

# **The impact of involuntary unemployment on mental well-being at a time of economic recession and the role of community interventions to strengthen people's resilience**

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## **Abstract**

This paper reports the findings of a qualitative study that explored the impact of involuntary unemployment at a time of economic recession on people's everyday life and mental well-being. The study was undertaken in Bradford, West Yorkshire, a city characterised by many years of economic downturn before the official start of the economic recession in January 2009. It focused on unemployed people in a 'transition phase' in the job market. These were young people (aged 18-25) who recently entered the job market, and older workers (aged 50 and over) who were closer to retirement age. Research has shown that these groups are particularly at risk of job losses during economic recessions and so at higher risk of reduced mental well-being and of mental health problems. The study involved 73 people and consisted of 16 focus group interviews. It identified six main sources of mental and emotional stress for the study participants and two sources of resilience factors. These sources of stress and of resilience are discussed in the wider context of the national and international literature on interventions aimed at supporting the mental well-being of unemployed people. The paper discriminates interventions according to the settings in which they were implemented, whether primary care, labour market, or the community. Consequently, it centres the discussion on the relevance of the study findings for the role of community based initiatives and interventions, and the link between them and primary care, to support and strengthen people's resilience and mental well-being. Such initiatives and interventions are considered in relation to the current debate around the Big Society and its implications for health policy, social services and welfare state provision.

## **Introduction**

A substantial body of literature shows that unemployment is negatively associated with mental health and well-being (among others, (McKee-Ryan *et al.*, 2005; Murphy & Athanasou, 1999; Paul & Moser, 2009; Waddell & Burton, 2006; Wanberg, Kammeyer-Mueller, & Shi, 2001) (Wanberg *et al.*, 2001). In a recent meta-analytic investigation containing 237 cross-sectional and 87 longitudinal studies, Paul and Moser (2009) pointed

out that the negative effect of unemployment on mental health<sup>1</sup> demonstrated in their study had considerable practical importance because it was “equivalent to an increase in the rates of persons with psychological problems with potential clinical severity from 16% [among the employed] to 34% [among the unemployed]” (p. 278).

Despite a wide body of research on the impact of unemployment on people’s mental health and well-being, only a few studies have investigated interventions that can help to improve health amongst unemployed people. The understanding of what interventions are effective and what groups of unemployed people benefit most is very important, as it can help to improve the mental health and well-being of unemployed people and, consequently, to reduce public spending by reducing the number of people out of work because of mental health problems.

This paper discusses the findings of a qualitative study on the mental well-being and resilience of people who became unemployed during the economic recession of 2009/2010 in the wider context of research on the impact of economic recessions on mental health and of the literature on interventions to promote unemployed people’s well-being. By presenting the lived experiences of unemployed people, the paper identifies the types of interventions needed to address the socio-psychological and material consequences of unemployment at times of economic recession. It then discusses the suggested interventions in relation to the current debate around the Big Society agenda, highlighting the tensions that characterise such a social policy agenda in relation to the promotion of mental health interventions for unemployed people.

The paper is divided into four main sections. The first section presents evidence of the impact of economic recessions on mental health at the population level. The second reviews

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<sup>1</sup> Paul and Moser (2009) operationalised the concept of mental health through the following six indicators: mixed symptoms of distress, depression, anxiety, psychosomatic symptoms, subjective well-being, and self-esteem.

some key studies on interventions aimed at improving unemployed people's mental health and well-being. The third section presents the methods of the study undertaken in Bradford (West Yorkshire) and presents its main findings. The final section offers a discussion of the findings of the Bradford study against the reviewed literature on mental health interventions and on the impact of economic recessions at the population level.

