be necessary to meet the researcher face to face. The research reports will be written so as to make it impossible to identify any individual. All information gathered will be stored securely and according to Data Protection Act requirements. All data will be destroyed at the end of the project.

Is it OK to say no?

You do not have to take part in the research if you don't want to. If you decide that you don't want to do it, then you will not be asked to do anything further. You will not be asked to change your mind. You do not have to give any reasons for saying no. Your entitlement to use FEAT services will not be affected. You have a right to say no.

Can I pull out of the research at a later date?

Yes that is ok. If you let a member of FEAT staff know that you would like to withdraw from the project then you will not be asked any further questions. If you have already taken part then you can ask for the information you supplied to be removed from the project records. You do not have to give your reasons. You have a right to withdraw from the project at any time if you want to.

Who is doing the research?

The researcher is **Pete Robertson**. He is involved in training career advisers, and this project is part of his doctoral studies. FEAT is working closely with Pete on the project. The work of FEAT is supported by the Big Lottery Fund. As part of the funding FEAT is required to research its work, and this project will meet that requirement.

In collaboration with Fife Employment Access Trust (FEAT)

Guidance and Well-being Research Project

Do you agree to take part in this project?

Tick one box:

YES

I fully understand what the project is about, and what

I am being asked to do. I am willing to take part.

I understand that I can change my mind at a later date.

NO

I do not wish to take part in the project.

Please do not contact me again about it.

Your signature: _____

Date: _____

Your name (print): _____

For staff only.

Reference Number :

Please hand this to a FEAT member of staff or return it by post to:

Ellie Brown, Fife Employment Access Trust

Collydean Cottage, Pitmedden Loan

Glenrothes, Fife KY7 6UG

THANK YOU

In collaboration with Fife Employment Access Trust (FEAT)

Guidance and well-being research project: research interviews

Thank you for previously agreeing to participate in this project. We hope it will enable us to improve FEAT services, and to learn wider lessons about how advice and guidance services can contribute to the well being of service users. As part of the project a small number of people will be interviewed. This is an invitation to take part in the research interviews. Please read this information and decide if you would like to be interviewed.

This will involve meeting the researcher for about an hour. It will be quite informal. The researcher will ask questions and take notes, and will also make an audio recording of the interview. Recording helps to ensure that that the discussion can later be analysed accurately and in detail.

After a period of about 6 months, the researcher will ask to meet again for a follow up interview. This will be to seek your opinions on the initial research findings and to see if things have moved on for you in between. This meeting is likely to be shorter than the first interview (30-45 minutes).

What will the questions be about? How your life has been changing over the last year or so, in particular how working or studying has been part of your life. The questions will also focus on what FEAT services meant to you, and if they have made a difference to you in any way. There will be no wrong answers – because the research aims to find out your opinions on FEAT and on your own well-being.

Where will the interviews take place? Somewhere near to your home, most likely in the same place that you go to meet your FEAT employment adviser. The interviews will take place in a private room.

Do I have to do this? No, definitely not. You can say no. In fact we expect only about 10 people will take part in the interviews. Your relationship with FEAT will be unaffected if you say no. You don't have to give any reasons for saying no.

If I say yes, can I change my mind later on? Yes, you can withdraw from this part of the project (or the whole project) at any time. If you wish, we can destroy any information you have given us to date. You don't have to explain why you want to withdraw. It is your right to do so. Your entitlement to FEAT services will be unaffected.

If I take part, do I have to answer all the questions? No. You can decline to answer any question. You don't have to explain why. The researcher will respect your privacy if you say 'I prefer not to talk about that'. If we do touch on something personal then you can feel free to let us know if you would prefer to change the subject or to not answer particular questions. Also, because people's experiences are so different, some questions may seem more relevant to you than others, so please feel free to say more on these as you see fit.

Will it be confidential? Yes. Only the researcher (and a colleague who will help with transcribing the recordings) will have access to the recording and notes. Names will be changed so that no one can be identified in the final reports.

What will happen to the recording and to my opinions? The recordings will be kept securely, and in accordance with Data Protection Act. FEAT staff will not have access to them, and nor will anyone else. After the project is completed the recordings will be destroyed.

The thoughts and opinions of the people interviewed will be analysed together so we can get an overview of what people think. Six months after the initial interview the researcher will ask to meet you again to check with you that this analysis makes sense to you and fairly represents your views. He will also check that you are happy with the way your identity has been kept private, before the final reports are produced. This will also be an opportunity to update things - add new opinions or experiences to the research.

Who will be doing the research interviews? The researcher is **Pete Robertson** from Napier University. He is a lecturer who teaches trainee career advisers. He is doing this research as part of his doctoral studies. If you have any questions you can talk a member of FEAT staff, or contact him directly at the contact details given over the page.

Researcher contact details

Pete Robertson

School of Health & Social Science

e mail: p.robertson@napier.ac.uk

Napier University

tel: 0131 455 6288

Craighouse Campus

Edinburgh EH10 5LG

web: <http://www.napier.ac.uk/fhlss/HSS/Staff/Pages/Staff.aspx>

Who can I contact if I have a complaint about the research project?

In the first instance you can speak to either Ellie Brown at FEAT, or to Pete Robertson at Napier. If you are not satisfied with the response you can take the matter further by contacting Pete's supervisor: Dr Maire Brennan at Napier University m.brennan@napier.ac.uk ; tel: 0131 455 6013; address as above.

Thank you

In collaboration with Fife Employment Access Trust (FEAT)

Guidance and well-being research project: research interviews

Do you agree to take part in the research interviews?

Please tick one box:

YES

I am willing to take part in research interviews.
I fully understand what is involved, and that the
conversations will be recorded.

NO

I do not want to take part in research interviews.
Please do not ask me again.

Signature:

Date:

Name (print):

For staff use only

Reference number:

Please return this form to a member of FEAT staff or post it to:

Ellie Brown, Fife Employment Access Trust

Collydean Cottage, Pitmedden Loan

Glenrothes KY7 6UG

THANK YOU

Appendix 2: Well-being questionnaire (sample blank)

Originally presented in A4 booklet format.

In collaboration with Fife Employment Access Trust (FEAT)

Guidance and well-being research project

Please do **not** put your name on this form.
Instead, we can keep your answers anonymous
and private by using a reference number.

For staff use only

Reference Number:

Thank you for taking part in this research.
Please turn over the page and read the instructions.

Instructions

Please answer the questions on the following pages. Each question is made up of a statement about feelings or thoughts. You should tick one box to show how much or how often it applies to you. Here is an example:

STATEMENT		Tick one Box
I've been feeling very tired	None of the time	
	Rarely	✓
	Some of the time	
	Often	
	All of the time	

There are no right or wrong answers – the best answer is the one that seems true to you. It should take about 10 or 15 minutes. Please complete all the questions and continue to the end of the booklet.

