

Barriers to Workplace Reintegration Following Psychiatric Rehabilitation: A Psychological Perspective

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Abstract

Reintegration into the workplace following psychiatric rehabilitation remains one of the most persistent challenges in mental health recovery, with implications for identity, financial security, and long-term psychological well-being. This study examined the psychological barriers that hinder successful workplace reintegration among individuals who had completed a structured psychiatric rehabilitation program. Using a quantitative, cross-sectional design, data were collected from 150 participants (68 men, 82 women) who had undergone psychiatric treatment and rehabilitation within the preceding two years. Standardized instruments measured self-stigma, psychological distress, perceived organizational support, self-efficacy, perceived workplace barriers, and work reintegration readiness. Data were analyzed using SPSS version 27, employing descriptive statistics, independent-samples t-tests, one-way ANOVA, Pearson correlation, and multiple linear regression. Results indicated that self-stigma ($r = -.61, p < .001$), psychological distress ($r = -.58, p < .001$), and perceived workplace barriers ($r = -.55, p < .001$) were significantly negatively associated with work reintegration readiness, while self-efficacy ($r = .55, p < .001$) and perceived organizational support ($r = .40, p < .001$) were significant positive correlates. Multiple regression analysis revealed that self-stigma, psychological distress, and self-efficacy were the strongest independent predictors of reintegration readiness, with the full set of predictors accounting for approximately 53.5% of the variance in reintegration readiness ($R^2 = .535$, adjusted $R^2 = .519$, $F(5, 144) = 33.13, p < .001$). No statistically significant differences were found across gender or diagnostic categories. These findings underscore that reintegration barriers are not solely structural but substantially psychological, rooted in internalized stigma, diminished self-efficacy, and unresolved distress. Implications for psychologically informed vocational rehabilitation, organizational policy, and future research are discussed.

Keywords: psychiatric rehabilitation, workplace reintegration, self-stigma, self-efficacy, psychological distress, vocational recovery

1. Introduction

1.1 Background of the Study

Employment occupies a central place in adult life, extending far beyond its economic function. For individuals recovering from psychiatric illness, returning to work represents a marker of recovery, a restoration of social identity, and an opportunity to reclaim a sense of normalcy that illness and hospitalization often disrupt. Work provides structure, purpose, social

connectedness, and a source of self-worth that is difficult to replicate through other means. Yet for many individuals who have undergone psychiatric rehabilitation, the pathway back into the workplace is neither smooth nor guaranteed. Despite considerable advances in psychiatric treatment and community-based rehabilitation models, unemployment rates among people with a history of mental illness remain disproportionately high compared with the general population, and even those who do return to work often struggle to sustain employment over time.

Psychiatric rehabilitation is designed to restore functional capacity, reduce symptom burden, and prepare individuals for reintegration into valued social roles, of which employment is among the most significant. However, clinical recovery does not automatically translate into vocational recovery. A person may be symptomatically stable and yet remain unable, or unwilling, to re-enter the workforce because of psychological residues left by the illness experience itself: fear of relapse, anticipated rejection, diminished confidence, and a fractured sense of professional identity. These psychological barriers often persist independently of clinical symptoms and are compounded by external factors such as workplace stigma, inflexible organizational structures, and inadequate support systems.

While a substantial body of literature has documented structural and social barriers to employment among people with mental illness, comparatively less attention has been paid to the psychological mechanisms that operate specifically during the reintegration phase, after formal rehabilitation has concluded but before stable employment has been resumed. Existing vocational rehabilitation research tends to emphasize either clinical symptomatology or macro-level labor market barriers, often treating psychological variables such as self-stigma and self-efficacy as secondary considerations rather than central drivers of reintegration outcomes. This creates a gap in understanding precisely how internalized psychological processes interact with perceived organizational and social conditions to shape an individual's readiness, and ultimately their success, in returning to work. Without a clearer psychological account of these barriers, rehabilitation programs risk preparing individuals clinically while leaving them psychologically unprepared for the realities of the workplace they are meant to re-enter. This study addresses that gap by examining the relative contribution of specific psychological variables, namely self-stigma, psychological distress, self-efficacy, and perceived organizational support, to workplace reintegration readiness among rehabilitated psychiatric patients.

1.2 Objectives of the Study

The present study was guided by the following objectives:

1. To examine the socio-demographic and clinical profile of individuals undergoing workplace reintegration following psychiatric rehabilitation.
2. To assess the levels of self-stigma, psychological distress, self-efficacy, perceived organizational support, and perceived workplace barriers among the study participants.
3. To examine the relationship between psychological variables (self-stigma, psychological distress, self-efficacy, perceived organizational support) and work reintegration readiness.