### **Mental health at times of economic downturn**

Research shows that unemployed people are two to three times more at risk of death by suicide compared to fully employed people (Blakely, Collings, & Atkinson, 2003; Gunnell, Platt, & Hawton, 2009; Platt, 1984). In a study on the impact of the Asian economic crisis (1997–1998) on suicide in Japan, Hong Kong, South Korea, Taiwan, Singapore and Thailand, Chang *et al.* (2009) showed a sharp increase in suicide mortality in some, but not all, of these Countries. The sharp increases in suicide were most closely associated with rises in unemployment. So, whilst there were 10,400 more suicides in 1998 compared to 1997 in Japan, Hong Kong, and Korea, these increases were not registered in Taiwan and Singapore, where the economic crisis had a smaller impact on GDP and unemployment (Chang *et al.*, 2009). Similarly, in a study on 26 European Union countries, Stuckler *et al.* (2009) reported that rapid and large rises in unemployment were associated with short-term rises in suicides (and homicides) in working-age men and women. In these contexts, every 1% increase in unemployment was associated with a 0.79% rise in suicides at ages younger than 65 years. However, this effect was stronger in countries with low spending on active labour-market programmes, and null or reversed in countries with high spending. Evidence that welfare support may offset the impact of unemployment on suicide was also offered in Howden-Chapman's and colleagues' (2005) comparative study on the impact of the recessions during the '80s and '90s in Finland and New Zealand. Despite the fact that unemployment rose to a greater extent in Finland than New Zealand, the increase in male

suicides was smaller in Finland, where social spending rose as a percentage of gross domestic product.

### **Mental health promotion interventions for unemployed people**

The literature suggests that mental health interventions are more likely to be effective if they are multifaceted and act on three levels (Department of Health, 2001; Health Scotland, 2005):

- the individual (knowledge, attitudes, self-esteem),
- the community (family and social support networks),
- wider society (social class, access to resources and services).

Three potential settings for interventions aimed at improving the mental health and well-being of unemployed people can be identified in the literature:

- primary health care,
- labour market programmes,
- the community.

These interventions are usually underpinned by some specific theories or views regarding the effectiveness of mental health interventions.

Overholser and Fisher (2009) interpret unemployment as a 'stressful life event', that is a situation that drains or exceeds people's perceived ability to cope. They classify strategies to manage stress in three main theoretical perspectives:

- Psychiatric perspective, which focus on the symptoms of emotional distress and label people's problems on the basis of the American Psychiatric Association (2000) 'Diagnostic and Statistical Manual of Mental Disorders, 4th. Edition' (DSM-IV). Interventions based on this perspective imply the use of psychotropic medications aimed at lifting people's mood.

- Psychological interventions, which focus on the cognitive processes that translate life stress into emotional distress. Interventions based on this approach aim to help people to make adaptive changes in their cognitive appraisal and behavioural coping styles.
- Social interventions, which focus on broader societal factors that play important roles in stress and coping, for example interpersonal functioning, occupational adjustment, and agency resources that might be available to help people deal with their stressors, for example job loss.

Overholser and Fisher (2009) suggest that the sadness, pessimism, and sense of failure associated with job loss are best addressed through a combination of psychological approaches and social intervention strategies; they are not appropriately suppressed via medications. They therefore argue for a socio-psychological approach to improve the mental well-being of unemployed people at a time of economic recession. This implies multi-agency interventions aimed at cultivating positive attitudes, realistic optimism, and specific job retraining skills.

**Interventions in primary health care.** In a recent review of the literature, Harris & Harris (2009) mentioned that the three most commonly used strategies used in primary health care to prevent, detect and manage the health problems of unemployed people were:

- raising GPs' awareness about the health problems of unemployed people;
- providing GPs with local information on levels and characteristics of unemployment;
- supporting GPs to act as referrers to employment and welfare services.

Harris and Harris (2009) mentioned that they could not determine the effectiveness of the above strategies used in the studies they reviewed because of their small nature and variable quality. They suggested two main types of initiatives as a basis for interventions and research (p. 121):

- Health checks offered by GPs for people who are or become unemployed, with a focus on common health problems (e.g., poor mental health and behavioural and biological risk factors for cardiovascular disease) and preventive care and management of conditions that could act as barriers to return to work (e.g. drug and alcohol misuse); and
- Social prescribing.

