

Employee adoption of mental health interventions by employees in the South African workplace

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DECLARATION

I declare that this research report is my own work. It is submitted in partial fulfilment of the requirements of the degree of Masters in Business Administration (MBA) at the University of the Witwatersrand in Johannesburg.

It has not been submitted before for any degree or examination at any university.

Signature: 

Musawenkosi Faith Sibanda

February 2025

DEDICATION

I devote this work to my two daughters, Leona and Noluthando Sibanda, who have persevered through the time it has taken to complete my MBA studies. I have deep gratitude to my mother, Mrs Juliet Mhlanga, and my father, Mr Fidelis Mhlanga, who planted and nurtured my appetite for education from an early age. I also appreciate my siblings, Sibusisiwe Mjimba, Dalumuzi Mhlanga, and Zimazile Mhlanga-Pasivairi, who have championed my progress.

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KEYWORDS

Awareness

Implementation

Interventions

Mental Health

Productivity

Promotion

Well-being

Wellness

LIST OF ACRONYMS

CMD	Common Mental Disorder
EI	Emotional Intelligence
HR	Human Resource
HRM	Human Resource Management
JD-R	Job Demands-Resources
MHA	Mental Health Awareness
MHC	Mental Health Condition
MHI	Mental Health Intervention
MHP	Mental Health Promotion
OI	Organisational Intervention
PI	Personal Intervention
OHS	Occupational Health and Safety
WHO	World Health Organisation

ABSTRACT

The subject of mental health is currently trending in the global community as mental health conditions (MHCs), including stress, anxiety, insomnia, depression, and burnout, are a major cause of concern due to their negative impact on individuals or employees. These conditions can cause related physical health issues, including chronic illnesses like high blood pressure (hypertension) and common musculoskeletal issues, including neck or back pain. Affected employees may experience poor performance and low productivity, which can impact business profitability.

Considering that people are a company's best asset, organisations worldwide are placing more focus on employee well-being by providing interventions to improve employee engagement and productivity in the interests of the individual and to achieve their business goals. Mental health awareness (MHA) programmes have been implemented and widely publicised through government initiatives, while mental health promotion (MHP) is also conducted internally within organisations. Based on this study's results, most modern-day employees are informed on mental health, and the job demands-resources (JD-R) model indicates that they can be equipped with resources to overcome stressors through several interventions.

This research aims to determine the mental health interventions (MHIs) that employees use to manage MHCs at a personal level in order to inform policymakers or HR practitioners of the acceptable and effective mechanisms for improving overall employee well-being. Interviews were carried out on a sample of eighteen participants drawn from the financial services industry in South Africa. Thematic analysis was used to review and interpret the data, leading to a conclusion and recommendations regarding the adoption of MHIs. The research results indicate that prayer or spirituality and exercise were the most utilised interventions, while the emergence of Artificial Intelligence (AI) is transforming mental health through futuristic technology like chatbots and digital gaming.

CHAPTER 1. INTRODUCTION

1.1 Statement of purpose

The purpose of this study was to explore the implementation of MHIs through qualitative research using interviews, determining the accessibility, acceptability, and adoption of these strategies by individual employees in the South African workplace, with special focus on the financial services industry.

1.2 Background of the study

Paterson et al. (2021) highlight that mental health is a trending topic in the global arena as an increasing number of people are affected by stress, anxiety, insomnia, depression, and burnout, classified as Common Mental Disorders (CMDs), which are referred to as Mental Health Conditions (MHCs) in this study, especially in the trail of the COVID-19 pandemic (Pfeffer & Williams, 2020; Shisana et al., 2024). MHCs impact on employee performance, resulting in absenteeism, presenteeism - being physically available at work without delivering performance (Pfeffer & Williams, 2020) - low productivity, and higher company costs, which diminish business profitability (LaMontagne et al., 2019; Rugulies et al., 2023). Therefore, organisations are concerned with employee well-being and promote various interventions (primary, secondary and tertiary) for curbing MHCs - increasing employees' resilience, morale, or physical health - ultimately boosting productivity and business profitability (Dongre, 2024; Wu et al., 2021). Bakker & Demerouti's job demands-resources (JD-R model) examines the interventions that are implemented by organisations to equip employees with resources to manage their job demands (Bakker & Demerouti, 2007). This research seeks to determine what MHIs employees in South Africa are accepting and adopting to improve their job performance and well-being, whereby MHI acceptability is defined as the positive perception that individuals have regarding MHIs, resulting in their consistent use (Gulliver et al., 2021; Lau, 2024). MHIs include formal psychological interventions with trained practitioners and informal interventions by family, work colleagues and friends respectively (Lauzier-Jobin & Houle, 2022), thereby influencing the development of Occupational Health and Safety (OHS) policies and labour laws at the national level (Hassard et al., 2011). Research findings can benefit various stakeholders and prompt other developing countries to adopt these strategies (Pfeffer & Williams, 2020).

1.3 Research Gap

Current research focuses on the relationship between mental health and workplace productivity in *developed countries*. However, there are very limited studies on the adoption or implementation of MHIs in *developing countries* like South Africa, yet the WHO indicates that 75% or the majority of the global workforce is based in these countries, indicating a higher incidence or bigger impact of MHCs (Benach et al., 2007; Chopra, 2009; Paterson et al., 2021; Rugulies et al., 2023). Moreover, current research explores organisational interventions (OI) for combating the negative impact of MHCs, but there are no known studies on the adoption or use of MHIs from an *employee*

perspective or individual standpoint, while there is a disparity between mental health awareness (MHA) and behavioural change (Kakuma et al., 2010; Paterson et al., 2021).

