Mental Health Challenges and Work

Advanced Topics and Future Research Directions

Edited by Emily H. Rosado-Solomon

First published 2026

ISBN: 978-1-032-78920-0 (hbk)
ISBN: 978-1-003-49117-0 (ebk)

2 Conceptualizing and Measuring Mental Health

A Clinical Psychology Perspective for Workplace Research

Sheila K. Hanson and Emily H. Rosado-Solomon

DOI: 10.4324/9781003491170-3

Routledge
Taylor & Francis Group
NEW YORK AND LONDON

2 Conceptualizing and Measuring Mental Health

A Clinical Psychology Perspective for Workplace Research

Sheila K. Hanson and Emily H. Rosado-Solomon

Introduction

Scholarship on work and mental illness has expanded, although challenges have stymied research integration across fields of study, especially heterogeneous construct definitions and measurements of mental health including mental illness, related symptoms, and nonclinical states of poor mental health (Rosado-Solomon et al., 2023). The heterogeneity obscures relationships between similar constructs and impedes any ability to uncover complementarity. Poor understanding of construct alignment and measurement may cause researchers to misinterpret their findings. Lack of precise measuring and conceptualizing mental health challenges can produce inefficient research, with resources spent on duplicate studies of extant knowledge instead of building on previous research.

These concerns predominate in management research, where increasing attention has gone to mental health challenges in a disjointed way. This construct heterogeneity is less prevalent in clinical psychology, which has a longer history of studying mental health challenges and more standardization of conceptual boundaries across studies. Diagnostic criteria for each identified mental illness are defined in the *Diagnostic and Statistical Manual of Mental Disorders, 5th edition* (*DSM-V-TR*). Periodic updates reflect changes in psychologists' understanding of various mental illnesses (Regier et al., 2013). The updating promotes alignment between construct and measurement, which enables diagnostic criteria to reflect current scientific understanding. This alignment is crucial to ensure that constructs defined in the manual represent accurately the disorders they are intended to diagnose, in turn fostering measurement precision. Clinical instruments have been developed to assess various mental illnesses using clinically derived approaches to diagnose and treat problems. Given the established body of research on mental health and mental illness in clinical psychology, we propose incorporating a clinical psychology perspective, which is essential to inform management scholars who conduct research on mental health and mental illness in the workplace.

DOI: 10.4324/9781003491170-3

This chapter has three goals. First, the chapter defines and differentiates mental illness and (poor) mental health, comparing mainstream definitions in clinical psychology to concepts published in management literature. Second, the chapter describes how and why measurement tools are used to study mental health and illness, noting challenges for adopting clinical instruments in nonclinical contexts and their use by persons who are not clinically trained. Third, the chapter highlights research implications for organizational scholars and management. In summary, this chapter provides a useful overview of measurement issues for organizational researchers.

Define and Differentiate Mental Illness and (Poor) Mental Health

Mental Health

Mental health is defined as "a state of mental well-being that enables people to cope with the stresses of life, to realize their abilities, to learn well and work well, and to contribute to their communities" (World Health Organization [WHO], 2022, p. 8). Other terms to describe positive states of mental health include mental well-being (Pollard, 2001) and thriving (Porath et al., 2012). A nuanced discussion of positive mental health constructs (e.g., thriving; Goh et al., 2022) is beyond the scope of this chapter, although such constructs are somewhat related to mental health challenges. Mental health is an integral component of health and well-being and "is more than the absence of mental disorder" (WHO, 2022, p. 8). Clinical psychologists provide mental health services somewhat analogous to physical health services that prevent or intervene with physical illness and promote health. Clinical psychologists focus on diagnosis and treatment of mental illness with a goal to enhance mental health in a holistic sense, as they work to improve coping skills, functioning, and quality of life to the degree possible (Cuijpers et al., 2014; Davidson & Roe, 2007). In research, clinical psychologists might refer to poor mental health as a relative term or use the phrase "negative mental health outcomes" (e.g., Emmer et al., 2024) to describe a range of issues.

Mental illness and poor mental health are related but distinct concepts often conflated in management literature (Follmer & Jones, 2018; Rosado-Solomon et al., 2023). Poor mental health is a broad concept that may not meet the threshold for a clinical diagnosis but still impacts well-being and functioning. It may include experiences of strain (Karasek, 1979), burnout (Maslach & Jackson, 1981), or general psychological distress (e.g., Hardy et al., 2003) without a diagnosed mental disorder. Unlike mental illness, poor mental health may or may not involve significant impairment. Some management studies use "mental health" as a catch-all term encompassing diagnosed mental illness and general psychological well-being (Rosado-Solomon et al., 2023). Others focus on mental well-being as distinct from poor mental health, recognizing that people can have generally good mental well-being while still experiencing symptoms of mental illness, just as people can be in generally good physical health (exercising, eating

well, etc.) while simultaneously experiencing a physical health concern (e.g., a broken ankle; Rosado-Solomon et al., 2023).