Social prescribing promotes the use of the voluntary sector within primary health care (South *et al.*, 2008). It involves signposting primary health care patients with non-clinical needs to local voluntary services, employment and welfare services available in their area, including support groups for people who are unemployed. There is growing evidence of the efficacy and cost effectiveness of this approach (Friedli *et al.*, 2009).

In the UK, the initial evaluation of the two demonstration sites for the Improving Access to Psychological Therapies programme showed that at the end of treatment 5% more of the treated population was in employment (range 4% to 10%) and not on Statutory Sick Pay (Clark, Layard, & Smithies, 2007).

**Interventions in labour market programmes.** A cognitive behaviour therapy intervention delivered through a Labour Market Program (Job Network Settings) in Sydney, Australia, was successful in improving the mental health of unemployed individuals in five small-scale trials (Harris *et al.*, 2009). However, the intervention proved difficult to scale up and evaluate comprehensively. Harris *et al.* (2009) conclude that, despite lack of evidence of their efficacy, Labour Market Programs represent an important setting in which to implement mental health promotion programs for unemployed people because they can reach high risk groups.

In a recent review of studies based in vocational programmes for unemployed people, Audhoe *et al.* (2009) discussed two interventions aimed at facilitating unemployed job

seekers to return to work and prevent possible negative mental health consequences of unemployment. These programmes were the United States JOBS II intervention program and the Finnish Tyohon job-search training workshop, which is a version of the JOBS II. They were both “based on theories of active learning process, social modelling, gradual exposure to acquiring skills, and practice through role playing, providing preparedness against setbacks during the job search process” (p. 9). Both programmes reported a significant effect on re-employment and decreasing psychological distress compared to the control group. However, Jobs II reported a positive effect only for the subgroup of unemployed people with poor mental health, which implies that there is limited evidence for an effective intervention aimed at improving mental well-being for unemployed people at large (Audhoe *et al.*, 2009). Audhoe and colleagues (2009) call for more research to evaluate whether a focus on mental health would improve the effects of re-employment programs. To this regard, they mentioned the encouraging findings of several Randomised Control Trials on cognitive-behavioural therapy interventions for certain physical diseases, for example myocardial infarction and non-specific low back pain.

In an older study, Eden & Aviram (1993) evaluated training designed to boost general self-efficacy (GSE) on job-search activity and on re-employment. The treatment increased re-employment among participants low in initial GSE but not among those with high GSE.

**Interventions in community settings.** This type of setting refers to the vast network of volunteer support groups and initiatives aimed at empowering people, such as, for example, the Community Health Champions initiative offered by the Altogether Better Programme (South, White, & Woodall, 2010). Although no literature was found on interventions aimed at unemployed people based in this setting, research shows that empowering approaches are beneficial to people’s mental health and well-being in work environments (Robinson, Raine, & South, 2010). Community settings can link with primary health care settings through social prescribing.

The literature reviewed in the previous section suggests that governments can have a crucial role in buffering the effects of unemployment on suicide and on unemployed people's mental health by adopting policies that maintain and reintegrate people at work. However, the current literature on interventions aimed at improving unemployed people's mental health and well-being primarily focuses on individual, i.e. psychological and emotional, support. The following section explores the experiences of unemployment of people who involuntarily lost their job during the economic recession of 2009/2010. It identifies six experiences that negatively affected the participants' mental well-being. Four consisted of the emotional and psycho-social consequences of involuntary job loss, which would benefit from health promotion interventions at the individual and community level. However, two represented manifest consequences of respectively job loss and job loss at a time of economic recession and would require wider social policy interventions.

## **Experiences of unemployment, mental well-being and support during the recession in Bradford**

### **Methods**

The study presented in this paper consisted of 16 focus group interviews with a total of 73 people, 33 males and 40 females, who had involuntarily lost their jobs at any point in time from July 2008. This date represents the start of the two quarters of negative economic growth that led Britain to officially enter recession in January 2009, the assumption being that people were made redundant as a consequence of the economic downturn. The study participants were recruited from July 2010 to October 2010 following three main routes: 'opportunistic' recruitment outside the main Job Centre Plus in Bradford, through managers of local community centres that run employment programmes, and through two announcements on a local radio station. This strategy aimed at recruiting unemployed people from a variety of work experiences. Men and women of each age group were interviewed separately to better investigate how gender affected their views. The



participants' age range spanned from 17 to 62: 37 were in the age group 17-25, 19 were in the age group 26-49, and 13 were in the age group 50-65. Seven study participants belonged to ethnic minority groups.