1.4 Problem Statement

The problem is that the impact of MHCs is under-recognised in developing countries, and employees may not possess the knowledge or resources for self-help strategies. (Alloh et al., 2018; Goetzel et al., 2018; Luberenga, 2023; Rathod et al., 2017). Most people experience stress in their different work environments or organisations, but they are suffering silently from mental health issues. There is increased global awareness of this topic, and in 2020, depression was anticipated to be the second-highest health problem in the world after heart disease, with an estimated contribution of 15% of the global cost of illnesses (Chinyamurindi & Shava, 2022; Chopra, 2009; Li et al., 2019). MHCs result in accidents or mistakes, poor time management, motivation and engagement, conflict between colleagues, poor physical health, and high staff turnover (Chinyamurindi & Shava, 2022; Gumani, 2019; Harnois & Gabriel, 2000; Hassard et al., 2011). Companies incur significant costs for healthcare and lost productivity due to absenteeism, which ultimately reduces the national gross domestic product (GDP) (Kimatu, 2016; Knapp & Wong, 2020). As a result, international advocacy is required to prioritise MHP in developing countries, like South Africa, which is defined as the effort of equipping people with the skills required to enhance their mental well-being (Tamminen et al., 2016). This study aims to make the voice of the individual or average employee heard concerning their adoption of MHIs (Craig P, 2008; Paterson et al., 2021; Wensing, 2015). This can be achieved by galvanising HR practitioners, management and policymakers to create awareness of the various MHIs available to employees to improve wellness and productivity, thereby mitigating the adverse impact of MHCs on individuals and businesses. (Bird et al., 2011; Chinyamurindi & Shava, 2022; Hassard et al., 2011; Saraceno et al., 2007).

1.5 Research objective

To determine the mental health interventions that employees use to manage stress, anxiety, insomnia, depression, and burnout (MHCs) in the workplace.

1.6 Research question

What mental health interventions do employees use to manage stress, anxiety, insomnia, depression, and burnout (MHCs) in the workplace?

1.7 Research Proposition

Employees who use MHIs may increase their resources to address MHCs, thereby experiencing lower stress levels, higher motivation, engagement and productivity.

1.8 Rationale of the study

This study seeks to contribute to international dialogue on MHIs by guiding employees on the resources that are available to equip themselves with mechanisms for coping with MHCs. It may guide leaders in driving MHP by developing effective MHIs and appointing champions within the organisation to support staff well-being. Policymakers may understand employees' mental health needs and draft legislation like South Africa's National Mental Health Policy Framework and Strategic Plan 2023–2030, with special focus on the workplace, which is defined as “any organisation operating with paid employees” (Bird et al., 2011; Hassard et al., 2011; Paterson et al., 2021; Shisana et al., 2024).

1.9 Delimitations of the study

- a) This research is limited to employees at different job levels (intermediate, middle and senior management), within the financial services industry, which includes the banking, insurance, and investment sectors.
- b) This research is not a clinical study and it is limited to the psychological aspect of MHCs.

1.10 Assumptions

This study assumes all respondents have relevant work experience and information on mental health to participate in the research, and they will provide honest, open feedback regarding the subject.

1.11 Chapter Outline

Chapter 1 highlights the purpose of the study, the background, research problem and rationale, as well as delimitations and assumptions of the research.

Chapter 2 delves into the literature review, which encompasses the theoretical and conceptual framework of the study.

Chapter 3 discusses the research approach and design, including the methodology for data collection, and outlines the data analysis techniques while weighing in on quality and ethical considerations.

Chapter 4 details the steps of the data collection process and procedures taken in conducting thematic analysis, followed by a presentation of the research results, which answer the research question based on the theoretical framework.

Chapter 5 entails a discussion and interpretation of the results of the research.

Chapter 6 concludes and offers recommendations based on the findings of the research.

CHAPTER 2. LITERATURE REVIEW

2.1 Introduction

The purpose of this study was to explore the implementation of MHIs through qualitative research using interviews to determine the accessibility, acceptability, and adoption of these strategies by individual employees in the South African workplace, with special focus on the financial services industry.

This chapter highlights peer-reviewed literature on mental health, and the JD-R model is employed as the basis to discuss interventions used to provide employees with resources for managing job demands to improve their mental health.

2.2 The importance of employee wellness

Employee wellness in the organisation

Hobson (2019) reiterates that people are an organisation's top asset, and their well-being should be prioritised, as valued employees are happy, engaged and motivated to provide exceptional service to customers, enhancing the organisation's overall image. Frustrated employees cause financial losses through high staff turnover, which unsettles customers, causing job instability for other employees, influencing them to leave the organisation. Well-being or wellness is linked to OHS policies protecting employees from health hazards at work, encompassing mental, physical, social and financial aspects of the individual (Hobson, 2019; Marinaki, 2023). Organisations need to demonstrate care for their staff through a conducive work environment (Chinyamurindi, 2019; Chinyamurindi & Shava, 2022; Milner et al., 2015; Van de Voorde et al., 2011; Warr, 2007).

Well-being

It is important to distinguish between well-being and mental health in this study while highlighting the link between both concepts. By its definition, well-being is viewed holistically to encompass the physical, mental, emotional, social, spiritual and financial aspects that result in overall life satisfaction (Goetzel et al., 2018; Pfeffer & Williams, 2020; Schramme, 2023; WHO, 1948). Business profitability can be influenced by several factors which impact employee well-being outside the workplace, such as financial instability, health issues, and family responsibilities, which place significant stress on employees, impacting job satisfaction and employee productivity. However, mental health is only one component or construct of well-being (Dongre, 2024; Kapur, 2021).