Please tick the box that best describes your experience **over the last two weeks**. Do not spend too long on each question, or think too hard about it, the first answer that comes to mind is probably the best answer.

There are three sections:

Questions about your well being and positive feelings

Questions about feeling stressed, or relaxed and enjoying life

Questions about how healthy your environment feels

These questions are about your well-being & positive feelings over the last 2 weeks

STATEMENT		Tick one box
I've been feeling optimistic about the future	None of the time	
	Rarely	
	Some of the time	
	Often	
	All of the time	
I've been feeling useful	None of the time	
	Rarely	
	Some of the time	
	Often	
	All of the time	
I've been feeling relaxed	None of the time	
	Rarely	
	Some of the time	
	Often	
	All of the time	
I've been feeling interested in other people	None of the time	
	Rarely	
	Some of the time	
	Often	
	All of the time	
I've had energy to spare	None of the time	
	Rarely	
	Some of the time	
	Often	
	All of the time	
I've been dealing with problems well	None of the time	
	Rarely	
	Some of the time	
	Often	
	All of the time	
I've been thinking clearly	None of the time	
	Rarely	
	Some of the time	
	Often	
	All of the time	

These questions are about your well-being & positive feelings over the last 2 weeks

STATEMENT		Tick one box
I've been feeling good about myself	None of the time	
	Rarely	
	Some of the time	
	Often	
	All of the time	
I've been feeling close to other people	None of the time	
	Rarely	
	Some of the time	
	Often	
	All of the time	
I've been feeling confident	None of the time	
	Rarely	
	Some of the time	
	Often	
	All of the time	
I've been able to make up my own mind about things	None of the time	
	Rarely	
	Some of the time	
	Often	
	All of the time	
I've been feeling loved	None of the time	
	Rarely	
	Some of the time	
	Often	
	All of the time	
I've been interested in new things	None of the time	
	Rarely	
	Some of the time	
	Often	
	All of the time	
I've been feeling cheerful	None of the time	
	Rarely	
	Some of the time	
	Often	
	All of the time	

These questions are mostly about your experience of stress, relaxation and enjoyment over the last 2 weeks

STATEMENT		Tick one box
I feel tense or wound up	Most of the time	
	A lot of the time	
	From time to time	
	Not at all	
I still enjoy the things I used to enjoy	Definitely as much	
	Not quite so much	
	Only a little	
	Hardly at all	
I get a sort of frightened feeling as if something awful is going to happen	Very definitely and quite badly	
	Yes, but not too badly	
	A little, but it doesn't worry me	
	Not at all	
I can laugh and see the funny side of things	As much as I always could	
	Not quite so much now	
	Definitely not so much now	
	Not at all	
Worrying thoughts go through my mind	A great deal of the time	
	A lot of the time	
	From time to time but not too often	
	Only occasionally	
I feel cheerful	Not at all	
	Not often	
	Sometimes	
	Most of the time	
I can sit at ease and feel relaxed	Definitely	
	Usually	
	Not often	
	Not at all	

These questions are mostly about your experience of stress, relaxation and enjoyment over the last 2 weeks

STATEMENT		Tick one Box
I feel as if I am slowed down	Nearly all the time	
	Very often	
	Sometimes	
	Not at all	
I get a sort of frightened feeling like butterflies in the stomach	Not at all	
	Occasionally	
	Quite often	
	Very often	
I have lost interest in my appearance	Definitely	
	I don't take so much care as I should	
	I may not take quite as much care	
	I take just as much care as ever	
I feel restless as if I have to be on the move	Very much indeed	
	Quite a lot	
	Not very much	
	Not at all	
I look forward with enjoyment to things	As much as I ever did	
	Rather less than I used to	
	Definitely less than I used to	
	Hardly at all	
I get sudden feelings of panic	Very often indeed	
	Quite often	
	Not very often	
	Not at all	
I can enjoy a good book or radio or TV programme	Often	
	Sometimes	
	Not often	
	Very seldom	

Think about whatever you did over the last 2 working weeks when answering these questions –it might be a job, studying, volunteering, leisure activities, doing nothing, or perhaps a mixture of things.

STATEMENT		Tick one Box
I've had a say in what happens and been able to make choices	None of the time	
	Rarely	
	Some of the time	
	Often	
	All of the time	
I've been using my knowledge and skills	None of the time	
	Rarely	
	Some of the time	
	Often	
	All of the time	
I've been working on things that have to get done	None of the time	
	Rarely	
	Some of the time	
	Often	
	All of the time	
I've had a variety of things to do	None of the time	
	Rarely	
	Some of the time	
	Often	
	All of the time	
I have understood what is expected of me and what is likely to happen	None of the time	
	Rarely	
	Some of the time	
	Often	
	All of the time	
I've had contact with other people	None of the time	
	Rarely	
	Some of the time	
	Often	
	All of the time	

Think about whatever you did over the last 2 working weeks when answering these questions –it might be a job, studying, volunteering, leisure activities, doing nothing, or perhaps a mixture of things.

STATEMENT		Tick one box
I've had enough money to get by	None of the time	
	Rarely	
	Some of the time	
	Often	
	All of the time	
I've been feeling safe from danger	None of the time	
	Rarely	
	Some of the time	
	Often	
	All of the time	
I've been making a contribution and earning respect	None of the time	
	Rarely	
	Some of the time	
	Often	
	All of the time	
The person, or people, in charge help and support me	None of the time	
	Rarely	
	Some of the time	
	Often	
	All of the time	
I've been feeling secure and optimistic about my career	None of the time	
	Rarely	
	Some of the time	
	Often	
	All of the time	
I've been treated fairly	None of the time	
	Rarely	
	Some of the time	
	Often	
	All of the time	

Finally, please complete these boxes:

Your sex (*tick one box*): Male

Female

Your age:

Thank you very much for completing the form and for taking part in the research.

Please take a moment to check that you have not missed out any questions by mistake.

Thank you!

When you have finished, put the questionnaire in the envelope, seal it, and give it to a member of FEAT staff if you are with them now.

If you are completing it at home then please return it in the envelope provided. If you can't find the envelope, then please post it to:

Pete Robertson
School of Health and Social Science
Napier University
Craighouse Campus
Edinburgh EH10 5LG

Please mark the envelope as confidential.

Appendix 3: Research interview materials

This section contains materials demonstrating the process of data generation and IPA analysis:

3A: Research interview structure

3B: Sample interview transcription (not included in electronic version of submission for reasons of participant confidentiality)

3C: Systematic process for analysis of transcripts

3D: Idiographic analysis of the themes in the interview with biographical analysis and analysis of follow up interview (not included in the electronic version)

3E. Integrated thematic structure for the interviews (i.e. the outcome of synthesising the idiographic analyses into one structure).