The focus group interviews were transcribed in full and the transcripts analyzed using a thematic approach (Silverman, 2009). The Computer Assisted Qualitative Data Analysis Software Nvivo 8.0 (QSR, 2010) was used to organise and help with the systematic exploration of the interview transcripts. The analyses were undertaken by the first author and then, for validity purposes, the themes identified were discussed and reviewed among all of the authors.

Ethical approval for the study was obtained from the Faculty Research Ethics Committee at Leeds Metropolitan University. All participants in the interviews were given an information sheet detailing the project and their rights to withdraw from it at any time.

### **Study findings**

This section reports on the findings of the study participants' experiences of unemployment during the economic recession and on the impact that this event had on their everyday life, mental well-being, and quality of life. It is divided into three sections. The first section investigates the impact of job loss on the study participants' mental well-being and it focuses on their main sources of stress. The second section looks at elements of resilience and at factors that buffered the impact of unemployment on the participants' mental well-being. The third section examines the study participants' views and experiences of help and support, both from their private social networks and from the statutory and voluntary sectors.

The study participants discussed several ways in which the experience of firstly losing their

job followed by the acquired status of unemployment impacted on their mental well-being<sup>2</sup>.

In particular, six experiences that negatively affected the participants' mental well-being were discussed across all the focus group discussions and are here explored:

- financial strain;
- loss of time structure and motivation;
- anger;
- stigma;
- loss of social role;
- job market competition.

Financial strain and job market competition were two manifest consequences of respectively job loss and job loss at a time of economic recession. The remaining four experiences consisted of the emotional and psycho-social consequences of both involuntary job loss and the acquired status of unemployed.

**Financial strain.** One of the main sources of stress associated with the experience of unemployment was the financial strain caused by the subsequent income loss. Financial strain affected the study participants' mental well-being in two ways. On the one hand, there were the constant thoughts and fear of not having enough money to get by for the week or the month, especially for those who had family and children, which were major stressors.

This form of stress often had additional effects on family relations:

R1: Me and my missus nearly split up and everything over it 'cause of the lack of money, bills to pay [...] It were very hard. It puts a big strain on your family, you know  
(Focus group with males 18-25)

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<sup>2</sup> In this study mental well-being is defined as "a positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment" (Department of Health, 2010, p.12). See the Introduction chapter.

On the other hand, financial strain curtailed the study participants' ability to engage with their goals and plans, whether short, medium, or long term. This particular effect can be found expressed in some quotes from the previous section and in those quotes in which the participants compared their current situation to mere 'existence'. By this expression the participants meant to refer to the fact that, in their current situation, their main actions and goals were satisfying basic biological functions such as eating and sleeping, without having the financial capability to engage with wider goals:

The longer the study participants lived 'on the dole', the worse their financial situation was and, consequently, the harder its impact on their mental well-being through those two mechanisms.

**Loss of time structure, motivation and boredom.** The study participants, regardless of their sex and age, often talked about the impact that unemployment had on their everyday life in terms of losing time structure and routine. This was discussed as a frustrating experience that eventually affected their motivation to get out of their home and to engage in social or other activities. Some study participants reported how, in their experience, such a feeling of lack of motivation and boredom degenerated into a pathological state that induced their loved ones to suggest they looked for psychological help.

R1: There were days when I didn't get out of bed and just days run into one, when you're unemployed. You don't know what day's what. All you know is your signing day, I suppose. For me personally anyway.

R2: [...] You've got nothing to do all day. I mean luckily I have a dog to keep me busy and my cat you know, 'cos they need looking after, but I got really depressed and started to find it really hard to get out of bed in the morning (Focus group with females aged 18-25).