Two work-specific constructs, job strain and burnout, often appear in management studies on poor mental health (Bliese et al., 2017) and in clinical psychology literature (Deling et al., 2024). Scholars debate the relationship between these constructs and mental health challenges that are clinically derived (Bianchi et al., 2015). Some scholars note that job strain may have a causal relationship with mental illness (or symptoms thereof) (e.g., Madsen et al., 2017), whereas others view burnout and job strain as states of poor mental health that are problematic in their own right and that may lead to outcomes related more to the organization, such as turnover and impaired job performance. (For reviews on the consequences of burnout and strain, see Edú-Valsania et al., 2022, and Bliese et al., 2017, respectively.)

Mental Illness

To distinguish between mental health and mental illness, it is useful to consider how mental illness is defined. In clinical psychology, mental illness refers to diagnosable mental disorders characterized by significant disturbances in cognition and emotion regulation, or behavior that reflects dysfunction in psychological, biological, or developmental processes causing distress and impairment (American Psychiatric Association [APA], 2013). Mental illnesses are specific, diagnosable conditions like major depressive disorder (MDD) or generalized anxiety disorder (GAD).

Some types of mental illness share symptoms with constructs reflecting poor mental health. Bianchi and colleagues (2015) have shown significant empirical overlap between burnout and depression, with commonalities across various measures. However, a key distinction is that mental illness impairs two or more life domains (APA, 2013), whereas burnout is domain-specific and need not produce substantive impairment (Koutsimani et al., 2019). In other cases, there is a distinction between mental illness and poor mental health. For example, there is not only a strong association between worry and poor mental health but also significant heterogeneity. The presence of worry and poor mental health does not translate to a diagnosed mental illness such as GAD or MDD (Vîslă et al., 2022).

Given these differences, we now turn to measurement approaches in clinical psychology to explain the distinction between, and consequently the research implications of, various mental health constructs.

Measurement Tools Used to Study Mental Health and Illness: How and Why

Clinical psychologists use various measurement tools to study mental health and illness. Three ways to track and assess mental health conditions include screening, diagnosis, and monitoring of symptom severity and treatment outcomes.

Some tools are used with only one type of assessment; other tools can be used in multiple ways depending on their intended purpose. All are crucial for both clinical practice and research, providing standardized procedures to assess and track mental health conditions. We first review, then clarify, the implications of this framework for management researchers who wish to investigate mental health challenges.

Screening Tools

Screening tools are designed to identify, often by short questionnaires, individuals who may have mental health conditions. Two common examples are the generalized anxiety disorder-7 (GAD-7) and the Patient Health Questionnaire-9 (PHQ-9) developed for use in primary care settings. The GAD-7 is used widely to screen for anxiety symptoms indicating possible anxiety disorders (Spitzer et al., 2006). The PHQ-9 (Kroenke et al., 2001) is a self-report measure that aligns closely with DSM-5 criteria for MDD. It is commonly used to screen for depression but does *not* provide sufficient evidence of a MDD, as its purpose is to screen for depressive disorders with high sensitivity (Pettersson et al., 2015). Screening tools should not be interpreted as signaling a certain mental illness because a different diagnosis (e.g., bipolar disorder) may better explain symptoms in a full diagnostic assessment. These two examples of screening tools are often used in primary care settings and mental health clinics. They can be administered quickly and can provide early indication of potential issues to follow with comprehensive assessment.

The self-report tools above, as well as others, capture an individual's perception and understanding of their mental health (Smith, 2019). Self-report assessments are advantageous in clinical settings for quick screening and for referral to healthcare providers (Kroenke et al., 2001). They are efficient for collecting data on large populations because they are easy to administer and scalable online (Kolc et al., 2023). They are also useful because they do not require a clinician to have specialized expertise in psychology to administer an assessment, making them ideal for a primary care physician to refer patients to a specialist if needed. However, these tools are susceptible to bias and inaccuracy. Self-report measures may reflect a respondent's current mood (even though instructions specify reflection over the past two weeks), social desirability bias, or lack of insight into their own symptoms and mental health (Atkinson et al., 1997). This can lead to underreporting or overreporting of symptoms. An individual may underreport symptoms that are stigmatized or socially undesirable, such as substance abuse or certain psychiatric symptoms, to present themselves in a more favorable light (Gnambs & Kaspar, 2015). Deliberately inaccurate reporting is often referenced as "faking good" or "faking bad" to influence outcomes such as psychological readiness for military service (e.g., Boss et al., 2015). Individuals may infer

meaning from the research instrument itself (Schwarz, 1999). For these reasons, supplementing self-report measures with clinical interviews can enhance interpretation. Developing rapport and creating a supportive, non-judgmental environment in clinical interviews can encourage accurate reporting (Rogers, 1957), as individuals are more likely to disclose true experience when they feel valued (Miller & Rollnick, 2013).