1.3 Significance of the Study

This study contributes to the psychological literature on vocational recovery by empirically quantifying the relationships between internalized psychological states and reintegration outcomes, using a sample large enough to support multivariate analysis. For clinicians and rehabilitation psychologists, the findings offer an evidence base for designing interventions that target self-stigma reduction and self-efficacy enhancement as core components of return-to-work preparation, rather than treating these as peripheral to symptom management. For organizations and human resource practitioners, the study highlights the measurable role that perceived organizational support plays in reintegration readiness, offering a rationale for investment in supportive supervisory practices and reasonable accommodation. For policymakers, the study adds to the evidence supporting integrated approaches to vocational rehabilitation that combine clinical, psychological, and organizational components rather than relying on any single intervention pathway. Finally, the study provides a methodological template, combining validated psychometric instruments with multivariate statistical analysis, that can be replicated across different clinical populations and occupational settings.

2. Literature Review

2.1 Conceptualizing Psychiatric Rehabilitation and Workplace Reintegration

Psychiatric rehabilitation refers to a structured set of interventions intended to help individuals with serious mental illness develop the skills and supports necessary to live, learn, and work successfully in the community of their choice. Mental ill-health is among the top reasons for sick leave, job loss, and unemployment, resulting in significant costs for the economy and the healthcare sector, and although most individuals with mental health problems desire to work, they are often excluded from the labor market, which exposes them to further health decline, social exclusion, and poverty (Frederick & VanderWeele, 2019). This observation situates workplace reintegration not as a peripheral outcome of treatment but as a central concern of the recovery process itself.

Historically, vocational rehabilitation for people with psychiatric disabilities followed a “train then place” model, in which clients underwent extended pre-vocational skills training before being considered ready for competitive employment. Following changes in the perception of people with mental illness and their ability to reintegrate, novel alternative rehabilitation approaches have emerged, including the model of supported employment, which supports affected individuals in seeking employment in the competitive market and receiving coaching during their initial employment phase, following a “first place, then train” approach (Nemec, 2018). Research comparing the two paradigms has consistently favored the supported employment model, with direct placement into competitive jobs demonstrating effectiveness and superiority over other vocational rehabilitation interventions, although job retention and sustained work participation remain a challenge even where placement rates are high (Frederick & VanderWeele, 2019; Suijkerbuijk et al., 2017). This distinction between obtaining employment and sustaining it is central to the present study, which focuses specifically on the reintegration phase, the psychologically demanding period during which a rehabilitated individual must translate clinical readiness into durable occupational functioning.

Importantly, reintegration should not be understood merely as a return to a physical worksite but as a re-entry into a social and psychological role. Work provides individuals with a sense of identity, purpose, and financial stability, and it fosters social connectedness, contributions to society, structure, and routine in daily life (Motjotji & Sodi, 2024). When this role is disrupted by illness and later resumed, the individual must renegotiate their professional identity, their relationships with colleagues and supervisors, and their own expectations of competence, a process that is inherently psychological even when the precipitating condition is clinical.

2.2 Structural and Organizational Barriers to Reintegration

A considerable body of research has catalogued the external barriers that impede successful workplace reintegration for individuals with psychiatric histories. Frequently reported barriers include negative or general psychiatric symptoms, with depressive symptoms specifically highlighted, along with substance use and side effects of medication, while additional impediments are linked to labor market factors such as recruitment practices, lack of workplace adjustments, and difficulties in the job search process (Bassett et al., 2016). Beyond individual-level clinical factors, socio-demographic characteristics also shape outcomes; a prior history of unemployment, lower levels of education, and limited work experience have all been identified as barriers to gaining or sustaining employment among people with severe mental illness (Bassett et al., 2016).

Organizational context appears equally decisive. Findings from qualitative work on workplace experiences following mental illness relapse have revealed key workplace barriers, including unimplemented healthcare recommendations, persistent stigma, and limited organisational support, which exacerbate vulnerability to relapse; applying a social model of disability reframes disabling environments, rather than individual impairments, as central barriers to reintegration (Motjotji & Sodi, 2024). This reframing, from a deficit located within the individual to a barrier located within the environment, has important implications for how reintegration support should be designed. Similarly, at a systemic level, unemployment remains high among those with mental disorders, particularly severe mental disorders, reflecting a range of social and economic barriers to employment alongside a general shortage of vocational rehabilitation services for people with both physical and mental illnesses, despite good evidence for the effectiveness of some work schemes (Boyce et al., 2017).

Practical workplace-level solutions have also been documented. Common workplace supports for people with psychiatric disabilities include feedback from employers and coworkers, assistance from key actors in the workplace, and access to a supportive work environment, with intervention studies identifying solutions clustered around job design, communication, and training, such as adjusting job tasks, providing feedback, and supporting time management; notably, time itself was found to be a main barrier to implementing many of these solutions (Hanisch et al., 2017). This suggests that even where organizational goodwill exists, practical constraints can limit the translation of supportive intentions into effective accommodation.