**Loss of social role.** The loss of social role that followed the study participants' job loss was another experience that negatively impacted their mental well-being. Clearly, for many study participants work had a central role in building their sense of self. The loss of the work-related social role caused lower self-esteem in many of them.

R1: As a professional [...] somebody who has been earning good money and just suddenly you are unemployed, you've lost your dignity ... You've lost your morale, sometimes you recline to depression ... (Focus group with males aged 50-65)

Involuntary job loss is only one type of transition from unemployment to non-employment, although very common during an economic recession. Other forms of transitions are retirement, return to education, maternity leave, family care, and long term illness (Thomas, Benzeval, and Stansfeld, 2005). The main characteristic of involuntary job loss is that people do not have any control over it. Whilst people might choose a change of social role in other forms of transition (for example maternity leave or return to education), they are more likely to experience the change of social role caused by involuntary job loss as an unwanted change.

**Anger.** Several study participants, particularly the younger ones, experienced anger and rage, which often manifested in 'flipping' at other people. They often talked of how these feelings affected their relations with loved ones and were a cause of distress.

I realised that I were taking my anger out for me losing my job on the people that were closest to me, I felt as though I was hurting so why shouldn't other people [...] Then in the end I thought well, it's not fair on them, just cos I'm hurting. It's no reason for me to give them my problems (Focus group 1 with females aged 18-25)

Often anger and resentment were caused by experience of stigma.

**Stigma.** The study participants, regardless of their age and sex, talked extensively of the stigma that they felt attached to being unemployed and living on benefits. It is relevant to distinguish here between the concept of 'enacted stigma' and 'felt stigma' (Scambler, 2004). The concept of enacted stigma refers to episodes of actual discrimination experienced by the study participants on the grounds of the negative stereotypical views of unemployed people as lazy and unwilling to look for a job. The concept of felt stigma refers to both the shame associated with being unemployed and/or on the dole and the fear of encountering enacted stigma. Sometimes felt and enacted stigma were associated with the particular area of Bradford from which the study participants came from. Whilst some study participants reported episodes of enacted stigma, the vast majority talked of their felt stigma. Felt stigma and enacted stigma are both powerful sources of stress (Scambler, 2004).

Some older study participants talked about their felt stigma regarding their age. Others were not sure about this issue. In certain cases it was difficult to understand whether they had been actually discriminated in the job market because of their age (enacted stigma) or whether they feared they had been discriminated because of their age (i.e. felt stigma).

R1: It's just really difficult from when you've worked for a lot of years and then suddenly you know, you're out of work again. And trying to get back into work now, I'm facing indirectly from two employers, I'm too old at 46 [...] I've been told I'm too old. I'm too experienced.

R2: I've had that. I felt like that 'cos I've been for interviews (Focus group with females aged 26-49)

**Job market competition.** Often the study participants talked about the frustration of not being able to find a job due to the high number of competitors for each single job advertised. The frustration, sense of impotence, and lack of control regarding this issue clearly affected their mental well-being.

R1: You going down [to the job centre] week in, week out and there might be two or three jobs. By the time you've rung them, forty people's rung them.

R2: Yeah.

R1: And, it's like, oh.... And it gets to the point where you think, suck it man. What is the point? Because there's no work out there (Focus group with males aged 18-25)

**Resilience factors: Coping strategies and fall-back roles.** Several factors moderated the impact that the above mentioned experiences had on the study participants' mental well-being. The two most frequently discussed were:

- personal resources and coping strategies;
- the practical help and emotional support that they received from their family and friends.

This section explores the personal resources and strategies that the study participants used to cope with the stress caused by being unemployed. These were categorised into two groups:

- coping strategies, and
- fall-back roles.

The following section will discuss the type of help and support that reduced the impact of unemployment on people's mental well-being and quality of life.

*Coping strategies.* Some study participants adopted problem-focused coping strategies to deal with the above mentioned sources of stress. These consisted of a series of actions and behaviours that aimed at altering or managing the situation in which they found themselves (Julkunen, 2001). Examples of control-focused techniques were to keep trying to find a job and making plans of action.