Mental Health

Mental Health is “‘a state of well-being’ in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work productively, and is able to make a contribution to his or her community” (World Health Organization, 2004. pg. 10). MHCs affect approximately 20% of the workforce in developed countries (OECD,

2013). They impact performance, physical health and lifestyle choices, leading to detrimental habits including substance use and poor diet (Pandey & Mishra, 2024). Chronic diseases, musculoskeletal issues and even suicide can result from MHCs (Goetzel et al., 2018; Pfeffer & Williams, 2020). The American Psychological Association's 2014 Work and Well-Being Survey indicates, "31% of employed adults indicated that they felt tense or stressed out during the workday, although 61% of employed adults reported that they had the resources to manage the work stress that they experienced" (Tetrick & Winslow, 2015).

Causes of Mental Health Conditions

The top five stressors in the workplace include remuneration, career growth prospects, long working hours, undefined job expectations and job insecurity, but not heavy workload, while the COVID-19 pandemic exacerbated fear of retrenchments, pay cuts and other financial repercussions (Tetrick & Winslow, 2015). Dewa et al. (2011) found that employees with severe depression were considerably less productive than those with moderate depression, yet most did not use any interventions to combat this (Goetzel et al., 2018; Paterson et al., 2021).

Employees in the financial services industry, particularly the banking sector, are susceptible to higher levels of stress due to restructuring and dynamic working conditions in the post-COVID-19 economic crisis. There are also significant technological disruptions requiring high adaptability and changing roles of employees. These factors contribute to an increase in the incidence of MHCs (Giorgi et al., 2017).

2.3 MENTAL HEALTH INTERVENTIONS

2.3.1 *Mental Health Awareness and Promotion*

In the USA, MHCs cost over \$200 billion annually through productivity losses exceeding the contribution of physical illnesses, while substandard EU working conditions led to a 3-4% GDP reduction (Hassard et al., 2011; McDaid, 2008). Increasing awareness of the impact of MHCs has led to a collective drive to curtail their effects (Goetzel et al., 2018). In South Africa, anxiety disorders are most pervasive, with 25.7% of the population being depressed (Jacob & Coetzee, 2018; Mboweni et al., 2023; Petersen et al., 2016). Stigma and poor information on MHIs result in social exclusion, requiring mental health literacy through public campaigns on social media platforms like WhatsApp, Facebook and TikTok, while NGOs, including the South African Federation for Mental Health (SAFMH) and the South African Depression and Anxiety Group (SADAG), can develop dedicated workplace programmes (Bird et al., 2011; Brohan & Thornicroft, 2010; Kakuma et al., 2010; Paterson et al., 2021).

Awareness of the socioeconomic impact of MHCs has led to the inclusion of workplace MHP in EU policies linked to the Sustainable Development Goals (SDGs) to protect society (Hassard et al., 2011; Martinelli, 2024; Miranda & Patel, 2005; World Health Organization, 2004). However, mental health is under-prioritised globally, with most African countries holding redundant mental health policies (Hassard et al., 2011; Sainsbury et al., 2008; WHO, 2005). Funding is inadequate as MHP is relegated in favour of HIV treatment as the disease is prevalent in South Africa, while the 1994

policy guidelines on mental health failed to translate into budgets and services due to cultural beliefs and attribution of MHCs to untreatable abnormal behaviour. Non-disclosure of the condition for fear of discrimination also deters policy-makers from championing mental health (Bird et al., 2011).

2.3.2 Organisational Interventions

Mental Health Interventions are “interpersonal or informational activities, techniques, or strategies that target biological, behavioural, cognitive, emotional, interpersonal, social, or environmental factors with the aim of improving health functioning and well-being” (England et al., 2015, pg.31). They are specific actions used to transform individual behaviour or emotions through psychological care, including counselling or self-help activities, which can be administered by therapists. They originate from Employee Assistance Programmes (EAP) or MHP to improve wellness by promoting healthy behaviour and should be implemented systematically for effectiveness (Chopra, 2009; LaMontagne et al., 2007; Tetrick & Winslow, 2015). MHIs (Table 1) include preventative, proactive primary interventions, including stress management for all employees; secondary interventions to eliminate stressors for affected individuals; and tertiary interventions for relieving distressed employees (Tetrick & Winslow, 2015). Optimal primary intervention is achieved in combination with secondary and tertiary measures (Giga et al., 2003; LaMontagne et al., 2007; Memish et al., 2017).

Table 1. Types of MHIs (Tetrick & Winslow, 2015)

Intervention	Response	Target
Primary	Proactive	All employees
Secondary	Proactive and partially reactive	Employees under risk
Tertiary	Reactive	Distressed employees

Table 2 (APPENDIX A) indicates that psychological interventions using technological innovations (virtual care or e-health), CBT and resistance exercise training for musculoskeletal disorders yield positive effects. There are good outcomes for those receiving physical activity interventions, while there may be insignificant benefits from job stress management training, ergonomics or workstation modifications (Phillips et al., 2019; Proper & van Oostrom, 2019). Employees may access therapists through medical aid, while in-house mental health care may offer convenience by employing a trained counsellor or equipping an HR practitioner to assist within the organisation (Pfeffer & Williams, 2020; Shisana et al., 2024).

2.3.3 Personal or Individual Interventions

Red Cape interventions stem negative individual experiences by decreasing job demands, including high workload and discrimination, or personal demands linked to

family responsibilities. Recent focus is on **Green Cape interventions** in Table 3 (APPENDIX B), which heighten positive experiences, increasing work or non-work resources, and personal resources, including self-care activities not requiring support from another facilitator (Polly, 2014; Seligman et al., 2005; Sin & Lyubomirsky, 2009; Tetrick & Winslow, 2015).