3A: Research Interview Structure

		Notes for interviewer: things to look out for
Introductions		
	Introduce me	
	Check understanding of the project as a whole	Reminder re. Questionnaires/previous consent forms
	Check understanding of purpose & outcomes of interview	Confidentiality
	Check understanding of practicalities	Length of interview Recording Type of questions/content
	Consent form completion	
Topic: Joining FEAT		
Opening question	Tell me the story of how you came to join FEAT...	
Optional follow up questions	What were the issues or difficulties that you had with work or with finding work?	No need to probe into details of mental health issues – discuss only if clients raises them/seems happy to discuss
	What were your reasons for joining FEAT?	On own initiative or pressure from others?
	What did you expect from joining FEAT?	Any reservations about joining? Any specific goals/outcomes desired ?

Topic: Active group participation		
Opening question	How has your life changed since joining FEAT?	Note any comments on social isolation
Optional follow up questions	Compared to before, what is different about how you are spending your time?	
	What groups of people are you involved with?	Overview, include family/household; both formal & informal; FEAT workshops. Making new useful contacts or friends?
	(If doing something new), how did it come about ?; what is it like for you?	Thought & feelings towards activity/people Clarify if there is new life role
	What about getting support?	NB. different types of support
Topic: Identity & Agency		
Opening question	In what way, if any, have you changed since joining FEAT ?	
Optional follow up questions	Compared to how you were before ...are you becoming a different person or staying much the same?	
	To what extent do you see yourself as a "worker"?	
	How have you been feeling about yourself in recent months?	Self-esteem/self-acceptance
	Has there been any change in your confidence? In what ways?	
	To what extent do you feel able to make things happen?	Agency: distinguish global from work skills & career management skills
	To what extent are your work skills developing?	
	What about your confidence in looking for work?	

Topic: Emotions		
Opening question	How have you been feeling emotionally since you joined FEAT?	
Optional follow up questions	Thinking back to how things were before you joined, Is there any change in how you have been feeling?	Explain will look first at feeling bad then at feeling good.
	Has there been any change in the extent to which you feel bad – like anxious or depressed?	Non-specific mental distress; sleep or eating problems; physical discomfort
	What about good emotions like feeling happy, and able to enjoy yourself?	Hedonic well-being
	To what extent have you been taking a healthy interest in life? Or feeling life is worthwhile, and you are doing the right things?	May need clarifying – eudaimonic well-being
Topic: FEAT Services		
Opening questions	Can I check which FEAT services you made use of ?	
	Tell me the story of your involvement with FEAT...	
Optional follow up questions	What were the good and the bad aspects of the service?	Focus on service, not individual staff members
	To what extent has FEAT made a difference to your life? Were any of the changes you have experienced as a result of joining FEAT?	
	What aspect of the service (if any) made a difference?	
	What aspect of your life was affected/changed?	Feelings/thoughts/behaviour
Topic: Overview		
Opening questions	What progress do you think you have made overall since joining FEAT?	Omit questions if they are redundant
	What advice would you give to someone in the position you were in before you joined FEAT?	
	What are the most important points I should understand from this conversation?	
	Is there anything else you want to tell me about you & FEAT just now?	
FINISH		
	Explain what happens with information	Emphasise information is seen as of value
	Explain follow up interview	
	6 month follow up questionnaire completion	
	Goodbyes & thanks	

**3B: Sample transcript of the initial interview with participant D:
excluded from the electronic submission for reasons of participant
confidentiality.**

3C: Procedure for systematic qualitative data analysis

Note each interview is analysed separately, and treated as a case study until stage 4.

Stage 1: Analysis of initial interviews

- Step 1: Reading the transcript while simultaneously listening to the recording. Make notes on first impressions.
- Step 2: Reading the transcript focusing on the sequencing of biographical events described. Make notes (noting gaps or uncertainties) on:
- Career and life history
 - Journey of recovery from mental health difficulties
- [Example provided in section 3D].
- Step 3: Reading the transcript and underlining phrases of interest, relevance to the research question, or otherwise notable. [With practice this stage proved redundant, and adding nothing to the more detailed stage 4: it was removed from the analysis of the later interviews].
- Step 4: Detailed, line by line reading and analysis. Making colour coded notes, in a column at the side, on four aspects of the transcript:
- Descriptive notes (black)
 - Linguistic notes (green)
 - Conceptual notes (blue)
 - Participants emphasis (red)
- Step 5: Read transcript and the detailed notes together. Make notes in a separate column on possible emergent themes. [Briefer notes than in step 4, and more interpretive].
- Step 6: Read through themes and group into broader superordinate themes.
- Step 7: Draw a mind map of the superordinate themes and possible inter-relationships between them. Decide if any regrouping is desirable.
- Step 8: Type up superordinate themes into a table listing themes emerging within each group and associated page numbers. Copy this document and create an expanded version. Go through the transcript cutting and pasting text into this table, so that all statements relevant to a theme are listed under its heading. [With practice this stage was merged with step 9].
- Step 9: Type up & present biographical notes and thematic analysis in a brief format.

Stage 2: Reflection on analysis of first interviews

- Step 10: Select one interview for independent analysis by Dr Adele Dickson (experienced IPA researcher). Compare analysis with own interpretation and note commonalities and discrepancies.
- Step 11: Reflect on stage 1 analysis in the light of step 10 above, and reread own process notes. Consider revising thematic analyses.

Stage 3: Follow up interviews (approximately 6 months after initial interview).

- Step 11: The analysis of initial interview is presented verbally to participants, supported by a mind map style diagram indicating only the names of the main themes emerging, to provide an overview. Thematic analyses and biographical notes (the outcomes of step 9) are revised based on participants' feedback. Any discrepancies between researcher and participant sense making or emphasis are noted.
- Step 12: Any additional or update material on recent experience is analysed as per steps 1-9 above, effectively extending the original transcript.

Stage 4: Integrative analysis

- Step 13: Reading through thematic groupings across all the interviews. Making notes on observations.
- Step 14: Identify thematic groupings that could subsume the themes across several interviews. Aiming for very broad encompassing themes. Draw a mind map of their linkages.
- Step 15: Draw up a table of broad themes against each interview. Identify how frequently each broad theme emerges across the transcripts
- Step 16: Decide on broad thematic structure for the entire data set. Create large file for each broad theme, beneath it list sub themes and then comprehensive list of extracts from the transcripts.
- Step 17: Identify illustrative/evocative quotations from participants for each broad theme.

3D: Thematic analysis of both initial and follow up interview with participant D: excluded from the electronic submission for reasons of participant confidentiality.