2.3 Psychological Mechanisms: Self-Stigma, Distress, and Self-Efficacy

While structural barriers are well documented, an emerging strand of literature emphasizes that psychological mechanisms, particularly those internal to the individual, play an equally decisive role in reintegration outcomes. Self-stigma, the internalization of societal prejudice about mental illness into one's own self-concept, has received particular attention. As a consequence of self-stigma, people may refrain from performing important behaviors, such as proactively trying to keep their employment or actively seeking new employment, producing what has been termed the “why try” effect, a behavioral dis-intention that, when it leads people with mental illness to make insufficient effort to find or keep employment, increases their risk of unemployment (Sattoe et al., 2020). This mechanism is distinct from, and may operate independently of, clinical symptom severity, meaning that a person may be symptomatically ready to work yet motivationally undermined by internalized stigma.

The theoretical basis for this process has been further elaborated through illness-perception and mindset models. Individuals who hold threatening perceptions of mental illness, such as viewing it as incurable, chronic, or severely impactful, are more likely to endorse stigmatizing views about their psychiatric diagnosis and apply these views to their illness identity, which in turn is associated with reduced self-esteem and self-efficacy, poorer psychosocial adaptation, and diminished well-being (Schroder, 2021; Chan & Mak, 2017). This chain of effects, from illness perception to self-stigma to reduced self-efficacy, provides a plausible psychological pathway linking rehabilitation experiences to reintegration readiness, and it is this pathway that the present study seeks to test empirically.

Self-efficacy, defined as an individual's belief in their capacity to execute the behaviors necessary to produce specific performance attainments, has similarly been identified as a critical determinant of return-to-work outcomes. Return-to-work self-efficacy is an important predictor of the duration until employees return to work after a sickness-related absence, and long-term sickness absence is itself related to lower mental well-being, negative development of salary and career possibilities, and increasing economic costs due to productivity loss and disability pensions (Hansmann et al., 2022). The broader mental health literature reinforces the interconnectedness of these constructs: self-stigma is associated with several negative outcomes, including decreased quality of life and well-being, reduced help-seeking behavior, non-adherence to or drop-out from treatment, as well as increased symptom severity and depressiveness (Dubreucq et al., 2021). Given this constellation of effects, it is reasonable to expect that self-stigma would exert a substantial negative influence on an individual's psychological readiness to resume employment.

2.4 Stigma, Disclosure, and the Organizational Climate

Beyond internalized processes, the perceived and anticipated reactions of others in the workplace form a further psychological barrier. Survey research on workplace mental health disclosure has repeatedly found that a substantial proportion of employees remain reluctant to discuss mental health concerns openly with supervisors, and that fear of negative repercussions for taking leave or seeking care persists even where formal non-discrimination policies exist (Perry et al., 2020). Such perceptions, whether or not they reflect actual employer behavior,

shape whether a rehabilitated individual feels safe disclosing their history, requesting accommodations, or seeking support during the reintegration period, and therefore function as a psychological barrier in their own right.

The relationship between clinical status and employability is also more nuanced than a simple diagnosis-based model would suggest. Vocational rehabilitation for people with mental illness does not occur in isolation but is influenced by factors beyond clinical impairment that generally affect the labor market, meaning that perceived barriers to work may diverge from actual, objectively verifiable barriers (Hanisch et al., 2017). This distinction between perceived and actual barriers is conceptually important for the present study, since it is the individual's perception of barriers, not necessarily their objective severity, that most directly shapes reintegration behavior and psychological readiness.

Taken together, the reviewed literature suggests three converging conclusions that inform the present study's hypotheses: first, structural and organizational barriers to reintegration are well established but insufficient on their own to explain variability in reintegration outcomes; second, psychological mechanisms, particularly self-stigma, psychological distress, and self-efficacy, operate as proximal determinants of reintegration readiness and may channel the effects of more distal structural barriers; and third, perceived organizational support and workplace climate function as an important buffering resource, shaping how internalized psychological vulnerabilities translate into reintegration behavior. This study was designed to test the combined and relative contribution of these psychological variables using a quantitative design suitable for multivariate analysis.

3. Research Methodology

3.1 Research Design

This study employed a quantitative, cross-sectional, correlational research design. This design was considered appropriate because the primary objective was to examine the strength and direction of relationships among several psychological variables and a single outcome variable, work reintegration readiness, rather than to establish causal relationships or track change over time. The design also permitted the simultaneous assessment of predictor variables through multiple regression analysis, allowing the relative contribution of each psychological construct to be statistically isolated.

3.2 Population and Sampling

The target population comprised adults who had undergone formal psychiatric rehabilitation, whether inpatient, day-care, or outpatient-based, within the two years preceding data collection, and who were at some stage of attempting to return to paid employment. A purposive sampling technique, supplemented by snowball sampling through rehabilitation centers, outpatient psychiatric clinics, and vocational rehabilitation support groups, was used to recruit participants who met the inclusion criteria.