Although not as frequently used in clinical psychology, measures of burnout and job strain may be described as analogous to screening tools. They assess the extent to which one displays symptoms, but they are not often used to determine whether a person experiences burnout or strain. (For benchmarks of relative levels, see Maslach et al., 1996.) For readers interested in measuring these constructs, Edú-Valsania et al. (2022) present a review of burnout measurement and Hurrell et al. (1998) a review of measuring job strain.

Diagnostic Approaches

A second approach to measurement is diagnosis, which helps clinicians determine whether a person meets the criteria for an established mental illness. Self-report measures are used as a component of diagnosis, but diagnoses are not based solely on self-report measures. Self-report tools, clinician-rated measures, and clinical judgment approaches in mental health assessment offer unique insights and viewpoints. Self-report measures ask individuals to provide subjective information about symptoms of their own mental health through structured questionnaires or surveys (Schwarz, 1999). In contrast, clinician-rated measures rely on trained professionals evaluating the presence and severity of symptoms based on clinical judgment and observations during interviews or standardized assessments (Groth-Marnat, 2009). Clinical psychologists evaluate symptoms and functioning while incorporating behavioral observations and considering diagnostic criteria using clinical judgment (Groth-Marnat, 2009). This procedure is usually not possible for management researchers to replicate without an interdisciplinary team. It requires trained clinical judgment and integration of multiple information sources such as self-report measures, behavioral observations, and clinical interviews.

Diagnostic tools support clinicians in making formal diagnoses of mental health conditions. Clinical psychologists use standardized assessment tools validated through extensive research and often normed with multiple samples. Assessment and diagnosis often involve structured or semi-structured interviews and validated questionnaires that correspond to diagnostic criteria. Clinical interviews using clinician-rated measures are generally considered the gold standard for diagnosing mental health conditions in both research and practice (e.g., Subica et al., 2014).

In addition to measuring symptom presence and severity, clinician evaluation of an individual's mental health history is key to diagnosing mental illness. Many

types of mental illness have similar symptoms, and it is necessary to distinguish which symptoms are most associated with which conditions. A process called differential diagnosis can make this distinction. It is part of a larger diagnostic picture beyond individual assessment tools and measures. Sometimes, diagnostic tools used to measure symptoms (e.g., Barkley's Adult ADHD Rating Scale; Barkley, 2011) may mislead management researchers. Without supporting clinical data, a practitioner could misinterpret clinical levels of ADHD symptoms as ADHD, when these symptoms are explained by a different condition, such as generalized anxiety (Alarachi et al., 2024). Both self-report and clinician-rated measures play pivotal roles in mental health assessment and differential diagnosis. They offer complementary perspectives that contribute to understanding an individual's mental health status and treatment needs. Formal diagnosis is comprehensive. It includes quantitative data (self-reports, clinical assessment) and qualitative data (structured interviews, behavioral observation). Although management scholars do not conduct diagnostic assessment in their research, understanding the process serves as a useful way to highlight the divide between assessing symptoms and evaluating chronic mental illness.

Symptom and Outcome Monitoring Tools

In addition to screening and diagnostic tools, clinical psychologists use standardized assessment tools to measure changes in symptom severity over time and to monitor treatment effectiveness in reducing symptoms. Regular use of these measures can help guide therapeutic interventions and track progress. Assessment tools are essential in clinical practice to confirm diagnoses, plan treatment, and monitor progress. The same assessment tools may be used to screen symptoms, clarify diagnoses, and monitor symptoms in the same person over time to track individual changes. Thus, assessment tools may be used in similar but meaningfully nuanced ways, requiring care and consideration by trained mental health professionals.