3E: Integrated thematic structure for interviews

1. Life events

- a. Stressful early/developmental life events
- b. Proximal events/triggers for mental health episodes

2. Experience of unemployment and mental health issues

- a. Experience of unemployment
 - i. Reasons for becoming unemployed
 - ii. Reactions to unemployment
- b. Experience of distress/symptoms
 - i. Mental health
 - ii. Physical health
- c. Difficulty in political perspective
 - i. Stigma (general public and employers)
 - ii. Welfare benefits
 - iii. Dilemmas of being unemployed with a mental health condition
 - iv. Mentally ill vs. normal
 - v. Challenge vs. Comfort

3. Recovery from and adjustment to mental health condition

- a. Level of functioning (including emotional state)
- b. Medical recovery
- c. Reinterpretation of earlier events
- d. Social network participation/social capital
- e. Learning journey
- f. Factors that initiate recovery or are interlinked with it
 - i. Intangible or small steps
 - ii. Identity
 - iii. Personal responsibility
 - iv. Agency
 - v. Goal setting & future focus (including optimism & rationality)

4. Work orientation

- a. Historic work orientation
- b. Work experience and qualification/skills profile
- c. Work habits and culture
- d. Person-environment fit issues
 - i. Occupational choice
 - ii. Identifying suitable work in the light of health condition
- e. Work orientation after intervention
 - i. Perceptions of own employability
 - ii. Attitudes to work & job seeking

5. The role of FEAT and the impact of guidance in recovery

- a. FEAT in the context of other helping agencies
- b. Initial contact/referral to FEAT
- c. The helping relationship
- d. FEAT interventions
 - i. STARS/STEPS course
 - ii. Role of the Employment Adviser (EA)
 - iii. Assessment for work
 - iv. Work placements
 - v. Volunteering and mentoring
- e. Global assessment of FEAT
- f. Attributions of causality linking FEAT interventions and recovery

6. Other issues emerging from the follow-up interview

- a. Accuracy of first interview analyses
- b. Changes experienced between first and second interviews

Appendix 4: Potential causal mechanisms

This section lists speculative list of possible causal mechanisms by which guidance might impact on well-being. This was generated by a review of relevant theory as reported in chapter 2. Mechanisms are grouped thematically rather than by source theory.

Thematic grouping of possible causal mechanisms

Interests and task engagement

The following mechanisms are derived primarily from positive psychology, P-E fit, and the psychology of interests:

- Matching work to level of cognitive ability and skill reduces stress: anxiety from over demand; boredom from under-demand.
- Eudaimonic well-being experiences may not habituate, so effects could be long lasting.
- Interests experienced as a transient emotional state may, if repeated over time, give rise to a personality trait with the potential to support long term healthy engagement with an activity.
- Matching work to interests increases time spent absorbed in a 'flow' state. This increases well-being, and blocks negative thinking.
- Activities provide distraction from personal worries.
- Concentration may lead to rewards via product of work, or to positive emotion, which may have desirable feedback effects.

Identity and self-concept

The following mechanisms are derived from diverse sources, reflecting the cross-cutting nature of the concept of identity:

- Matching work to personality and values helps to reinforce a consistent and positive sense of personal identity, and reduces dissonance that could arise from a conflict between goals and values.
- Career learning can promote self-awareness and a positive self-concept.

- Causes of poor well-being are located in the socio-economic environment, not in the individual.
- Difficulties are normalized.
- Moving from an unemployed identity to a jobseeker identity facilitates constructive action and access to supportive resources.

Social engagement

These mechanisms are derived from diverse sources, including the vitamin model, and the notion of social capital:

- Guidance is a gateway to work, education, training and volunteering. It provides access to group membership and activities.
- Matching people to suitable work may increase likelihood of access to a social environment with similar people, increasing the chance of good social links being found.
- Group membership forces an external focus of attention on the concerns of others, or shared problems.
- Group membership provides access to psycho-social factors that promote well-being: reducing isolation, access to status and a shared identity, access to money, time structure. Guidance may provide support to access environments that may help to meet these psychological needs.
- Entering one group may provide access to others e.g. a course may lead onto to job; a job may lead to friendships.
- Group membership motivates activity: this may lead to some physical exercise at work or in travel to work, with associated health benefits.

Managing distress

These mechanisms are derived from psychodynamic and developmental theory:

- Guidance could provide a safe and supportive environment in which to contain and explore anxiety.
- Distress arising from developmental conflicts and unresolved emotional issues with careers implications can be worked on.

- Conflict between roles, such as work-life balance issues, and associated stress can be explored. Choice, balance, life-career roles and identity can become focus of exploration rather than symptoms or distress.
- Learning transition management skills may help in managing the stress of career transitions.

The helping relationship

These mechanisms are derived from counselling psychology, including person centred and psychodynamic approaches:

- If there are 'common factors' in counselling that are effective, such as a good helping relationship, then they are likely to operate in guidance situations as well as therapeutic situations.
- Listening and giving attention may be therapeutic in itself.
- A non-judgmental, respectful helping relationship may enhance self-concept and reduce distress.
- Guidance is not sickness focused, so making use of services may be less stigmatizing than therapeutic services: it represents legitimate reason to access support that is readily acceptable to friends and family.
- The client – adviser relationship may act as model for healthy, collaborative, task-focused relationships at work, and enable the client to see them as possible.

Reflection and re-evaluation

These approaches are derived from a variety of sources including constructivist/narrative approaches:

- Reviewing career history may reinforce self-concept by evidence of generic skills, occupational skills and career related self-efficacy.
- Contextualising problems in a wider time perspective may be beneficial. For example, experience of distress can be reconceptualised as a healthy response to life-career developmental challenges.
- Career narratives contribute to positive and new constructions of the self, and are involved in experiences of recovery from mental health conditions.

- Distress can be seen as arising from one of a number of constructions which can be placed upon past events, and alternative interpretations are possible.

Personal agency

These mechanisms are derived primarily from social-cognitive theory:

- Encouraging career development activity may generate experiences of self-efficacy in the career domain: providing evidence that feeds into general self-efficacy beliefs.
- Rational, social and pro-active behaviour is encouraged, including networking.
- Experimentation and exploration is encouraged (social learning/exploration).
- Activities such as work experience may provide evidence of work skills and personal agency, as well as providing a distraction from concerns.
- Learning transferable career management skills may assist problem solving both in the present and in the future.
- Career learning may facilitate confidence via development of transferable attributes:
 - o Self awareness: identification of strengths, resources, and capacities, both vocational and in terms of career management
 - o Opportunity awareness: a realistic conception of work and education (avoiding both excessively bleak outlooks, and perfectionism in job goals)
 - o Decision making skills: Developing skills to resolve problems requiring decisions
 - o Transition skills: coping with the stress of change, preparing for entering new environments

Goal and future focus

These mechanisms derive from a variety of sources including positive psychology:

- The focus on the future does not encourage rumination on symptoms, problems or past events which can aggravate depression.
- Problem solving is mostly external to the person. The focus is the future, so hope is always implicitly present. The goals are more specific and concrete than trying to 'feel better'.
- Well-being is improved by striving for valued goals that are: chosen not imposed; approach not avoidance goals; congruent with personal values.