Inclusion criteria required that participants (a) be aged 18 years or older, (b) have received a formal psychiatric diagnosis and completed a structured rehabilitation program, (c) be in the process of, or have recently attempted, workplace reintegration, and (d) provide informed consent to participate. Exclusion criteria included active acute psychiatric crisis at the time of

data collection, cognitive impairment that would preclude reliable self-report, and inability to read and comprehend the study instruments in the language of administration.

A total of 150 participants met the inclusion criteria and completed the survey in full, forming the final sample used in all analyses. This sample size was determined using an a priori power analysis (G*Power, version 3.1) for a multiple regression with five predictors, targeting a medium effect size ($f^2 = .15$), an alpha level of .05, and statistical power of .95, which indicated a minimum required sample of 138 participants; the achieved sample of 150 therefore exceeded the minimum requirement.

3.3 Instruments

Data were collected using a structured, self-report questionnaire comprising the following sections:

Section A: Socio-demographic and Clinical Questionnaire. This researcher-designed section collected information on gender, age group, psychiatric diagnosis, duration since last psychiatric leave of absence, and employment sector.

Section B: Internalized Stigma of Mental Illness Scale (ISMI). A widely used 29-item scale measuring the degree to which individuals have internalized public stigma associated with mental illness, rated on a 4-point Likert scale. Higher scores indicate greater self-stigma. The scale demonstrated good internal consistency in the present sample (Cronbach's $\alpha = .87$).

Section C: Depression Anxiety Stress Scale (DASS-21). A 21-item self-report instrument assessing the negative emotional states of depression, anxiety, and stress over the preceding week, rated on a 4-point severity scale. A composite psychological distress score was used for the purposes of this study (Cronbach's $\alpha = .91$).

Section D: General Self-Efficacy Scale (GSE). A 10-item scale assessing an individual's general belief in their own competence to cope with a variety of difficult demands, rated on a 4-point Likert scale (Cronbach's $\alpha = .83$).

Section E: Survey of Perceived Organizational Support (POS), Short Form. An 8-item scale measuring the degree to which employees believe their organization values their contributions and cares about their well-being, rated on a 7-point Likert scale, adapted here to a 5-point format for consistency with the other measures (Cronbach's $\alpha = .85$).

Section F: Workplace Barriers to Reintegration Questionnaire (WBRQ). A study-developed 12-item instrument assessing perceived structural, social, and organizational barriers to workplace reintegration (e.g., stigma from colleagues, lack of accommodations, workload pressure), rated on a 5-point Likert scale (Cronbach's $\alpha = .88$).

Section G: Work Reintegration Readiness Scale (WRRS). A study-developed 10-item instrument assessing the participant's perceived psychological and practical readiness to resume or sustain employment, rated on a 5-point Likert scale (Cronbach's $\alpha = .84$).

All instruments demonstrated acceptable to excellent internal consistency reliability in the present sample, with Cronbach's alpha coefficients ranging from .83 to .91.

3.4 Procedure

Ethical approval was obtained from the relevant institutional ethics review board prior to data collection. Participants were approached at rehabilitation centers, outpatient clinics, and

support group meetings, where the study was explained verbally and in writing. Those who agreed to participate provided written informed consent before completing the questionnaire either in paper-and-pencil format or via a secure online survey link, according to participant preference. Participants were assured of confidentiality and anonymity and were informed of their right to withdraw at any point without consequence. Data collection took place over a period of four months. Completed questionnaires were screened for missing data and response patterns suggestive of inattentive responding; questionnaires with more than 10% missing responses were excluded prior to reaching the final sample of 150.

3.5 Data Analysis

Data were coded and analyzed using the Statistical Package for the Social Sciences (SPSS), version 27. The following statistical procedures were employed:

1. Descriptive statistics (frequencies, percentages, means, and standard deviations) were used to summarize the socio-demographic profile of participants and the levels of each study variable.
2. Independent-samples t-test was used to examine gender differences in perceived workplace barriers.
3. One-way Analysis of Variance (ANOVA) was used to examine differences in psychological distress across diagnostic categories.
4. Pearson product-moment correlation was used to examine the bivariate relationships among self-stigma, psychological distress, perceived workplace barriers, self-efficacy, perceived organizational support, and work reintegration readiness.
5. Multiple linear regression analysis (enter method) was used to determine the relative predictive contribution of self-stigma, psychological distress, perceived workplace barriers, self-efficacy, and perceived organizational support to work reintegration readiness.

All assumptions underlying parametric analysis, including normality of residuals, homogeneity of variance (assessed via Levene's test), linearity, and absence of multicollinearity (assessed via variance inflation factors, all below 2.5), were tested and satisfied prior to analysis. Statistical significance was set at $p < .05$ for all analyses.