An example of a symptom management tool is the Beck Depression Inventory (BDI-II; Beck et al., 1996a). It is a self-report to assess the intensity of depressive *symptoms*, and it is widely used in both clinical and research settings. As a screening tool, the BDI-II can assess the presence and severity of depressive symptoms in clinical settings. It consists of 21 items that measure various symptoms of depression, including mood, pessimism, sense of failure, and physical symptoms such as fatigue and loss of appetite (Beck et al., 1996a). As a symptom-tracking tool, BDI-II may be used to track symptoms, monitor symptom changes over time during treatment, and adjust interventions accordingly (Gorman, 2015). As a research tool, the BDI-II represents *symptoms* rather than clinically diagnosed depressive disorders verified by clinicians. Clinical psychologists develop an evidence base for their clinical interventions, so both the BDI and BDI-II have served in randomized clinical trials to evaluate intervention effectiveness for depression (see Cuijpers et al., 2014).

Challenges in Using Clinical Instruments

Although assessments developed in a clinical setting are attractive to management scholars because of their rigorous development and validation, management researchers should consider certain challenges before adopting a clinically derived instrument. We now review some of the most notable challenges.

Contextual Validity

Clinical instruments are designed and validated within clinical settings to assess specific mental health constructs and disorders. Clinicians ensure that instruments have appropriate psychometric properties and clinical utility for their intended purpose. Extensive psychometric testing in clinical samples establishes the reliability, validity, sensitivity, and specificity of clinical instruments. For example, the original BDI was developed in 1961 to detect, assess, and monitor changes in depressive symptoms among individuals in psychiatric inpatient and outpatient settings (Beck et al., 1961). A second version of the inventory (BDI-II) was developed using a psychiatric adult outpatient sample and a control group (Beck et al., 1996b). Although the BDI-II provides information about the presence and severity of depressive symptoms, a formal diagnosis should *not* be made without clinical assessment by a qualified mental health professional (Beck et al., 1996b). When using clinical assessment tools in nonclinical contexts like a workplace, the relevance and interpretation of clinical measures as with the BDI-II could differ significantly. The comorbidity of other conditions like Post-Traumatic Stress Disorder (PTSD) in service members and veteran populations may be important (Reis et al., 2020).

On the other hand, some measures were not intended for clinical use. For example, in personality research, many Big Five personality instruments (those that measure extraversion, neuroticism, conscientiousness, openness to experience, and agreeability; Walton et al., 2008) do not have the content or sensitivity to assess the entire range of each construct (Dilchert et al., 2014). Therefore, commonly used personality instruments are not appropriate from which to make clinical research inferences, even for those that demonstrate extreme levels of a given trait. Although clinical psychologists have moved toward dimensional personality assessment, this does not mean that high levels of a personality trait automatically translate to a diagnosed mental illness (e.g., Narcissistic Personality Disorder [NPD]; Day et al., 2024). Rather, clinical psychologists use other assessment tools, such as the MMPI-3, to assess personality pathology and other forms of psychopathology together with a clinical interview (Ben-Porath & Tellegen, 2020).

Clinical Expertise and Scope

Management researchers lack the clinical training necessary to determine appropriate assessment tools, and then administer them and interpret the results. For example, using clinical instruments such as the Structured Clinical Interview for

DSM Disorders (SCID) and the Minnesota Multiphasic Personality Inventory (MMPI) series requires extensive training or supervision. A research version of the SCID-5 is available (First et al., 2015). Administering and interpreting with the MMPI-3 require specialized education and training on its structure, scales, and interpretation guidelines (Ben-Porath & Tellegen, 2020). An error in understanding assessment results can lead to misdiagnosis or inappropriate treatment recommendations (Ben-Porath & Tellegen, 2020).

Inadequate training may cause failure to contextualize test administration, such as by missing cultural or situational factors, which can skew results. Overreliance on tests and measures can lead to overlooking important information from clinical interviews, history, or other assessments, resulting in biased or incomplete conclusions (Graham, 2021). Practitioners and researchers must understand the limitations of assessment tools. For instance, tools designed for screening and symptom monitoring have a short temporal referent; in other words, they are meant to address symptoms over a time period of about two weeks. Scores should not be interpreted to represent events outside the temporal referent, such as a work event that occurred in prior years (Rosado-Solomon et al., 2023). As another example, persons with clinically significant symptoms of anxiety or depression do not necessarily have a diagnosed mental illness (e.g., GAD or MDD), so it is not appropriate to make inferences about participants having mental illness based on symptom measures. Clinically significant symptoms according to the DSM-V/V-TR refer to symptoms that are severe and frequent enough to impact negatively an individual's ability to function in multiple life domains, such as work and social settings (APA, 2013, 2022). An example of misguided inference might be assuming a person with high levels of depressive symptoms has experiences similar to those of someone with clinical depression, such as when facing stigma or navigating identity-related issues. In their review of mental health and work, Rosado-Solomon and colleagues (2023) found several studies that made just such an inference, highlighting the need for more nuanced insight when interpreting results.