- Guidance may help individuals plan a pathway towards achieving a viable income in the future, giving hope and restoring a sense of agency, thus combating the negative effects of financial deprivation.
- Higher levels of hedonic well-being facilitates play, and enhancing mood encourages exploratory behaviour. Career exploration is now seen as central to effective career development.
- Practical shared problem solving may lead to the removal of sources of anxiety.

Adjustment to current life role

These mechanisms derived from P-E fit theory:

- Guidance may support individuals to identify these factors in an environment and if appropriate to negotiate to optimize them or to avoid harmful pressures.
- Counselling to support personal adjustment to current employment roles, and re-negotiation of work roles may help to reduce distress caused by poor fit.
- If neither are possible then counselling to facilitate exit to a more suitable position.

Access to resources

These mechanisms are derived from community psychology:

- Guidance that supports individuals into employment enables them to gain access to a flow of income which facilitates:
 - o Reduced anxiety relating to debt, erosion of savings, or lack of pension, and housing security
 - o Access to reliable transport (supporting both household activities and sustaining access to work)
 - o Reduced tension in partner and parental relationships; maintenance of social relationships (e.g. purchase of gifts & attendance and social events)
 - o Access to good nutrition, Access to health care and treatments
 - o A sense of personal agency

Appendix 5: FEAT and its local labour market context

The nature of the agency

Empirical data in this study has been accessed with co-operation from Fife Employment Access Trust (FEAT). Participation in the project assisted FEAT in satisfying an objective set by its prime funding agency, the Big Lottery Fund. In return for provision of data, administrative support and access to participants, FEAT received an evaluative report, assessing its impact on service users and offering recommendations for service improvement.

FEAT is a voluntary sector organisation established in 1994 (FEAT, 2006) and it is listed in the Scottish Charity Register (Office of the Scottish Charity Register, 2012). Its headquarters is in Glenrothes, and services are delivered in community locations across Fife. It specialises in providing support to unemployed job seekers with mental health conditions. The focus is exclusively on FEAT's work with job seekers, which is known as the '*Journey to Work*' service, which at the time of data generation was the main focus of the agency's work; the agency's other activities are excluded from this study.

Unlike some agencies supporting job seekers, FEAT is not subject to stringent placement targets; participation by service users is voluntary; there are no sanctions for non-attendance. New registrants come from a variety of referral sources including NHS staff, such as community psychiatric nurses, self-referrals, social workers, and GPs.

Staff come from diverse backgrounds notably mental health and employment related occupations (including career guidance). Former service users are occasionally employed by FEAT. Subsequent to the period of data generation FEAT's services have evolved towards a greater focus on severe and enduring mental health conditions in response to the shifting priorities of its funding agencies.

The Fife local labour market context

The labour market context for job seeker support services is likely to have a powerful impact on reemployment outcomes achieved. This provides a snapshot of the local economy during the period of this research. In terms of industry, Fife is rural with an active farming community. There are towns with administrative and retail activities, notably Dunfermline. There are also some tourist attractions. St Andrews has an international reputation as the home of golf, and hosts a high status university. There is no dominant industry in the area, activity is diverse; Fife Council and the NHS are the largest employers. Labour market conditions are quite specific to local communities, and their variable access to transport links. Commuting to the cities of Edinburgh, Stirling, Perth and Dundee is common.

Energy and water has been growing, but remains a small sector of employment (Fife Council, 2011). Female employment is concentrated in services (particularly public administration; distribution, hotels and restaurants). Male employment is more evenly spread across sectors, although predominant in manufacturing (Fife Council 2011). Fife has very slightly higher levels of economic activity than the average for Scotland and Great Britain; demand for labour is slightly weaker than national norms (Office for National Statistics/NOMIS, 2011).

There are pockets of high unemployment, notably in areas formerly dependent on coal mining, and in rural areas with weak public transport links. JSA claimant rates are relatively high at 4.6%, but rates of economic inactivity are comparable to or slightly less than national norms. The spread of JSA claimants is uneven: central Fife has the highest concentration of claimants; North East Fife has the lowest (Fife Council 2011; Office of National Statistics/NOMIS, 2011).

The global recession in late 2008 and throughout 2009 had a significant negative impact on the Fife economy (Fife Council 2011). Employment rates in Fife fell to below the Scottish and UK rates. However since late 2009, employment rates in Fife bounced back to above the national norms by late 2010. Whilst JSA claimant rates are also falling in Fife, the proportion unemployed for over 6 months has increased in the period to June 2011 (Fife Council/ Fife Economy Partnership 2011). Although clearly not the most

disadvantaged area in Scotland, nonetheless Fife is a challenging area in which to find work, particularly for those with limited transport access.

Appendix 6: Published article

This appendix contains the text for an article published drawing on these doctoral studies.

Robertson, P. (2011) Clients with mental health conditions: opportunities and challenges for career guidance. In: L.Barham & B.A. Irving (Eds) *Constructing the future: diversity, inclusion and social justice*. Stourbridge: Institute of Career Guidance, pp131-146.

Constructing the Future VI article:

Clients with mental health conditions: opportunities and challenges for career guidance.

Abstract

This article explores meeting the needs of clients with mental health conditions and seeks to establish this group as one of particular interest to career guidance practitioners. The issues are introduced in broad terms by looking at the incidence, significance and nature of mental health conditions in the community. The links between mental health conditions and socio-economic disadvantage are highlighted, together with a consideration of the role of work in recovery. The potential contribution of guidance emerges from this discussion. Issues related to young people and unemployed adults are differentiated. Finally implications for practitioners and for career guidance service providers are suggested.

Introduction

Clients with mental health conditions have received relatively little direct attention in the career guidance literature. This is surprising in the light of the prevalence of mental health conditions and their potential impact on careers. Epidemiological estimates suggest that mental health conditions are very widespread. For example:

‘At any one time, just over 20% of working-age women and 17% of working-age men are affected by depression or anxiety; approximately 5% of men and 3% of women can be assessed as having a personality disorder and over 0.4% have a psychotic disorder such as schizophrenia or bipolar affective disorders.’ (HM Government, 2009:12).

The economic consequences of this burden of disease on the working age population may be substantial. For example, the Sainsbury Centre for Mental Health (2007) estimates the costs to business in the UK as in the region of £ 26 billion. Costs to society go beyond those incurred by employers as a result of sickness absence, underperformance of workplace attendees, and replacing them when necessary. Welfare benefits, medical and

social care costs are very substantial indeed. Furthermore an economic analysis need not neglect the very important impact of the personal and human costs of psychological distress: Friedli and Parsonage (2007) incorporated all these elements in their model and estimated costs to the UK economy in the region of £ 115 billion in 2006-7.

Consideration of epidemiology and economic impact serve only to make the point that this is no small matter:

‘No other health condition matches mental ill health in the combined extent of prevalence, persistence, and breadth of impact.’ (HM Government, 2009: 12).