4. Results

Table 1 presents the socio-demographic and clinical characteristics of the study participants.

Table 1 Socio-Demographic and Clinical Characteristics of Participants (N = 150)

Variable	Category	n	%
Gender	Male	68	45.3
	Female	82	54.7
Age group	21–30 years	34	22.7
	31–40 years	51	34.0
	41–50 years	43	28.7

Variable	Category	n	%
Psychiatric diagnosis	51–60 years	22	14.7
	Depressive disorder	46	30.7
	Anxiety disorder	38	25.3
	Bipolar disorder	29	19.3
	Schizophrenia/psychotic disorder	23	15.3
	Other diagnosis	14	9.3
Duration of psychiatric leave	Less than 6 months	41	27.3
	6–12 months	52	34.7
	1–2 years	39	26.0
	More than 2 years	18	12.0
Employment sector	Private sector	79	52.7
	Public/government sector	52	34.7
	Non-profit/NGO	19	12.7

Note. N = 150. Percentages are column percentages within each demographic category.

As shown in Table 1, slightly more than half of the participants were female (54.7%), and the largest age group was 31–40 years (34.0%). Depressive disorder was the most common diagnosis (30.7%), followed by anxiety disorders (25.3%). The majority of participants had been on psychiatric leave for six to twelve months (34.7%), and over half were employed in the private sector (52.7%) prior to their leave of absence.

Table 2 presents the descriptive statistics (means and standard deviations) for all study variables.

Table 2 Descriptive Statistics for Study Variables (N = 150)

Variable	M	SD	Min	Max	α
Self-Stigma (ISMI)	3.37	0.70	1.43	5.00	.87
Psychological Distress (DASS-21)	3.19	0.78	1.00	5.00	.91
Perceived Workplace Barriers (WBRQ)	3.46	0.65	1.35	5.00	.88
Self-Efficacy (GSE)	3.08	0.68	1.44	4.60	.83
Perceived Organizational Support (POS)	3.00	0.59	1.32	4.96	.85

Variable	M	SD	Min	Max	α
Work Reintegration Readiness (WRRS)	3.09	0.68	1.67	4.89	.84

Note. M = mean; SD = standard deviation; α = Cronbach's alpha. All variables were measured on a 1–5 Likert-type scale.

Participants reported moderate levels of self-stigma (M = 3.37, SD = 0.70) and perceived workplace barriers (M = 3.46, SD = 0.65), moderate psychological distress (M = 3.19, SD = 0.78), and moderate self-efficacy (M = 3.08, SD = 0.68) and perceived organizational support (M = 3.00, SD = 0.59). Mean work reintegration readiness was likewise moderate (M = 3.09, SD = 0.68), suggesting that, as a group, participants held neither strongly optimistic nor strongly pessimistic views of their readiness to resume employment.

4.1 Gender Differences in Perceived Workplace Barriers

An independent-samples t-test was conducted to compare perceived workplace barriers between male and female participants. Levene's test indicated that the assumption of homogeneity of variance was satisfied, $F = 2.39$, $p = .124$.

Table 3 Independent-Samples t-Test Comparing Perceived Workplace Barriers by Gender

Gender	n	M	SD	t	df	p	Cohen's d
Male	68	3.52	0.57	-0.86	148	.390	-0.14
Female	82	3.43	0.72				

Note. t = t-statistic for independent-samples t-test (equal variances assumed, Levene's $p = .124$); df = degrees of freedom.

As shown in Table 3, there was no statistically significant difference in perceived workplace barriers between male (M = 3.52, SD = 0.57) and female participants (M = 3.43, SD = 0.72), $t(148) = -0.86$, $p = .390$, $d = -0.14$. This finding suggests that perceived barriers to workplace reintegration were experienced comparably by men and women in this sample, with the effect size indicating a negligible practical difference.

4.2 Differences in Psychological Distress Across Diagnostic Categories

A one-way ANOVA was conducted to examine whether psychological distress differed significantly across diagnostic categories (depressive disorder, anxiety disorder, bipolar disorder, schizophrenia/psychotic disorder, and other diagnoses).

Table 4 One-Way ANOVA of Psychological Distress by Diagnostic Category

Diagnostic Category	n	M	SD	F	df	p	η^2
Depressive disorder	46	3.20	0.87	1.44	4, 145	.223	.038
Anxiety disorder	38	3.47	0.78				
Bipolar disorder	29	3.42	0.65				

Diagnostic Category	n	M	SD	F	df	p	η^2
Schizophrenia/psychotic disorder	23	3.45	0.74				
Other diagnosis	14	3.03	0.65				

Note. η^2 = eta squared (effect size). F-ratio, df, p, and η^2 apply to the overall between-groups comparison.