Cultural Sensitivity

Clinical instruments are often developed and validated within specific cultural and clinical populations, and their applicability and validity may vary across different cultural and organizational contexts (Van de Vijver & Tanzer, 2004). Differences in cultural norms, work environments, and organizational structures affect how individuals perceive and respond to items on these instruments. Clinical instruments may not be culturally sensitive or appropriate for diverse workplace populations, potentially leading to biased or inaccurate results (Follmer & Jones, 2018). For example, in populations with East Asian heritage, depression is more likely to manifest as somatic symptoms (headache, body aches) than in Western contexts, where affective symptoms (sadness, low mood) are more

likely (Sue & Sue, 1987). In samples disproportionately affected by known systematic trends, researchers should consider whether a given assessment tool is likely to capture phenomena of interest. This example underscores the need to use assessment tools that are validated and normed for relevant populations, especially in cross-cultural or international research. Several common assessment tools have been validated in multiple languages and various cultural contexts, including the BDI-II (Wang & Gorenstein, 2013) and the PHQ-9 (Murray et al., 2022).

Ethical Considerations

Unique ethical considerations may dictate the selection of clinical instruments for a management setting, especially in studies lacking clinician involvement. Popular scales include items that may produce sensitive information, and management researchers must think about how to handle information if it indicates a risk of harm. The PHQ-9, commonly used to measure symptoms of depression, asks about an individual's thoughts of self-harm (Wu et al., 2020). Especially in cases where researchers might be able to trace the identity of a respondent, such as with a master coding sheet, researchers must consider what they will do if they learn of a participant's thoughts of self-harm (e.g., suicidal ideation), as there may be an ethical obligation to act on this information. Such planning is typically done in clinical psychology research, where a protocol is developed for potential scenarios before research begins (Goodsmith et al., 2021). Alternatively, researchers may consider using a measure that does not risk producing such information. Institutional Review Boards (IRBs) will sometimes weigh in on guidelines for research on sensitive topics. Continuing the previous example, the PHQ-8 is a well-validated version of the PHQ-9, identical to the original measure omitting the item on thoughts of self-harm (Wu et al., 2020).

Using clinical instruments in nonclinical settings may raise ethical concerns about the use of diagnostic tools outside clinical practice. It is essential to consider potential consequences, such as implying the relevance of a mental health challenge to participants who may not share the view that it aligns with their professional or personal identities (American Psychological Association, 2017), resulting in alarm, distress, or confusion. Using clinical instruments in a workplace may raise ethical issues of privacy, confidentiality, or discrimination. Employees may feel uncomfortable disclosing sensitive mental health information to employers (Dimoff & Kelloway, 2019) or may be tempted to "fake good" if they do not trust researchers to maintain confidentiality. These potential outcomes suggest the negative consequences of accidental confidentiality breach for data on mental health challenges. Such a scenario could open liability for researchers and employees if the material is identified by participants' employers, or if it influences workplace decisions or violates employment laws and regulations (Dimoff & Kelloway, 2019).

Research Implications

In this chapter, we focus on quantitative research strategies that involve clinical psychology and that use clinical measurement tools and approaches to assess mental health and mental illness in workplace research. This is an opportunity for management scholars to address the importance of mental health and mental illness at work, introducing another field of study, clinical psychology, into management research.

Misuse of tests and measurements, whether through inadequate training or misinterpretation, can lead to harmful consequences for those being assessed in workplace research studies with implications for workplace settings. Management scholars who wish to conduct workplace research can focus on improving conceptual precision with clinical measures and tools. Studies that use Experience Sampling Methodology (ESM; Gabriel et al., 2019) to gather repeated measures of symptoms should rely on assessment tools that have been validated for symptom monitoring. Likewise, studies that investigate more static relationships, such as the impact of a major work event on long-term mental health, might select a different tool that better captures enduring symptoms. Most importantly, it is critical to provide strong transparency about the research methods, measures used, and rationale for those choices in order to help readers interpret and utilize the evidence in the studies.

Extensive training is needed to navigate measurement considerations. Interdisciplinary research teams could integrate both the management and the clinical psychology perspectives. Including a "native speaker" in clinical psychology may be of benefit in conducting new research and reviewing existing research. There is evidence of this approach in multidisciplinary reviews (Howard et al., 2022), but fields often operate independently (Rosado-Solomon et al., 2023). Yet there is precedent for interdisciplinary practice, as clinical psychologists often work side by side with psychiatrists and other medical professionals to leverage the expertise of more than one field. Bringing together interdisciplinary research teams of management scholars and clinical psychologists is one way to leverage assessment tools aiming toward best practice and ethical use. We view it as aspirational and desirable for clinical psychologists to partner with management researchers for shared benefit. Joining forces captures the expertise in both fields, informing research design, execution, and results.