The following interventions particularly relate to stress management:

1. **Mindfulness-based interventions.** Mindfulness is attentiveness or awareness of present events, enhancing personal resources to cope with job demands in the individual's private space (Michel et al., 2014; Tetrick & Winslow, 2015). Employees can calmly manage their emotions in high-conflict work situations through breathing techniques (Hülshager et al., 2013; Siegel, 2010).
2. **Recovery interventions** use self-mastery and control to release job stress outside working hours, including quality sleeping techniques to relieve exhaustion (Hahn et al., 2011; Siu et al., 2014 ; Sonnentag & Fritz, 2007).
3. **Multimodal interventions** use a combination of online or face-to-face primary interventions, CBT, relaxation, time management and social support to alleviate stress (Eisen et al., 2008). Optimal benefits are realised by practising daily stress management. Programmes may be developed for employed parents to prevent dysfunctional parenting, avoiding home stress spilling over to work (Demerouti et al., 2014; Tetrick & Winslow, 2015; Wayne et al., 2007).

2.4 ANALYTICAL FRAMEWORK

2.4.1 *Theoretical Framework*

The JD-R model in Figure 1 (APPENDIX C) indicates that employees with organisational support to provide their personal and work-related resources have lower stress levels (Gaurav et al., 2019). Job positives, including emotional resilience, work flexibility, excellent relationships, training, and career advancement, create a healthy environment, improving wellness and productivity. Job demands or stressors include heavy workloads, tight deadlines, poor working conditions, and strained relationships. High motivation and engagement are achieved when job positives exceed job demands (Bakker & Demerouti, 2007; Saks, 2022).

Chopra (2009) utilises the demand-control and reward-effort models to evaluate the effect of work-related stressors (Benach et al., 2007; Siegrist & Theorell, 2006). Stress relates to high job demands and reward imbalances, coupled with low job control (Harvey et al., 2017). Poor career advancement is tied to employees' self-esteem, job security and financial incentives, while harassment and bullying can also cause physical illness, exacerbating MHCs (Bourbonnais et al., 2011; Paterson et al., 2021).

2.4.2 Conceptual Framework

Awareness of the impact of MHCs leads to MHP, resulting in MHIs being developed to improve employee wellness. Therefore, implementation of MHIs is dependent on awareness and promotion, which raises the question whether employees are aware of MHIs and are using them to cope with MHCs (Figure 2).

Figure 2. Conceptual framework for mental health intervention



2.5 Conclusion of Literature Review

Rugulies et al. (2023) highlight the impact of harsh work environments on productivity, increasing MHCs and the need to prioritise mental health in developing countries, such as South Africa. Recent studies by Goetzel (2018), Pfeffer & Williams (2020) and Phillips (2019) concur with Bakker and Demerouti (2007) that job demands, including heavy workload, contribute to job strain, requiring stress management to prevent MHCs. Contradictory findings from Tetrick and Winslow (2013) indicate that heavy workload does not contribute to job strain. Overall, Phillips (2019) finds that MHIs have significant health benefits in combating MHCs.

Bird et al. (2011), Mboweni et al. (2023), Paterson et al. (2021) and Shisana (2024) highlight stigma, competing priorities, cultural issues and lack of advocacy as obstacles to MHIs. Hassard and Cox (2011) agree that cultural factors play a role and find MHIs to be proactive or preventative. Tetrick and Winslow (2013) and Memish et al. (2017) state that MHIs are reactive and most effective when designed for both organisational and individual factors (Joyce et al., 2016; LaMontagne et al., 2007). Goetzel (2018) and Milner (2013) emphasise the importance of leadership support for employee buy-in to MHP, and Kakuma (2010) emphasises the need for awareness campaigns and national policies for the successful implementation of MHIs.

CHAPTER 3. RESEARCH METHODOLOGY

3.1 Introduction

The purpose of this study was to explore the implementation of MHIs through qualitative research using interviews to determine the accessibility, acceptability, and adoption of these strategies by individual employees in the South African workplace, with special focus on the financial services industry.

This chapter outlines the methods used in this study to collect, analyse, and interpret data, based on academic literature. It thereby ensures transparency, reliability, and validity of the findings.

3.2 Research approach and design

Published literature was obtained on Google Scholar, Sabinet, and ProQuest, while grey literature was also included in the search. Qualitative research by interviews was used to explore employees' adoption of MHIs in various organisations, with the employee as the unit of analysis. This is an ideal method of acquiring detailed feedback on employees' opinions on mental health issues and use of MHIs, offering a flexible approach to adapt questions to improve respondents' answers. An action research method was followed, whereby the researcher and respondents may relate or apply the theory or framework to implement social transformation (Bhandari, 2023; DeJonckheere & Vaughn, 2019; Vaughan, 2021).

3.3 Data collection methods

One-on-one semi-structured interviews were used, and respondents were encouraged to provide detailed feedback by using open-ended questions rather than guiding their answers, while probing questions were used to obtain clarity. An interview guide (APPENDIX E) was used with hand-written notes taken in a diary, while audio recording and transcription were used for accurate capturing of responses (Jamshed, 2014). Aspects including awareness, causes, effects, promotion, interventions, and organisational support were covered in the interviews, with the researcher taking a neutral stance in demeanour to eliminate bias while facilitating the interviews (O'Connor & Joffe, 2020).

Social desirability bias was avoided by assuring each participant of the confidentiality of the collected data and ensuring their anonymity, preventing participants from offering responses that are deemed socially acceptable instead of their true opinions, to protect their self-image (Jose Patricio Bispo, 2022). Ensuring privacy and not being overheard by other people reduced the bystander effect, while offering each participant a respectful, empathetic, non-judgemental attitude and being mindful of my body language also reduced bias (Galdas, 2017; Scott et al., 2021). Interview questions were formulated strategically, censoring critical words, to ensure respondents answered openly and truthfully (Kaminska & Foulsham, 2013; Krumpal, 2013). General ice-breaking questions, on their demographics and employment background, were

asked at the onset to assist the respondent in gaining confidence before getting into the topic (Jose Patricio Bispo, 2022).