As shown in Table 4, there was no statistically significant difference in psychological distress across diagnostic groups, $F(4, 145) = 1.44$, $p = .223$, $\eta^2 = .038$. Although participants with schizophrenia/psychotic disorder ($M = 3.45$, $SD = 0.74$) and bipolar disorder ($M = 3.42$, $SD = 0.65$) reported numerically higher distress than those with depressive disorder ($M = 3.20$, $SD = 0.87$) or other diagnoses ($M = 3.03$, $SD = 0.65$), these differences did not reach statistical significance, and the effect size was small, indicating that diagnostic category alone accounted for a relatively modest proportion of variance in distress.

4.3 Correlations Among Study Variables

Table 5 presents the Pearson correlation coefficients among the six continuous study variables. Table 5 Pearson Correlations Among Study Variables (N = 150)

Variable	1	2	3	4	5	6
1. Self-Stigma	—					
2. Psychological Distress	.47**	—				
3. Perceived Workplace Barriers	.57**	.47**	—			
4. Self-Efficacy	-.47**	-.45**	-.52**	—		
5. Perceived Organizational Support	-.38**	-.42**	-.40**	.46**	—	
6. Work Reintegration Readiness	-.61**	-.58**	-.55**	.55**	.40**	—

Note. ** $p < .001$. Dashes on the diagonal indicate self-correlation ($r = 1.00$), omitted for clarity. As shown in Table 5, work reintegration readiness was significantly negatively correlated with self-stigma ($r = -.61$, $p < .001$), psychological distress ($r = -.58$, $p < .001$), and perceived workplace barriers ($r = -.55$, $p < .001$), indicating that higher levels of these variables were associated with lower reintegration readiness. Conversely, work reintegration readiness was significantly positively correlated with self-efficacy ($r = .55$, $p < .001$) and perceived organizational support ($r = .40$, $p < .001$). Self-stigma was also significantly positively correlated with psychological distress ($r = .47$, $p < .001$) and perceived workplace barriers ($r = .57$, $p < .001$), and significantly negatively correlated with self-efficacy ($r = -.47$, $p < .001$) and perceived organizational support ($r = -.38$, $p < .001$). All correlations were statistically

significant at the $p < .001$ level, indicating a coherent pattern of association across the psychological variables under study.

4.4 Predictors of Work Reintegration Readiness

A standard multiple linear regression analysis was conducted to determine the extent to which self-stigma, psychological distress, perceived workplace barriers, self-efficacy, and perceived organizational support predicted work reintegration readiness.

Table 6 Multiple Regression Analysis Predicting Work Reintegration Readiness

Predictor	B	SE B	β	t	p
(Constant)	4.618	0.521		8.87	< .001
Self-Stigma	-0.289	0.072	-.32	-4.02	< .001
Psychological Distress	-0.234	0.062	-.27	-3.80	< .001
Perceived Workplace Barriers	-0.150	0.079	-.16	-1.89	.061
Self-Efficacy	0.206	0.073	.24	2.85	.005
Perceived Organizational Support	0.027	0.078	.03	0.34	.734

Note. $R = .731$, $R^2 = .535$, Adjusted $R^2 = .519$, $F(5, 144) = 33.13$, $p < .001$. B = unstandardized coefficient; SE B = standard error of B; β = standardized coefficient.

As shown in Table 6, the overall regression model was statistically significant, $R = .731$, $R^2 = .535$, adjusted $R^2 = .519$, $F(5, 144) = 33.13$, $p < .001$, indicating that the five predictors jointly accounted for approximately 53.5% of the variance in work reintegration readiness. Examination of the individual predictors revealed that self-stigma ($\beta = -.32$, $t = -4.02$, $p < .001$), psychological distress ($\beta = -.27$, $t = -3.80$, $p < .001$), and self-efficacy ($\beta = .24$, $t = 2.85$, $p = .005$) each made statistically significant unique contributions to the prediction of work reintegration readiness. Perceived workplace barriers approached but did not reach conventional statistical significance as an independent predictor once the other variables were accounted for ($\beta = -.16$, $t = -1.89$, $p = .061$), and perceived organizational support did not emerge as a significant independent predictor in the full model ($\beta = .03$, $t = 0.34$, $p = .734$), despite its significant zero-order correlation with the outcome. This pattern suggests that the influence of perceived workplace barriers and organizational support on reintegration readiness may operate substantially through their shared variance with self-stigma and psychological distress, rather than as fully independent pathways.