Conclusion

This chapter integrates clinical psychology and scholarly management perspectives, differentiating mental illness from poor mental health. In describing the assessment processes of screening, the diagnostic and symptom management tools used by clinical psychologists, and the challenges of using clinical instruments in management research, this chapter brings to light multiple implications

for research and practice. The chapter shares a pragmatic overview of measurement considerations for organizational researchers through the lens of clinical psychology research and practice.

References

Alarachi, A., Merrifield, C., Rowa, K., & McCabe, R. E. (2024). Are we measuring ADHD or anxiety? Examining the factor structure and discriminant validity of the Adult ADHD Self-Report Scale in an adult anxiety disorder population. *Assessment*, *31*(7), 1508–1524.

American Psychiatric Association (APA). (2013; 2022). *Diagnostic and statistical manual of mental disorders* (5th ed.; DSM-5) and DSM-5-Text Revision (DSM-5-TR).

American Psychological Association. (2017). *Ethical principles of psychologists and code of conduct*. https://www.apa.org/ethics/code/

Atkinson, M., Zibin, S., & Chuang, H. (1997). Characterizing quality of life among patients with chronic mental illness: A critical examination of the self-report methodology. *American Journal of Psychiatry*, *154*(1), 99–105.

Barkley, R. A. (2011). *Barkley Adult ADHD Rating Scale-IV (BAARS-IV)*. Guilford Press.

Beck, A. T., Steer, R. A., Ball, R., & Ranieri, W. F. (1996b). Comparison of Beck Depression Inventories-IA and –II in psychiatric outpatients. *Journal of Personality Assessment*, *67*, 588–597.

Beck, A. T., Steer, R. A., & Brown, G. K. (1996a). *Manual for the Beck Depression Inventory-II*. Psychological Corporation.

Beck, A. T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry*, *4*(6), 561–571.

Ben-Porath, Y. S., & Tellegen, A. (2020). *MMPI-3 manual for administration, scoring, and interpretation*. University of Minnesota Press.

Bianchi, R., Schonfeld, I. S., & Laurent, E. (2015). Burnout–depression overlap: A review. *Clinical Psychology Review*, *36*, 28–41.

Bliese, P. D., Edwards, J. R., & Sonnentag, S. (2017). Stress and well-being at work: A century of empirical trends reflecting theoretical and societal influences. *Journal of Applied Psychology*, *10*, 389–402.

Boss, P., König, C. J., & Melchers, K. G. (2015). Faking good and faking bad among military conscripts. *Human Performance*, *28*(1), 26–39.

Cuijpers, P., Karyotaki, E., Weitz, E., Andersson, G., Hollon, S. D., & van Straten, A. (2014). The effects of psychotherapies for major depression in adults on remission, recovery and improvement: A meta-analysis. *Journal of Affective Disorders*, *159*, 118–126.

Davidson, L., & Roe, D. (2007). Recovery from versus recovery in serious mental illness: One strategy for lessening confusion plaguing recovery. *Journal of Mental Health*, *16*(4), 459–470.

Day, N. J. S., Green, A., Denmeade, G., Bach, B., & Grenyer, B. F. S. (2024). Narcissistic personality disorder in the ICD-11: Severity and trait profiles of grandiosity and vulnerability. *Journal of Clinical Psychology*, *80*(8), 1917–1936.

Deling, L., Legerski, J.-P., & Hanson, S. K. (2024). Burnout in applied behavior analyst technicians: The role of personality and stress. *Current Psychology (New Brunswick, N.J.)*, *43*(13), 11627–11641

Dilchert, S., Ones, D. S., & Krueger, R. F. (2014). Maladaptive personality constructs, measures, and work behaviors. *Industrial and Organizational Psychology*, *7*(1), 98–110.

Dimoff, J. K., & Kelloway, E. K. (2019). With a little help from my boss: The impact of workplace mental health training on leader behaviors and employee resource utilization. *Journal of Occupational Health Psychology*, *24*(1), 4–19.

Edú-Valsania, S., Laguía, A., & Moriano, J. A. (2022). Burnout: A review of theory and measurement. *International Journal of Environmental Research and Public Health*, *19*(3), 1780.

Emmer, C., Dorn, J., & Mata, J. (2024). The immediate effect of discrimination on mental health: A meta-analytic review of the causal evidence. *Psychological Bulletin*, *150*(3), 215–252.