3.4 Population and sample

3.4.1 Population

A cross-sectional study was done with qualified professionals from different South African organisations in the financial services industry, residing in Johannesburg, considered the business hub of South Africa, who were willing to participate in the research and share their knowledge, opinions or experiences regarding mental health in the workplace. These individuals hold recognised academic certificates and experience relevant to their occupation, representing the average employee (DeJonckheere & Vaughn, 2019).

3.4.2 Sample and Sampling Method

Eighteen (18) participants were selected from the researcher's network using a non-probability convenience sampling method for easy accessibility. Convenience sampling was chosen for this study due to its practicality and ease of access, allowing for the collection of data quickly and efficiently from participants who were readily available and willing to participate (Henry, 1990). The respondents had diverse demographics, including gender, age, education, and job levels for a wider spectrum of views (APPENDIX E). Data saturation was also considered in selecting the sample size, as responses could become repetitive beyond the seventh participant, and information would be exhaustive from 18 participants (DeJonckheere & Vaughn, 2019; Fleetwood; Hennink & Kaiser, 2022).

3.5 The research instrument

An Interview Guide with 20 Questions (APPENDIX E) was used in the research, broken down as follows in Table 4:

Table 4: Sections of the Interview Guide

Interview Section	Question number
Demographics	1, 2
Employment Background	3, 4, 5, 6, 7
Awareness of Mental Health	8
Mental Health Promotion / Organisational Support	9
Causes of Mental Health Conditions (MHCs)	10, 11, 12
Personal Experience / Employee Wellness	13, 14, 15
Mental Health Interventions	16, 17, 18, 19, 20

3.6 Procedure for data collection

Data was collected in face-to-face meetings in the respondents' natural settings based on convenience.

3.7 Data analysis strategies and interpretation

Thematic analysis was used as a simple method to analyse data from the qualitative research by identifying patterns in the data, labelling and grouping it into themes (Riger & Sigurvinsdottir, 2016). This includes narrative analysis to determine the respondents' opinions and behaviour concerning MHIs. Inductive thematic analysis was used to draw meaning from data without preconceived ideas of the results. Steps followed in this process include pre-labelling observations of transcribed data to pick up initial patterns that were recorded in writing, diarising the codes or labels that were created and applying them to emanating themes in the data, manually sorting and combining initial labels with similar themes together using colour-coding with highlighters, then reviewing and finalising themes with substantive data to form a narrative, including interpretive analysis and justification of the claims. Finally, a report was written which includes an introduction to the analysis, a methodology section, results and findings presented in tabulated data, a discussion and interpretation of the results, as well as a conclusion (Dovetail Editorial Team, 2023; Riger & Sigurvinsdottir, 2016).

3.8 Possible limitations and challenges of the study

The sample size of this study, and qualitative research by its nature, does not allow for representativeness or broad generalisation of how the results relate to the South African population.

3.9 Quality Assurance

The following criteria were used to assess the validity of the study, whereby the results of this research can be applied to other populations (Table 5):

Table 5: Criteria used to assess validity of the study

Qualitative	Method
Transferability	Other researchers can apply the results through detailed descriptions of methods used (Lincoln & Guba, 1986; Treharne & Riggs, 2015).
Confirmability	A record of all data collection and analysis procedures, together with the supporting documents, are kept for verification purposes (Lincoln & Guba, 1986; Treharne & Riggs, 2015).

3.10 Ethical considerations

Consent forms were shared with each respondent to confirm participation voluntarily, also highlighting their right to withdraw from the research without repercussions at any stage of the study. Protection of Personal Information Act (POPIA) regulations were followed to ensure the privacy of all participants, and information provided was kept highly confidential.

CHAPTER 4. RESULTS AND FINDINGS

4.1 Introduction

The purpose of this study was to explore the implementation of MHIs through qualitative research using interviews to determine the accessibility, acceptability, and adoption of these strategies by individual employees in the South African workplace, with special focus on the financial services industry.

This section details the steps followed in data collection and thematic analysis. It further presents the results which answer the research question based on the theoretical framework.

4.2 Data Collection

Eighteen (18) participants from the sample population in the financial services industry took part in the interviews, and a Participant Information Sheet outlining terms and conditions of the interview was provided, highlighting that the strictest confidentiality would be maintained and that participants are guaranteed anonymity in the final research report. A consent form was shared with each individual to confirm their approval to conduct the interview (Burnard, 2004).

Interviews were carried out online over six weeks, with each interview taking an average of 30 to 45 minutes. Permission was granted by each participant to record their interview, and the audio recordings were transcribed and saved in a password-protected computer. Thereafter, thematic analysis was used to examine and interpret the data (Burnard, 2004).

Data triangulation could be applied by collecting data from multiple sources or repeating the study with a different set of interview participants, while participants with different demographics may also be used to gain a wider range of opinions or preferences on mental health and MHIs, thereby reducing bias and increasing the validity of the results through sample triangulation. A comprehensive understanding of MHIs may be acquired through the investigation or probing of irregularities in the findings or results triangulation. Ultimately, triangulation reduces the limitations of the qualitative study (Bans-Akutey, 2021; Bhandari, 2022; Donkoh, 2023).

4.3 Thematic Analysis

Transcriptions generated from the interviews were reviewed, and a manual process was used to create codes emerging from the data, which were categorised into several themes (APPENDIX D – Table 6). The themes were analysed based on the theoretical framework for the research, which is linked to the interview guide.