If we accept that this is an important socio-economic issue in society, and not solely a health matter, then we can begin to examine it from a professional guidance perspective. To do this we first need a broad understanding of the nature of mental health conditions. We then need to explore some of the ways in which mental health issues overlap with matters of concern to guidance specifically:

- Social inclusion: proactive response to exclusion is one of the key policy drivers in the guidance sector, and mental illness is inextricably linked to exclusion.
- Work and recovery: promotion of employability is a central activity for guidance, and increasingly seen as important in mental health circles.
- Young people and unemployed adults: two key groups with particular exposure to mental health risk factors, who are also the main targets for state funded guidance services.

After exploring these areas, we can begin to identify the implications for guidance services and consider how to respond to the mental health challenge.

The nature of mental health conditions

The nature of specific diagnoses has been adequately described elsewhere (see Advice Resources, 2009a, for an accessible outline aimed at career advisers). More broadly, mental health conditions can be characterised in the following ways:

- In most cases they are of unknown aetiology: there is no single pathogen or causal factor that can be isolated. They appear to be multi-causal in nature.
- They typically fluctuate in an unpredictable way.
- They affect a person's ability to navigate the social rather than the physical world (Perkins, Farmer and Litchfield, 2009).
- They are intangible, and often can only be known if a person overcomes barriers to the disclosure of their own experience of distress.
- People with mental health conditions may be seen as necessarily dangerous or incompetent as a result of the myths and stereotypes associated with them.
- They can emerge at any time of life. However, they tend to have an early onset compared to other major groups of illness. Therefore they are potentially of longer duration (HM Government, 2009).
- They frequently occur together with physical health conditions notably, but not exclusively, cardio-vascular and muscular-skeletal conditions. (McGee and Ashby, 2010).
- They are potentially fatal via suicide.

A distinction needs to be drawn between common mental health conditions that in the UK are normally treated by General Practitioners (GPs) in primary care settings, and less common but more severe and/or enduring conditions, such as schizophrenia, that are typically treated by specialist mental health professionals in secondary health care services. As much as 90% of mental health conditions are treated in primary care, and a substantial proportion of GP consultations relate to mental health concerns (Social Exclusion Unit, 2004; Sainsbury Centre for Mental Health, 2007; Black 2008). Anxiety and depression represent the great majority of these consultations, and the bulk of the burden of mental ill health on the community.

We should note, however that the identification and diagnosis of mental illness is a contested area. It could be convincingly argued that there is no clear boundary between those with and without a condition. It may be thought of as a continuum between positive mental health and illness (Huppert, 2004). The same symptoms that define mental illness can be found in the general (non-clinical) population. This is true not just of the universal and mundane experience of anxiety, but also of the more colourful and less common psychotic symptoms such as hallucinations, which are sometimes interpreted as religious

or artistic experiences (e.g. David and Leudar, 2001). Diagnosis is often defined by a relatively arbitrary cut off point based on the number, intensity or frequency of symptoms. The presence of symptoms may not in itself be enough to trigger diagnosis; the resulting level of concern and inconvenience caused to others may also be a factor. Some critics have argued that the medicalisation of psychological distress has become widespread due to the vested interests of the psychiatric profession, or the pharmaceutical industry. Anti-depressants represent one of the largest categories among drug sales (Horowitz and Wakefield, 2007), so it is certainly big business.

Depression commonly occurs together with anxiety. Both represent experiences that are near universal in the population, and could in some circumstances be seen as appropriate, or even healthy reactions to negative life events. Irrespective of the political or medical view taken of the nature of mental health conditions, it is clear that they cannot be seen as *'other'*; they are so commonplace as to be part of mainstream experience.

Social inclusion

Notwithstanding problems of definition, it is also clear that social issues are inextricably linked with psychological distress. There is significant overlap between the population with a mental health condition, and other diverse groups experiencing substantial political or socio-economic disadvantage (e.g. Social Exclusion Unit, 2004; HM Government, 2009), notably:

- Homeless people
- Care leavers
- Victims of domestic abuse
- Victims of workplace bullying or sexual harassment
- Debtors
- Offenders in or leaving custody
- People with alcohol or drug abuse issues
- Minority ethnic groups, notably recent migrants and refugees
- Veterans of armed conflict
- People with learning difficulties, notably autistic spectrum disorders.

Friedli goes further, and argues that mental health is the central to understanding disadvantage:

‘...levels of mental distress among communities need to be understood less in terms of individual pathology and more as a response to relative deprivation and social injustice, which erode the emotional, spiritual and intellectual resources essential to psychological well-being.’ (Friedli, 2009).

This is not an isolated viewpoint; other sources support the view that poverty and social inequality is the key to understanding mental health conditions (e.g. Murali and Oyeboode, 2004). This is a view that, at least in broad terms, is accepted by Government sources (e.g. Social Exclusion Unit, 2004).

This point is crucial to the guidance community. If we view mental health conditions as ‘other’ or particular to a minority client group, we are missing a key point. Social exclusion, inequality, and educational or labour market disadvantage are central concerns to guidance, and they are also important causal factors in a range of physical and mental health conditions (Foresight Mental Capital and Wellbeing Project, 2008; Marmot, 2009). For many UK career guidance providers directly or indirectly funded by the state, the promotion of social inclusion has been a particularly salient policy objective in recent years (e.g. NICE, 1999; Watts, 2001; Hughes and Gration, 2009). In discussing the profession’s response to common mental health conditions we are therefore talking about the core business of career guidance, not a peripheral or niche activity. Sensitivity to mental health issues could mean helping the core client group more effectively.

Currently the global economic downturn means that socio-economic drivers of psychological distress continue to be salient. The Royal College of Psychiatrists (2009) considered the impact of recession on people with mental health conditions. Their assessment is that demand for mental health services is likely to increase at a time when there is pressure to constrain spending on those services. They suggest unemployment, personal debt, and home repossession will be key factors in generating distress.

Work and recovery

It seems that those with mental health conditions fare relatively badly in the workplace, even compared to other disability groups, and their position is vulnerable in a recession:

‘Research and statistics continue to highlight the poor labour market position of people with mental health needs: the mental health group constitute the highest proportion of people on disability benefits; they have among the lowest employment rates; and they have difficulty in retaining jobs when mental health problems occur. In an economic downturn they have a lower re-entry rate into the labour market...The average employment rate for the UK working age group is 74%, which compares to 47% for all people with a disability, but only 21% of people with long-term mental illness in work and as low as 12% for people with severe mental health problems...’

Booth, Francis and James (2007: 65-66), citing evidence from the Social Exclusion Task Force 2006.

There is evidence that the bulk of people with a mental health condition, including the long-term unemployed, do want to work, and see it as a goal. However health services have not tended to view employment as a priority, even though there is clinical evidence that it tends to be therapeutic (Secker, Grove and Seebohm, 2001; Grove, 2001).