First, M. B., Williams, J. B. W., Karg, R. S., & Spitzer, R. L. (2015). *Structured clinical interview for DSM-5—Research version* (SCID-5 for DSM-5, Research Version; SCID-5-RV). American Psychiatric Association.

Follmer, K. B., & Jones, K. S. (2018). Mental illness in the workplace: An interdisciplinary review and organizational research agenda. *Journal of Management*, *44*(1), 325–351.

Gabriel, A. S., Podsakoff, N. P., Beal, D. J., Scott, B. A., Sonnentag, S., Trougakos, J. P., & Butts, M. M. (2019). Experience sampling methods: A discussion of critical trends and considerations for scholarly advancement. *Organizational Research Methods*, *22*(4), 969–1006.

Gnambs, T., & Kaspar, K. (2015). Disclosure of sensitive behaviors across self-administered survey modes: A meta-analysis. *Behavior Research Methods*, *47*(4), 1237–1259.

Goh, Z., Eva, N., Kiazad, K., Jack, G. A., De Cieri, H., & Spreitzer, G. M. (2022). An integrative multilevel review of thriving at work: Assessing progress and promise. *Journal of Organizational Behavior*, *43*(2), 197–213.

Goodsmith, N., Zhang, L., Ong, M. K., Ngo, V. K., Miranda, J., Hirsch, S., Jones, F., Wells, K., & Chung, B. (2021). Implementation of a community-partnered research suicide-risk management protocol: Case study from community partners in care. *Psychiatric Services*, *72*(3), 281–287.

Gorman, J. M. (2015). Comorbid depression and anxiety spectrum disorders. *Depression and Anxiety*, *32*(9), 699–701.

Graham, J. R. (2021). *MMPI-3: Assessing personality and psychopathology*. Oxford University Press.

Groth-Marnat, G. (2009). *Handbook of psychological assessment*. John Wiley & Sons, Inc.

Hardy, G. E., Woods, D., & Wall, T. D. (2003). The impact of psychological distress on absence from work. *Journal of Applied Psychology*, *88*(2), 306.

Howard, M. C., Follmer, K. B., Smith, M. B., Tucker, R. P., & Van Zandt, E. C. (2022). Work and suicide: An interdisciplinary systematic literature review. *Journal of Organizational Behavior*, *43*(2), 260–285.

Hurrell, J. J., Nelson, D. L., & Simmons, B. L. (1998). Measuring job stressors and strains: Where we have been, where we are, and where we need to go. *Journal of Occupational Health Psychology*, *3*(4), 368–389.

Karasek, R. A. (1979). Job demands, job decision latitude, and mental strain: Implications for job redesign. *Administrative Science Quarterly*, 285–308.

Kolc, K. L., Tan, Y. X. K., Lo, A. Z. Y., Shvetcov, A., Mitchell, P. B., & Perkes, I. E. (2023). Measuring psychiatric symptoms online: A systematic review of the use of inventories on Amazon Mechanical Turk (mTurk). *Journal of Psychiatric Research*, *163*, 118–126.

Koutsimani, P., Montgomery, A., & Georganta, K. (2019). The relationship between burnout, depression, and anxiety: A systematic review and meta-analysis. *Frontiers in Psychology*, *10*, 1–19.

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine*, *16*(9), 606–613.

Madsen, I. E., Nyberg, S. T., Hanson, L. M., Ferrie, J. E., Ahola, K., Alfredsson, L., Batty, G. D., Bjorner, J. B., Borritz, M., Burr, H., Chastang, J. F., de Graaf, R., Dragano, N., Hamer, M., Jokela, M., Knutsson, A., Koskenvuo, M., Koskinen, A., Leineweber, C., . . .& IPD-Work Consortium. (2017). Job strain as a risk factor for clinical depression: Systematic review and meta-analysis with additional individual participant data. *Psychological Medicine*, *47*(8), 1342–1356. https://pubmed.ncbi.nlm.nih.gov/28122650/

Maslach, C., & Jackson, S. E. (1981). The measurement of experienced burnout. *Journal of Organizational Behavior*, *2*(2), 99–113.

Maslach, C., Jackson, S. E., & Leiter, M. P. (1996). *Maslach Burnout Inventory manual* (3rd ed.). Mind Garden.

Miller, W. R., & Rollnick, S. (2013). *Motivational interviewing: Helping people change* (3rd ed.). Guilford Press.