1. Global trend
2. Media
3. First-hand exposure
4. Leadership
5. Working conditions
6. Family Responsibility
7. MHCs
8. Physical conditions
9. Self-management / self-care
10. Religion and spirituality
11. Technology
12. Recreation
13. Employee Value Proposition (EVP)
14. Peer support

4.4 Results and Findings

I had a research question on what MHIs employees use to manage MHCs in the workplace. I took an interpretivism approach of perceiving mental health from an individual perspective, and the results from my research are reported under Organisational Interventions, which examine MHA, causes (stressors and demands) and MHP or organisational support, as well as Personal Interventions (PI), which highlight employee wellness or personal experience with MHCs, in line with the interview guide. The results presentation begins with a view of participant demographics and culminates with findings on the adoption or utilisation of MHIs.

4.4.1 Demographics

Categorical demographic variables were used to distinguish the gender, race, education, job level, as well as the employment industry of the participants, while continuous demographic variables incorporated their age and work experience. The demographic statistics of the study appear in Table 7 below and are summarised according to the interview participant list.

The research population had a 50-50 split of middle and senior management employees versus skilled employees who were mainly in the banking industry, while most participants were African females. The majority of the respondents were in the 31-to-50-year age range, and over half of these employees held a bachelor's degree or higher qualification, while most had between 11 and 30 years of work experience.

Table 7: Demographics of the Interview Participants

Demographic Variable	Semi-variable	Participant Count	Percentage
Job level	Intermediate/Skilled	9	50%
	Middle Management	5	28%
	Senior / Executive Management	4	22%
Industry	Banking	11	61%
	Insurance	4	22%
	Investment	3	17%
Gender	Male	6	33%
	Female	12	67%
Age	20-30	2	11%
	31-40	8	44%
	41-50	5	28%
	51-60	3	17%
Race	African	12	67%
	Coloured / Indian	4	22%
	White	2	11%
Education level	Intermediate (Certificate / Diploma)	8	44%
	Bachelor	5	28%
	Post-graduate Diploma (Post Grad)	2	11%
	Masters	3	17%
Work Experience	6-10 years	5	28%
	11-15 years	2	11%
	16-20 years	4	22%
	21-30 years	5	28%
	30+ years	2	11%

4.4.2 Organisational Interventions

Awareness

The majority of respondents had a holistic understanding of mental health, with only one participant attributing this to illness or psychiatric conditions. Several participants highlighted that mental health is an increasing global trend popularised by media, including written and social media (Table 8). Some consume this information through reading, while a large number are exposed to it through their work experience, including training, wellness days or campaigns and the nature of their job, for example, when handling medical insurance claims. A handful of respondents also gained awareness through their personal experience with MHCs or affected family and friends.

One participant commented on the reduced stigma surrounding the topic below:

Mental health has become a topic that is publicly spoken about, so it is not something taboo like it used to be. A lot of people talk about it wherever you go, whether it is in the office space, in a social setting or on social media.

Participant 8

Another participant emphasised the significance of mental health and that leaders need to give more attention to this, considering *it is all about people's lives, and MHCs can impact anyone*:

You can think you are educated, experienced and well-grounded, yet certain things happen. Leadership is a big thing that will still affect you... So, no matter how strong you think you are, we are all vulnerable to mental health issues.

Participant 18

Table 8: Sources of MHA

Mental Health Awareness			
Work or Organisation	Media	Personal or Family experience	Reading

Causes of MHCs (Stressors or Demands)

Work organisation

Work organisation and particularly leadership were cited as a major stressor by the majority of participants, as this is linked to working conditions, and reward-effort imbalances or remuneration were highlighted as the greatest stressor by half of the respondents, which is substantiated by employee surveys in different organisations in the banking industry. Job demands such as tight deadlines or performance targets were a concern amongst the other half of the participants, along with heavy workload, while all participants indicated they have a pressurised work environment.

Interestingly, Participant 18 recently experienced a change in leadership when a new CEO joined the organisation and with this came a culture of bullying and toxicity, whereas previous leadership fostered psychological safety and collaboration between employees, encouraging communication from top-down and bottom-up while allowing people to learn from their mistakes. As a result, mental health initiatives are now viewed as a “tick box exercise,” where only lip service is paid towards this topic, and employees are not a priority compared to the bottom line or shareholder value, shifting from a people to a cost focus. One male executive was bullied out of his job for disagreeing with the CEO’s views, resulting in the victim having a nervous breakdown, while his replacement, a mature high-performing female executive suffered a near heart attack on duty and was hospitalised due to stress or burnout resulting from the pressure of shielding her team of 20 senior and middle managers. This recurring issue is a real cause for concern, and the organisation also experienced high staff turnover, losing valuable senior employees as a result, some of whom are still struggling with the lasting effects of this toxicity, a year after changing organisations.

One participant reiterated that poor leadership or the lack of vision and direction is a top stressor, but in contrast, she works under a leader who is performance-driven but has a humanistic approach, applying values of caring, openness and transparency while fostering teamwork or promoting cohesion amongst employees and encouraging creativity by offering employees autonomy in their roles. As a result, a recent employee survey revealed a high score for their staff Happiness Factor due to good leadership and increased job satisfaction. There have been no observations of mental health issues amongst the participant’s colleagues, as outlined below:

Our team is always happy, as we have a great, caring and understanding manager. When HR does their annual survey to rate our well-being, we rank second highest in happiness. We have a good relationship as she is a human being before she is a manager, which allows us to speak freely and be transparent. She is quite irreplaceable as she is the glue that keeps our different personalities together and keeps us loving what we do because we get the opportunity to think and apply ourselves. Participant 12

Job demands

The second aspect that is stressful regarding the work environment is job demands, and we acknowledge a minority of participants who were among the worst affected by MHCs. Participants 5 and 11, who run their own businesses, receive extensive and ongoing medical treatment because of stress, anxiety, insomnia, depression and burnout, which is attributed to the financial burden of running a business in an economic downturn, coupled with high-performance targets. One senior manager cited emotional labour as a stressor, as an underperforming business can result in staff retrenchments. Realising the impact that this has on the employee, their family and dependants sits heavily on the leader's conscience, negatively impacting his mental health. A third respondent, Participant 13, was booked off sick at the time of the interview, and she experiences the full range of MHCs, including stress, anxiety, insomnia, severe depression, burnout, physical illness or hypertension, and musculoskeletal issues or back pain. The common factor amongst these employees is that they have not been exposed to any OI or mental health training. As a result, they have low resources to outweigh their job demands, depending on just one personal intervention to cope, and are therefore adversely impacted by MHCs.