Other study participants engaged in emotion-focused coping strategies. These consisted of activities aimed at reducing or managing one's emotional distress (Julkunen, 2001). Based on Latack's (1986) scale of coping, emotion-focused copings strategies were categorized into three types:

- control-oriented strategies, i.e. searching for emotional support,
- escape or avoidance strategies, i.e. denial, trying to forget the whole thing,
- 'symptom management', i.e. exercise and relaxation.

Escape strategies included 'unhealthy' strategies such as excess drinking, smoking, and taking illegal drugs.

The study participants' emotion-focused coping strategies differed on the basis of their gender and age. The majority of the male study participants tended to engage in avoidance or symptom management strategies, such as doing exercise, and showed reluctance to engage in searching for emotional support, that is in control-oriented strategies. This led them to live their experience of unemployment as a 'private' issue, despite the common nature of the causes of their unemployment. On the other hand, women tended to look more actively for emotional support and they did not discuss examples of escape or symptom management strategies.

Pride and fear of appearing to be begging for money were the main causes of avoidance strategies and for not actively searching for emotional support among men, regardless of their age. Clearly, having a job was important not only financially, but also because it helped to fulfil the social role of breadwinner with which the study participants identified themselves. 'Complaining' about not having a job was seen as admitting failure with regard to that goal. Older male study participants referred to the strength of their character and to the view that 'men' do not talk about their personal problems; they "laugh them off" or "bottled them up".

Both young and older men referred to their upbringing as the main cause of their negative attitude towards sharing their distress and emotional problems with others. However, one young study participant seemed to be more open to share his emotions:

R1: I've got my pride.

R2: Pride, innit, yeah.

R1: I don't want no one to dent it and I won't want to dent it myself by saying, oh, yeah, I can't get a job, I'm useless, to somebody who'll be, like, what?

R2: Shut up or something.

Interestingly, women, regardless of their age, shared this view that 'men' do not talk about their emotions. They attributed it both to an element of masculinity (it was not a "blokey" thing to do) and to the fact that men are expected to be breadwinners, so they cannot talk about their issues because that would mean admitting failure. Women, regardless of their age, viewed themselves as more open to sharing their emotional problems and stress with other women. They also often actively looked for emotional support from friends and relevant others when they needed it, which helped some of them to recover from depressive symptoms.

*Fall-back role.* Having a 'fall back' social role, such as housekeeping, for females, parenthood and volunteering, for both males and females, was often helpful to compensate the stress associated to the loss of one's work-role and to give a structure to one's days:

R1: I used to volunteer when I were out of work [...]

R2: Yeah, I've done some volunteer work [...] I've worked there previously, helping out now and again if I'm not doing nought [...]

R3: I'll go and have a game of footy (Focus group with males aged 18-25).

However, having a 'fall back' role was not necessarily related to the type of coping strategy adopted by the study participants to deal with their other sources of stress. This was



particularly the case among the younger study participants. Some of them fulfilled their roles as parents and then also either smoked cannabis or drunk in excess.

**Resilience factors: Social support and access to services.** This section explores the study participants' sources of support and their attitudes, views, and experiences of services in relation to their mental well-being. It also reports the main themes that emerged from the interviews with the stakeholders of mental health and other related services in Bradford.

*Help and support from family and friends.* Those among the study participants who had a family, or had contact with their families, stressed the importance of this source of support. Often families were the first and more important source of practical help and material support; they offered shelter and money when needed. However, not all of the study participants talked about family members as ideal sources of emotional support. Some study participants found their families a fundamental source of both practical and emotional support, others received material support, but not emotional support. In these latter cases, friends, or even unknown people, were indicated as better candidates to discuss problems with. Sometimes the study participants experienced at home that type of pressure and stigmatisation that are typical of enacted stigma and 'victim-blaming'.

R1: [...] Talking to a family member, they've got their two penny's worth to put in haven't they? They know the situation and that.

R2: Yeah and if they're arguing they could bring it all up all the time (Focus group 1 with females aged 18-25)

Often it was a close family member or friend who understood that the study participants had serious depressive symptoms and that they needed help. As seen in the previous section, women tended to be more active in looking for emotional support, however, they often shared the same type of views and reluctance as men when it came to accessing formal services.