Murray, A. L., Hemady, C. L., Do, H., Dunne, M., Foley, S., Osafo, J., Sikander, S., Madrid, B., Baban, A., Taut, D., Ward, C. L., Fernando, A., Thang, V. V., Eisner, M., Hughes, C., Fearon, P., Valdebenito, S., Tomlinson, M., Pathmeswaran, A., & Walker, S. (2022). Measuring antenatal depressive symptoms across the world: A validation and cross-country invariance analysis of the Patient Health Questionnaire-9 (PHQ-9) in eight diverse low-resource settings. *Psychological Assessment*, *34*(11), 993–1007. https://pubmed.ncbi.nlm.nih.gov/36227303/

Pettersson, A., Boström, K. B., Gustavsson, P., & Ekselius, L. (2015). Which instruments to support diagnosis of depression have sufficient accuracy? A systematic review. *Nordic Journal of Psychiatry*, *69*(7), 497–508.

Pollard, T. M. (2001). Changes in mental well-being, blood pressure and total cholesterol levels during workplace reorganization: The impact of uncertainty. *Work & Stress*, *15*(1), 14–28.

Porath, C., Spreitzer, G., Gibson, C., & Garnett, F. G. (2012). Thriving at work: Toward its measurement, construct validation, and theoretical refinement. *Journal of Organizational Behavior*, *33*(2), 250–275.

Regier, D. A., Kuhl, E. A., & Kupfer, D. J. (2013). The DSM-5: Classification and criteria changes. *World Psychiatry*, *12*(2), 92–98.

Reis, D. J., Namekata, M. S., Oehlert, M. E., & King, N. (2020). A preliminary review of the Beck Depression Inventory-II (BDI-II) in Veterans: Are new norms and cut scores needed? *Psychological Services*, *17*(3), 363–371.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, *21*(2), 95–103.

Rosado-Solomon, E. H., Koopmann, J., Lee, W., & Cronin, M. A. (2023). Mental health and mental illness in organizations: A review, comparison, and extension. *Academy of Management Annals*, *17*(2), 751–797.

Schwarz, N. (1999). Self-reports: How the questions shape the answers. *American Psychologist*, *54*(2), 93–105.

Spitzer, R. L., Kroenke, K., Williams, J. B. W., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder the GAD−7. *Archives of Internal Medicine*, *166*, 1092–1097.

Subica, A. M., Fowler, J. C., Elhai, J. D., Frueh, B. C., Sharp, C., Kelly, E. L., Allen, J. G., & Reynolds, C. R. (2014). Factor structure and diagnostic validity of the Beck Depression Inventory-II with adult clinical inpatients: Comparison to a gold-standard diagnostic interview. *Psychological Assessment*, *26*(4), 1106–1115.

Sue, D., & Sue, S. (1987). Cultural factors in the clinical assessment of Asian Americans. *Journal of Consulting and Clinical Psychology*, *55*(4), 479–487.

Van de Vijver, F. J. R., & Tanzer, N. K. (2004). Bias and equivalence in cross-cultural assessment: An overview. *European Review of Applied Psychology*, *54*(2), 119–135.

Vîslă, A., Stadelmann, C., Watkins, E., Zinbarg, R. E., & Flückiger, C. (2022). The relation between worry and mental health in nonclinical population and individuals with anxiety and depressive disorders: A meta-analysis. *Cognitive Therapy and Research*, *46*(3), 480–501.

Walton, K. E., Roberts, B. W., Krueger, R. F., Blonigen, D. M., & Hicks, B. M. (2008). Capturing abnormal personality with normal personality inventories: An item response theory approach. *Journal of Personality*, *76*, 1623–1647.44

Wang, Y. P., & Gorenstein, C. (2013). Psychometric properties of the Beck Depression Inventory-II: A comprehensive review. *Revista Brasileira de Psiquiatria*, *35*(4), 416–431.

World Health Organization. (2022). *World mental health report: Transforming mental health for all*. World Health Organization. https://www.who.int/publications/i/item/9789240049338

Wu, Y., Levis, B., Riehm, K. E., Saadat, N., Levis, A. W., Azar, M., Rice, D. B., Boruff, J., Cuijpers, P., Gilbody, S., Ioannidis, J. P. A., Kloda, L. A., McMillan, D., Patten, S. B., Shrier, I., Ziegelstein, R. C., Akena, D. H., Arroll, B., Ayalon, L.,. . . Thombs, B. D. (2020). Equivalency of the diagnostic accuracy of the PHQ-8 and PHQ-9: A systematic review and individual participant data meta-analysis. *Psychological Medicine*, *50*(8), 1368–1380. https://pubmed.ncbi.nlm.nih.gov/31298180/