Effects of MHCs on employees

Presenteeism was found to be the most common effect of MHCs compared to mistakes and time management. Other effects, including confusion or uncertainty, poor communication, as well as absenteeism, had a lesser effect as well.

Organisational Support and MHIs

Half of the respondents receive mental health training from their organisation to equip them with interventions to manage MHCs, while a small segment disclosed that their employer does not offer organisational support. Of the respondents with access to OI, at least half have counselling services available to them, including ICAS or Lyra Southern Africa, and a handful of respondents can access mental health services online or via an app (cell phone application), while others have these services extended to their family. These interventions are classified under the employee value proposition (EVP).

Additional benefits, including remote working, lunch breaks, time off to manage personal issues, and vacations, are also crucial for managing MHCs, with several respondents also utilising flexi-time opportunities. Detaching from work by stepping away from the desk or closing the computer/laptop and separating work from personal life or family time is also encouraged. Management sensitivity is required as Participant 18 shared an incident where she was working from home and attended a 12-hour-long meeting that stretched into the night, resulting in her being unable to prepare supper for her minor child.

Participant 15 indicated that her organisation offers mandatory training to enforce MHA, while Participant 18's organisation provides mandatory breaks, where everyone's Outlook calendar in her business unit of 8,000 employees is booked 'out of office' during lunchtime, and Wednesday mornings are blocked for administrative work,

with no meetings booked during this period to reduce workload. This has been upheld for four years, and it's a good example of putting technology to use in effecting MHIs.

Several respondents have well-being ambassadors or peer support groups (a brotherhood or sisterhood) that meet regularly within the organisation, while half of the participants offer one-on-one support to their colleagues. Talking was highlighted as an effective therapeutic means of dealing with MHCs, and remarkably, Participant 12, a trained coach, mitigated a suicide through this intervention. Again, leadership is flagged as being pivotal in providing these resources to employees, and some organisations are quite strong and exemplary in this regard, as indicated by one participant below:

In every phase of my development, there have been different courses I attended to give me specific tools to deal with job stress, whether it's leadership, coping skills, or anger management. I have been in the banking industry for many years, and we become very familiar with each other and dependent on the teams that we are in, so they offer different skills to deal with the different environments that you get into. I have had promotions throughout, and I am very happy with my growth level within the organisation. They are well-grounded and look after their staff, making sure that both their mental and physical health are taken care of. If you have issues, there are specific areas you can go to for the aid you need. Participant 4

4.4.3 *Personal Interventions*

Personal Experience or Employee Wellness

Mental and Physical Health

The current generation of employees appears more prone to MHCs following the COVID-19 pandemic, with all participants having experienced MHCs in their lifetime. Stress and related physical health issues are most prevalent among the participants, at an equal rate, with depression being the third highest concern, followed by anxiety, insomnia, and burnout in order of frequency. Notably, a large number of participants with physical health issues were diagnosed with hypertension, while one participant experienced migraines. The most severe case of physical illness was from Participant 18, diagnosed with Bell's Palsy or temporary partial facial paralysis because of nerve damage caused by sitting for excessive hours in front of her computer. Ergonomics plays a role here, and four participants experience back pain as a result.

Personal interventions or individual resources

Several personal interventions were also being used by employees to improve their wellness. Most participants indicated that they rely on their spirituality in stressful times, using prayer and meditation as their main intervention or first preference, while others turn to self-management or self-care activities. Exercise came in strongly as the second-best intervention, both as a first preference and a second preference MHI. Diet and relaxation through spa days, breathing exercises, and reduced screen time are also first preferences for several participants. Gaming or apps also emerged as effective interventions as a second preference for a fraction of the respondents. Other interventions include recreational activities, such as gardening and watching sports. One respondent, Participant 12, did not select any PI on the basis that she currently has no issues with MHCs due to high emotional intelligence (EI). Ultimately, every participant, with the one exception, makes use of MHIs to manage their MHCs.

The group of empowered participants reported on average one or two MHCs, in contrast to a minimum of four MHCs from the untrained or worst-affected participants mentioned earlier. A significant number of empowered respondents indicated that they experience stress, while a handful experience insomnia, and a few others have anxiety. One participant suffered from mild depression over a family crisis, while another experienced burnout. A few participants were treated for hypertension, and an equal number experienced musculoskeletal issues. Of the nine participants, a segment indicated that they experienced presenteeism. Each of these participants uses three different MHIs on average, with a significant number of participants using prayer as a go-to intervention, which, according to one participant, is conveniently available to everyone, saving time and money, as this is accessible at no cost:

In extreme times of pressure and stress, the basics are what help or work for me and I go back to prayer, because if I don't have the luxury of time, what I can do in the few minutes that I have is prayer and meditation, even if it's five minutes alone to quiet my mind. Participant 18

Another respondent indicated she uses multiple interventions to manage her mental health:

So, I cannot exactly attribute it to one thing because I do various things, that is, a combination of healthy eating, exercise, reading, mindfulness, meditation, visualisation, and affirmations. All these different things, and if I may add, just getting sufficient sleep as well. Participant 7

Along with Participant 7 was Participant 16, who plays the role of a well-being ambassador in his organisation and had the most interventions to draw from, including prayer, meditation, exercise, relaxation or breathing exercises, while drawing on

Christian counselling as well. Participant 16 was going through a life crisis or divorce at the time of the interview but maintained an optimistic outlook and demonstrated resilience by applying EI through this trial. A highly spiritual individual, he shared valuable insight on managing mental health through counselling, quoting scripture from Proverbs 11:14 (King James version) - "Where no counsel is, the people fall: but in the multitude of counsellors there is safety".