**Access to services. Study participants' views and experiences.** The experiences and views of the study participants regarding services are grouped into three main categories: Job Centres, Doctors, and voluntary and other relevant services.

*Job Centre.* The study participants had contrasting views on the services they received from the Job Centre. Several study participants were frustrated from having to wait six months before being able to receive full support to look for a job, including starting retraining courses. Among those who were enrolled in retraining courses, some found them useful, others demotivating and a waste of time. The main reason given for this was that all unemployed people were offered the same kind of courses regardless of their previous experiences and education.

Some study participants thought that they had not been given full information regarding the services available from the Job Centre, for example about crisis loans or claiming for a bus pass. Others had been given that information. Some had learnt about the service from each other at the focus group or had been told by friends or family members.

R1: I never got told anything about crisis loans or anything when I were at the Job Centre. [...] I were actually eligible to claim for a bus pass for the first month because, it's a month in hand when you work and it were someone else that told me [...]

R2: It weren't like that with me.

R3: [...] They didn't tell me, I had to hear it from my family.

R2: I think I asked so many questions, that's why I probably know [All laugh] (Focus group with females aged 18-25)

Overall, the study participants found the mechanisms of signing in every fortnight frustrating and stigmatising.

*Doctors.* Both males and females expressed reluctance to go to the GP to address their symptoms of depression and stress. The main reasons were that they did not want to be

prescribed antidepressant tablets, which were seen as a source of stigma, and that they thought that the only solution to their problems was finding a job. One young woman who went to the GP to ask for help for her depressive symptom was offered cognitive therapy, but was informed that there was a waiting list of 10 months.

R1: The last time I spoke to anybody they turned round to me and said you need to see a doctor, he says because you look clinically depressed. And I said well you know what's he going to do, give me tablets? It's not going to help me. I said all they're doing is putting you into a label, they're giving you tablets like beta blockers, things like that which take all the emotion away and make you into a zombie, that's not what you want.

R2: Worse thing you could do to yourself, start on that [...]

R3: Because when you go to the GP what they do they class you as somebody clinically depressed [...] What somebody needs is a psychological comfort, somebody who knows your problem, who understands your problems and who is ready to talk to you about it (Focus group with males aged 50-65)

*Other relevant services.* Several study participants had a proactive approach to their financial problems and looked for practical help and support. Several used the Citizen Advice Bureau services and found them helpful. A young woman was referred to a psychological consultant by the Job Shop, and she found that very helpful. However, none of the study participants mentioned other voluntary sectors services, such as those offered by Mind in Bradford, or Relate.

When the study participants were asked what services would ease their financial and emotional problems, several of them suggested two main options. With regard to the financial problems, they suggested that those who cannot afford to keep up with the

payment of their utility bills should be given a chance to stop and postpone their payments for a while. As one woman put it:

If you lose your job and you get into debts you don't get the help from like the [utilities] companies 'cos you can ring them and tell them that you're struggling with your bills and they're still sending you the snotty letters and the nasty phone calls and it don't help people. (Focus group with females aged 26-49).

With regard to the emotional support, the several quotes reported in this section show that many study participants found counselling services with people who they did not know were beneficial for their mental well-being.

## **Discussion**

The study reported in this paper set out to explore the impact of involuntary job loss at a time of economic recession on people's everyday life (their goals, lifestyle) and mental well-being (their morale, self-esteem, and experience of distress). The study identified six main experiences that had a major impact on the study participants' mental well-being. These were:

- the financial strain caused by income loss;
- the difficulty to find a job due to the stronger market competition;
- the loss of time structure in the day;
- the loss of social role;
- anger and frustration for one's situation; and
- the stigma attached to being unemployed.

The impact of these experiences on people's mental well-being was moderated by two main sets of resilience factors, their coping strategies and their social and emotional support.

Some study participants engaged in problem-focused coping strategies, which research has shown to be important for successfully re-entering the job market (Julkunen, 2001).