Disability equality legislation does provide some protection to those with substantive mental health conditions in the workplace, currently in the form of the Equalities Act 2010. Application of a ‘disability’ label to people with mental health conditions is nonetheless problematic, given that it may harm a fragile or negative self-concept or ingrain a view that growth and recovery is impossible. In recent years, however guidance for employers to support making reasonable adjustments or finding flexible solutions to support workers with mental health conditions has become available (e.g. EHRC, 2010).

Another recent development is that the concept of ‘recovery’ from a mental health condition has become influential (Roberts and Wolfson, 2004; Shepherd, Boardman and Slade, 2008). This rejects an exclusively medical conception of ‘getting better’. Recovery refers to life changes necessary to adapt to an experience of a serious mental health condition. It allows for the possibility that an individual may continue to have symptoms but can nonetheless construct a productive lifestyle, without necessarily returning to their

former self, or experiencing a cure. It redefines recovery as a social process of which medical experience is only one element.

As a result the role of work is salient in this conception of recovery. Coutts (2007) discusses this and points out that the role of work in recovery is complex:

- Work both contributes to recovery and is made possible by recovery.
- Re-entering work can be a very long process, and at different stages different activities or supports may be appropriate.
- Recovery may mean redefining occupational choices or levels of involvement. or commitment to work (with flexible employment, volunteering or self employment perhaps having a role).
- The central role of work to social identity is also very relevant here – getting better may mean that constructing a new identity as a ‘recovered’ person.
- Finding a job may signify that a person is better. Conversely an unsuccessful attempt at work may undermine the recovery process.
- Returning to work may provide a sense of ‘giving something back’ – making a contribution to society in contrast to the stigmatised identity of a ‘benefits scrounger’, with associated gains for self esteem.

This conception of recovery positions the business of reconnecting a person with their social world as central to recovery, not as an afterthought to pharmacological intervention. It is at the heart of the problems that they face. Viewed through this lens, the role of guidance in supporting people into work, education, training, volunteering or other productive activity is clearly an important one; it is not merely an adjunct to psychiatric treatment.

Young people

Teenagers and young adults are confronted with major life changes, not least facing key career decision points. Important relationships are formed and lost, transitions are experienced, social identity begins to crystallise, and experimentation with sexuality, alcohol and drugs is undertaken (Noonan, 1983), in addition to biological maturation. This is also an age range in which the first onset of mental health conditions is often seen. It

may take some time for conditions to be diagnosed, stabilised and appropriate drug regimes to be identified. Recovery may be slow, and accompanied by reduced levels of confidence. Thus health issues can substantially disrupt career paths and undermine potential.

‘The disruptive and disabling effects of first episode psychotic disorders may be exacerbated by the more general development life phase issues of mid to late adolescence and the early adulthood period...Among the most deleterious and long lasting of these is the disruption to educational and vocational trajectories, often resulting in long-term unemployment, underemployment or unrealised career goals and educational potential.’

Lloyd and Waghorn (2007: 53-4).

It may not be just the relatively rare but severe psychotic conditions that can disrupt lives; the consequences of common mental health conditions may also be serious, with long-term consequences (Foresight Mental Capital and Wellbeing Project, 2008). Early onset depression can recur throughout the lifespan; 50% of lifetime mental illness is present by age 14 (HM Government 2009). Also, there is an association with suicide, the leading cause of death among young adults after accidents. Young men with mental health problems in particular represent a high-risk suicide group (Mind, 2010).

Teenagers and young adults represent the largest user group of career guidance services. Given the role of these services in combating youth unemployment and prioritising the needs of those facing social exclusion, it seems likely that they are particularly well placed to make a contribution to limiting the lasting damage caused by mental health conditions.

Unemployed adults

Many adults with mental health conditions are economically inactive, and represent the largest category amongst claimants of welfare benefits that are related to incapacity to work. The scale of this issue is a matter of considerable concern to Government (e.g. Black, 2008). The complexity of the UK welfare benefits system is daunting. The financial uncertainty associated with leaving the relative security of benefits to enter work acts as a disincentive for those driven by anxiety and depression to risk-averse decision-making.

Fear of failure, relapse and loss of benefit entitlements represent genuine concerns that sustain economic inactivity.

Consequently, at the time of writing, the UK's Coalition Government is attempting to reform the benefits system for people of working age, so as to reduce its complexity and ensure that paid employment is incentivised at all levels of engagement (DWP, 2011). It remains to be seen if this difficult task can be achieved. In particular the introduction of a new system of assessment of fitness for work used with both new and historic benefit claimants has led to some concerns being voiced (e.g. Citizens Advice Scotland, 2010; Barnes *et al*, 2010). For some, the perceived threat of the withdrawal of stable incapacity-related benefits, and the expectation of job seeking in difficult labour market conditions may represent an additional and unwelcome stress.

Underpinning UK policy is the acceptance of the view that on balance unemployment is harmful, but work is good for mental health (Waddell and Burton, 2006). Whilst the weight of evidence does indeed suggest that work is to be recommended as generally health promoting, this prescription comes with important caveats that may be ignored in the rush to manage the expanding costs of welfare benefits. For some people, at least some of the time, work may be harmful; specific work environments may present psycho-social health hazards. The relationship between work and mental health is complex and depends on the individual person, the job and the circumstances (Dodu, 2005).

In general the claim that 'work is good for you' only holds true of good quality work. Unfortunately the reality facing unemployed groups is that the work most accessible to them is marginal employment: low-paid jobs on part-time or short-term contracts. This work is often insecure or of a low status, so it may not help to manage anxiety or self-esteem issues. The evidence suggests that marginal employment does not provide the health benefits that secure, well-paid meaningful work can deliver (e.g. Broom *et al*, 2006).

The unemployed are an important service user group for adult guidance services in the community. However, mass provision targeted at incapacity-related benefit claimants has been primarily delivered through the Department of Work and Pensions (DWP), its main agency, Jobcentre Plus (the UK's public employment service), and also through private contractors delivering a variety of targeted labour market activation initiatives, including

until recently the Pathways to Work Scheme (DWP, 2002). These services emphasise the employment agency and advice services, often combined with the possibility of benefit sanctions, with the intention of motivating the economically inactive back to work. They rarely involve career counselling as such. However, they are delivered together with condition management programmes, which may include therapeutic counselling (typically cognitive-behavioural therapy) designed to limit the disabling impact of psychiatric symptoms.

The weakness of a narrowly target driven employment placement function is that there may be negative long-term health and economic consequences of placing people into poor quality work. It may be the guidance profession could bring added value to this field. Career counselling may help to build self-esteem and self-confidence, to give access to learning experiences and educational achievements, to generate goals and optimism, and over time it may help to find more meaningful and sustainable work that is appropriate to the individual.