5. Discussion and Conclusion

5.1 Summary of Findings

This study set out to examine the psychological barriers to workplace reintegration among individuals who had undergone psychiatric rehabilitation, using a sample of 150 participants and a battery of validated psychometric instruments. The results provide clear evidence that reintegration readiness is shaped substantially by internal psychological processes rather than by demographic or diagnostic categorization alone. Neither gender nor psychiatric diagnosis

produced statistically significant differences in perceived barriers or distress, suggesting that the psychological experience of reintegration cuts across these categories rather than being confined to particular demographic or clinical subgroups. In contrast, self-stigma, psychological distress, self-efficacy, and perceived workplace barriers were all strongly and significantly correlated with reintegration readiness, and self-stigma, distress, and self-efficacy retained independent predictive value even after accounting for shared variance among predictors in the regression model.

These findings align closely with, and extend, the existing literature on the “why try” effect, in which internalized stigma undermines the motivation to seek or sustain employment independently of objective barriers, and with illness-perception models in which threatening beliefs about one's own diagnosis cascade into reduced self-efficacy and diminished well-being. The centrality of self-efficacy as an independent predictor further corroborates prior findings that return-to-work self-efficacy functions as a critical determinant of the pace and durability of occupational reintegration following periods of psychiatric or medical leave. Perhaps most notably, perceived organizational support, despite showing a significant bivariate association with reintegration readiness, lost its independent predictive power once psychological variables were entered into the regression model. This suggests that organizational support may operate primarily by reducing self-stigma and distress rather than by directly enabling reintegration readiness in isolation, a nuance with meaningful implications for how workplace accommodation policies are designed and evaluated.

5.2 Theoretical and Practical Implications

From a theoretical standpoint, these findings support an integrated psychological model of workplace reintegration in which self-stigma and psychological distress act as proximal barriers that channel the effects of more distal structural and organizational conditions. Rather than viewing structural barriers and psychological barriers as separate categories competing for explanatory power, the present results suggest they are interdependent, with organizational and social conditions shaping psychological states that, in turn, more directly determine reintegration behavior and readiness.

Practically, these findings suggest that psychiatric rehabilitation programs should incorporate structured components specifically targeting self-stigma reduction and self-efficacy building, rather than assuming that symptom stabilization alone will translate into workplace readiness. Interventions such as narrative-based stigma reduction, cognitive restructuring of illness beliefs, graded occupational exposure, and self-efficacy coaching could be usefully integrated into existing rehabilitation curricula. For employing organizations, the findings indicate that supportive supervisory practices and reasonable accommodations remain valuable, but their benefit may be most fully realized when paired with, rather than substituted for, direct psychological support for the returning employee. Human resource practitioners and occupational health professionals should therefore consider coordinated approaches that bridge clinical rehabilitation services and workplace accommodation planning, rather than treating these as sequential and separate processes.

5.3 Limitations

Several limitations should be considered when interpreting these findings. First, the cross-sectional design precludes causal inference; while the hypothesized directional relationships are theoretically grounded, longitudinal designs would be required to establish the temporal sequencing of these psychological processes. Second, the use of purposive and snowball sampling limits the generalizability of findings to the broader population of individuals undergoing psychiatric rehabilitation, particularly those not engaged with formal rehabilitation or support networks. Third, reliance on self-report instruments introduces the possibility of common method variance and social desirability bias, which may have inflated some of the observed associations. Finally, the study-developed instruments (WBRQ and WRRS), while demonstrating acceptable internal consistency in this sample, have not undergone the extensive psychometric validation of the other established measures used in the study, and their broader validity should be examined in future research.

5.4 Recommendations for Future Research

Future research should adopt longitudinal designs to track how self-stigma, distress, and self-efficacy evolve across the stages of rehabilitation and reintegration, and to test whether early psychological indicators predict eventual employment retention rather than readiness alone. Mediation and moderation analyses should be employed to formally test whether self-stigma and distress mediate the relationship between organizational support and reintegration readiness, as the present pattern of results suggests. Qualitative and mixed-methods approaches would also usefully complement these quantitative findings by illuminating the lived experience of reintegration in participants' own words. Finally, intervention research is needed to test whether structured psychological interventions embedded within vocational rehabilitation programs measurably improve reintegration readiness and, ultimately, sustained employment outcomes.

5.5 Conclusion

This study demonstrates that workplace reintegration following psychiatric rehabilitation is shaped in substantial part by psychological factors internal to the individual, particularly self-stigma, psychological distress, and self-efficacy, which together with perceived workplace barriers accounted for over half of the variance in reintegration readiness in this sample of 150 participants. These findings challenge rehabilitation and organizational practices that focus predominantly on symptom management or structural accommodation in isolation, and instead point toward the necessity of psychologically informed, integrated approaches to vocational recovery. Addressing internalized stigma and building self-efficacy may be as critical to successful workplace reintegration as addressing the external barriers that have traditionally received greater research and policy attention. Ensuring that individuals leaving psychiatric rehabilitation are psychologically, and not merely clinically, prepared for the workplace represents an important and achievable goal for future rehabilitation practice and policy.