However, men were found to be reluctant to look for emotional support; women were more open to share their distress with relevant others in order to find relief from it. Research has

shown that both emotion-focused coping strategies, particularly looking for emotional support, and problem-focused strategies are important for the mental well-being of the unemployed (Julkunen, 2001). Several young male study participants talked about abusing alcohol and taking illegal drugs to cope with their stress; these unhealthy coping strategies were not mentioned in other focus groups.

Families were referred to as a fundamental source of practical and material help; they were often able to offer shelter and money when needed. Nonetheless, not all the study participants had a family to rely on. Also, not all the study participants found family members the best people to turn to for sharing their stress and unemployment related problems.

This study indicates the need to help unemployed people to address both the socio-psychological and emotional consequences of involuntary job loss, i.e. the loss of time structure in the day, the loss of social role, anger and frustration, and the stigma attached to being unemployed, and its material and manifest consequences, i.e. financial strain and lack of jobs.

Interventions set in primary care, labour market programmes, and in the community aimed at addressing the emotional and psycho-social consequences of unemployment can have a major positive impact on unemployed people's mental health and well-being, particularly at times of economic recession, when lack of jobs can imply periods of longer unemployment. However, unemployed people's difficulty in finding a new job and their financial problems may need wider socio-economic interventions. These cannot be delivered at the individual or community level, but involve structural interventions, i.e. government interventions aimed to sustain and expand the job market and interventions aimed at helping people financially during unemployment.

The Coalition Government Big Society agenda is about moving power away from central

government and giving it to local communities and individuals. It has three main aims

(Cabinet Office, 2011):

- Empowering communities – helping and enabling local people to have more of a say in how decisions are made in their area and about the services they receive.
- Changing and opening up public services – encouraging public sector organisations and individuals to demonstrate new and innovative ways of delivering public services and enabling charities, social enterprises, private companies to deliver public services.
- Promoting social action – encouraging people to be more involved in their communities and to volunteer and give money.

These three aims can potentially all help to further expand interventions at the individual and community level to address the emotional and psychosocial effects of unemployment. The literature on the interventions aimed at improving the mental health and well-being of unemployed people has shown that cognitive behavioural therapy work well with unemployed people clinically diagnosed with mental health problems, but not with the population of unemployed people at large. There is therefore a need to develop non-psychological and non-pharmacological interventions for unemployed people suffering the socio-psychological and emotional consequences of job loss, particularly at times of economic recession, when the number of unemployed people rises dramatically. The Big Society agenda, theoretically, could help to create and support such interventions by favouring self-help initiatives aimed at strengthening people's control, self-efficacy, and self-esteem and, therefore, contribute to reduce felt stigma. In particular, the Big Society agenda could help:

- to extend the use of self-help and support groups among unemployed people, for example through the Work Clubs recently started by the Department for Work and Pensions or through the Community Health Champions initiative;

- to strengthen the network of charities and social enterprises as well as private organizations involved in helping unemployed people to strengthen their personal working profile as well as in offering emotional and psychological support;
- to extend the collaborations between primary care and the voluntary sector for early diagnosis and interventions for mental health problems such as anxiety and depression, for example through initiatives such as social prescribing;
- to expand people's involvement in volunteering activities, which can further help to address emotional and psychological issues, in particular those related to lack of structure to the day and loss of social status.

Nevertheless, there are two main tensions to be highlighted in relation to the role of the Big Society agenda in the promotion of the mental health and well-being of unemployed people at times of economic recession. On the one hand, because of the cuts to public investments, the Big Society agenda is criticised for the fact of undermining the possibility of third sector stakeholders to operate effectively. On the other hand, such an agenda runs the risk to shadow similarly important, wider socio-economic government interventions aimed at addressing structural issues that cause unemployment and/or delay job markets recovery, which the reviewed literature on suicide rates at times of economic recession showed can have a major impact at the population level, and material issues such as unemployed people's financial difficulties. They can also overestimate the capacity of weaker segments of the society, such as unemployed people, to be empowered and to have real choice in relation to what services they prefer to use to meet their needs (see, Coote, 2010).

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