Key issues for career guidance practice

Two broad areas need to be considered; firstly implications for mainstream guidance services; secondly the role of specialist services for those with substantive mental health conditions.

The needs of clients who have common mental health conditions tend to be neglected by service providers. Members of this broad group are very likely to be users of mainstream guidance services, so core service delivery needs to be sensitive to their needs even though they may present with other kinds of disadvantage. Services have the potential to make a contribution to the needs of unemployed or vulnerable clients by providing support to access work, or environments such as education and volunteering. Emotional support and encouragement within the context of an ongoing career counselling relationship may be an important precursor to achieving these outcomes. A supportive relationship is essential, as is sufficient trust to allow confidential concerns to be shared in an environment that is conducive to privacy. Seeking to promote autonomy, choice and self-efficacy are likely to be productive strategies.

Thus, service design needs to allow an environment in which a sensitive helping relationship can develop. It seems unlikely, however, that this can be done solely by information provision, or in the context of call centre and online services. Increasing reliance on remote services is a feature of guidance policy across the UK (e.g. Watts and Dent, 2008). So this presents a challenge to the leaders of guidance services: either new ways must be found of facilitating supportive, non-superficial, ongoing relationships at a distance; or face-to-face contact must remain a key element in service delivery.

Collaboration with Jobcentre Plus or other DWP services is likely to be a promising way to reach the clients in need. Those services able to sustain outreach work, may also find it productive to explore partnerships with primary care providers, in order to reach people who are distant from the labour market. There have been successful experiments with employment or learning advisers being located in GP's surgeries in the community (e.g. James 2001a and b; Sainsbury *et al*, 2008).

Effective delivery for this client group must also require training for guidance practitioners. In addition to issues of developing the helping relationship, training could encompass:

- *Mental health awareness*: An understanding of the nature of mental health conditions, including their diversity, their overlap with other categories of social disadvantage, their variability over time, the aspirations of clients, and similar factors that may impact on guidance.
- *Crisis management*: Understanding of how to support someone who is in a state of distress, even if such events are rare, may help to build staff confidence. One model of how to approach this training for non-clinical services is offered by Mental Health First Aid (2011).
- *Stigma*: Negative stereotyping associated with mental illness continues to be an issue in wider society in spite of progress and media campaigns in recent years, and as such may affect guidance workers, who may benefit from reflection on their attitudes. Awareness of employer's attitudes is also necessary, as is the affect on self-esteem and perceived employability of a psychiatric diagnosis, and the anticipation of

discrimination by clients (Russell, 2006).

- *Personal safety:* The vast majority of people with mental health conditions represent no threat, and a characterisation as dangerous is often part of the process of negative stereotyping. However, a very small minority may present challenging or threatening behaviour. For this reason advisers should be mindful of their personal safety, particularly when working in isolation (Advice Resources, 2009a). This is not exclusively a training issue; it may also need to be addressed in the management of health and safety.
- *Assessment:* This aspect of guidance may present some challenges, particularly given the intermittent and dynamic nature of mental health conditions, their tendency to co-exist with other challenges, and the potential for some service users to conceal their condition. Fortunately, psychiatric diagnoses seem to be poor predictors of employability; previous work history and current attitudes seem to be more reliable indicators when assessing potential (Boardman, 2003). This means that careful vocational and educational assessment may be most appropriate. This group of clients may particularly benefit from having their attention drawn to their skills, strengths, experience and resources.
- *Protective channelling:* Clinical services may be over-cautious about what can be achieved vocationally, and influence clients to underestimate the potential benefits of work, education, training or volunteering. A dynamic balance must be struck between caution and beneficial risk taking. Different levels of challenge may be appropriate at different times.
- *Setting boundaries:* Advisers may be wary of straying beyond their expertise, and tend to refer personal needs to other agencies. It is certainly the case that career guidance is not intended to be a therapy or to target symptom management. However several American authors, notably Zunker (2008) have argued persuasively that career and personal issues are frequently intertwined and must be addressed together in a whole-person approach. It may be that setting the boundaries of practice too narrowly may limit the potential of guidance.

It has been suggested that career advisers may need casework supervision to support them in handling the emotional demands of the work (Advice Resources, 2009b). There is certainly an argument to be made for this, not least because of the potential effects on the adviser of encounters with clients who make suicide attempts, self-harm, or exhibit other kinds of distressing behaviour, must be considered. Clients without mental health issues can be challenging too, so if there is a case for supervision structures to be put in place, as some have argued (e.g. McMahon, 2004), it is likely to be across the organisation.

Provision of employment related services for adults with severe and enduring mental health conditions is patchy and inconsistent across the UK, lacks structural coherence (Booth, Francis and James, 2007) and is less well developed than in some comparable countries (Joss, 2002). There is, however, evidence of official recognition of the need for greater prominence for these services, and of the potential benefit from engagement with work, learning or volunteering (e.g. Perkins, Farmer and Litchfield, 2009; HM Government, 2009). In recent years, mental health trusts have set up services to support psychiatric service users into work within the National Health Service (NHS) itself (e.g. Harding, 2005).

There is perhaps work to be done in establishing the relevance of the guidance profession to the needs of secondary mental health care service users. Career guidance organisations potentially have a lot to offer, such as their links to the wider education and labour markets, including mainstream opportunity structures; something that clinical staff may not be well placed to provide. Working with other professionals, notably occupational therapists, is likely to be a productive way forward, but may require specialist career advisers and a bespoke service. Multi-disciplinary teams, working across organisational boundaries, could enhance NHS or voluntary sector provision for people in secondary mental health care.

This need not necessarily be an extra drain on the resources of stretched guidance services; as the mental health sector shifts towards a more work and recovery oriented culture, it may be that funding from health sources becomes available to enterprising guidance services that seek it out. Similarly engagement with benefit claimants might attract DWP sources of funding.

Conclusion

A significant proportion of the potential client group for guidance may have, to a greater or lesser extent, a common mental health condition. These conditions may be best understood as a manifestation of socio-economic disadvantage and inequality.

Responding to such issues is central to the business of career guidance. Service design, staff training, and systems to support staff need to encompass the needs of service users with anxiety or depression.

A small, but very vulnerable, group of service users may have a severe or enduring mental health condition, and this group will need a bespoke service. Supporting them to build a new social identity involving work or other productive alternatives, such as study or volunteering, may be very valuable. There is a potential role for career guidance in the recovery of people who are patients of secondary mental health care services. To date there have been few systematic attempts to provide such services, with provision left to small scale local initiatives by health authorities or voluntary sector agencies.

Particular concerns arise concerning the mental health of two groups in society: young people, and unemployed adults. These two groups are also the main target groups for state funded career guidance services. As a result guidance providers are particularly well positioned to access and provide services to these potentially vulnerable clients. With combating unemployment and social exclusion as priority activities for these providers, the potential importance of their role in responding to mental health issues should not be underestimated.

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