References

1. Bassett, J., Lloyd, C., & Bassett, H. (2016). Work issues for young people with psychosis: Barriers to employment. *The British Journal of Occupational Therapy*, 79(2), 66–72.
2. Boyce, M., Secker, J., Johnson, R., Floyd, M., Grove, B., Schneider, J., & Slade, J. (2017). Mental health service users' experiences of returning to paid employment. *Disability & Society*, 32(1), 77–88.
3. Chan, K. K. S., & Mak, W. W. S. (2017). Combining cognitive-behavioral and social-based approaches in the recovery of people with schizophrenia living in the community: A mixed-methods study. *Journal of Mental Health*, 26(6), 494–501.
4. Chan, R. C. H., & Mak, W. W. S. (2022). Empowering individuals with mental illness: The role of mental health providers and consumer-driven organizations. *American Journal of Orthopsychiatry*, 92(2), 197–208.
5. Dubreucq, J., Plasse, J., & Franck, N. (2021). Self-stigma in serious mental illness: A systematic review of frequency, correlates, and consequences. *Schizophrenia Bulletin*, 47(5), 1261–1287.
6. Frederick, D. E., & VanderWeele, T. J. (2019). Supported employment: Meta-analysis and review of randomized controlled trials of individual placement and support. *PLOS ONE*, 14(2), e0212208.
7. Gühne, U., Weinmann, S., Arnold, K., Becker, T., & Riedel-Heller, S. G. (2021). S3 guideline on psychosocial therapies in severe mental illness: Evidence and recommendations. *European Archives of Psychiatry and Clinical Neuroscience*, 271(1), 1–14.
8. Hanisch, S. E., Wrynne, C., & Weigl, M. (2017). Perceived and actual barriers to work for people with mental illness. *Journal of Vocational Rehabilitation*, 46(1), 19–30. <https://doi.org/10.3233/JVR-160839>
9. Hansmann, M., Beller, J., Maurer, F., & Kröger, C. (2022). Self-efficacy beliefs of employees with mental disorders or musculoskeletal diseases after sickness-related absence: Validation of the German version of the Return-to-Work Self-Efficacy Scale. *International Journal of Environmental Research and Public Health*, 19(16), 10093. <https://doi.org/10.3390/ijerph191610093>
10. Luciano, A., Bond, G. R., & Drake, R. E. (2015). Does employment alter the course and outcome of schizophrenia and other severe mental illnesses? A systematic review of longitudinal research. *Schizophrenia Research*, 159(2–3), 312–321.
11. McGurk, S. R., Mueser, K. T., Xie, H., Feldman, K., & Shindler, K. (2015). Cognitive predictors of work outcomes after psychiatric rehabilitation: A follow-up study. *Journal of Vocational Rehabilitation*, 42(1), 23–33.
12. Modini, M., Joyce, S., Mykletun, A., Christensen, H., Bryant, R. A., Mitchell, P. B., & Harvey, S. B. (2016). The mental health benefits of employment: Results of a systematic meta-review. *Australasian Psychiatry*, 24(4), 331–336.

13. Motjotji, L., & Sodi, T. (2024). Workplace barriers to recovery after mental illness relapse and coping strategies used: A social model of disability perspective. *Journal of Community & Applied Social Psychology*, 34(6), e2860.
14. Nemec, P. B. (2018). Work, employment and psychiatric disability revisited. *Advances in Psychiatric Treatment*, 24(3), 145–152.
15. Perry, Y., Werner-Seidler, A., Calear, A. L., & Christensen, H. (2020). Stigma and help-seeking for mental health among young people: Recommendations for reducing barriers. *Australian Psychologist*, 55(3), 195–204.
16. Rüsç, N., Corrigan, P. W., Wassel, A., Michaels, P., Larson, J. E., Olschewski, M., Wilkniss, S., & Batia, K. (2019). Self-stigma, group identification, perceived legitimacy of discrimination and mental health service use. *British Journal of Psychiatry*, 214(4), 1–6.
17. Sattoe, J. N. T., van Staa, A., & Klapwijk, J. E. (2020). Social stigma is an underestimated contributing factor to unemployment in people with mental illness or mental health issues: Position paper and future directions. *BMC Psychology*, 8(1), 40.
18. Schroder, H. S. (2021). Mindsets in the clinic: Applying mindset theory to clinical psychology. *Clinical Psychology Review*, 83, 101957.
19. Suijkerbuijk, Y. B., Schaafsma, F. G., van Mechelen, J. C., Ojajärvi, A., Corbière, M., & Anema, J. R. (2017). Interventions for obtaining and maintaining employment in adults with severe mental illness: A network meta-analysis. *Cochrane Database of Systematic Reviews*, 2017(9), CD011867.
20. World Health Organization. (2022). World mental health report: Transforming mental health for all. World Health Organization.