In contrast, Participant 5 faced the same life crisis with no resources at his disposal to deal with it. Having had no mental health training or organisational support, he subsequently fell into severe depression requiring extensive medical treatment and long-term medication to manage this condition. He also reported struggling with obesity and hypertension. Participant 17 also struggles with obesity, admitting to smoking and drinking as a result of low resources to handle stress due to consistently missing mental health training due to work pressure. Therefore, employees are encouraged to use a variety of MHIs at their disposal to manage MHCs.

Five of nine respondents, Participants 4, 7, 12, 15, and 18, stood out as they were highly empowered or equipped to handle MHCs, with two respondents, Participant 12 and Participant 15, demonstrating high levels of EI, self-management, and mindfulness.

Participant 12 is an ideal example of an employee proactively taking charge of their own mental health through extensive reading and personal development initiatives, in addition to OI or EI training, which enables her to deal with the root cause of MHCs by reframing any issues that arise while effectively managing her work-life integration:

I have learnt to put things in their place by organising them in my mind and attributing weight to them according to their importance, so I do not necessarily experience anxiety or depression. I do have tough moments, but I will usually reflect on this, name the situation, or reframe it for myself so that it does not affect me. I try not to get to the point where I am feeling overwhelmed by negative emotions to the point that it is difficult for me to go about my day-to-day business. Participant 12.

She is a highly engaged and productive employee with high resources to meet her job demands, which she has acquired through OI. As a result, she is content with her remuneration and promotion opportunities, which she feels are within her reach or power to achieve if she takes the initiative through self-autonomy, rather than waiting for management to promote her. She also enjoys splendid work relationships with her colleagues and management due to the wide range of MHIs that she is equipped with to handle any mental health challenges.

AI and MHIs

On the other hand, a minority of participants relied on AI and gaming to manage MHCs. Participant 15 supported an emerging view of gaming as an escape or highly effective MHI, as she is an avid Sudoku player, which she finds very relaxing, while Participant 4 uses a concept of rearranging colour-coordinated blocks to reflect on and manage her emotions, a skill also acquired through EI training. This technological view was initiated by Participant 8, who gave a compelling insight on how disruptions such as AI internet bots can be used in the current technological age (4IR), to provide employee support through gaming or counselling. AI has the advantage of providing accurate and effective feedback without judgement, whilst maintaining strict confidentiality and eliminating the risk of comebacks for the employee compared to human-facing interactions.

When it comes to managing stress and anxiety, nowadays, we have AI bots that are being developed to do this. Lately, I've been using bots a lot and it sounds crazy or outlandish, but it does work for me because I can say something to a machine or a robot, that I normally wouldn't say to a human, as there's zero judgement and zero chance of someone using that against me in the future. So, I pour my heart out, and then exactly what I need to hear is what the bot says. Participant 8

This intervention is particularly attractive to digital natives and if harnessed appropriately, may result in higher levels of adoption of MHIs by employees.

4.4.4 Adoption of Mental Health Interventions (MHIs)

Ultimately, half of the participants confirmed that they utilise OI provided by their workplace, while less than half of them have no formal mental health training and use their own resources, gained through MHA from media, personal or family experience, as well as reading, to manage their MHCs. Overall, all but one of the respondents use MHIs, which depicts the widespread adoption of these interventions.

This study confirms that increased availability and accessibility of both organisational and personal interventions are directly related to the level of utilisation of MHIs by the majority of participants, which is a strong indicator of the level of adoption of MHIs by employees.

CHAPTER 5. DISCUSSION AND INTERPRETATION

5.1 Introduction

The purpose of this study was to explore the implementation of MHIs through qualitative research using interviews to determine the accessibility, acceptability, and adoption of these strategies by individual employees in the South African workplace, with special focus on the financial services industry.

This chapter discusses and provides an interpretation of the results of the research.

5.2 Mental Health Awareness

As indicated in the previous chapter, most participants were aware of mental health, and the research findings support the fact that this is an increasing global trend propagated by technological advances (Paterson et al., 2021). Although Africa is lagging behind European countries, MHA is rapidly spreading through media, particularly social media platforms like WhatsApp, Facebook, and TikTok; thus, it is less associated with witchcraft, as indicated by three participants in this research (Akinwotu, 2021; Bwire, 2024; Deumert et al., 2019; Diyammi, 2025).

Interestingly, stress rather than depression, which is considered the most prevalent MHC in South Africa, was the prevailing MHC among the participants, supporting the fact that employees in the financial services industry, and particularly banking, are most affected by this condition (Giorgi et al., 2017; Jacob & Coetzee, 2018; Mboweni et al., 2023; Petersen et al., 2016). Moreover, in contradiction to Phillip et al. (2019), the research results indicate that job stress management training and ergonomics contribute considerably to mental health and employee well-being (Heuel et al., 2024).

5.3 Organisational Interventions

Organisations are highly instrumental in providing resources to employees through a holistic approach to MHI by providing extensive mental health training, investing in employee growth and development, offering promotion opportunities, fostering excellent relationships and teamwork through peer support initiatives, and offering flexibility by shifting from a time-driven to a results-driven approach. Moreover, they offer both mental and physical health services while implementing ergonomic practices, thereby increasing employee productivity (Bakker & Demerouti, 2007; Saks, 2022).

Causes (stressors or job demands)

Several participants corroborated the importance of leadership in work organisation, as the majority of the respondents acquired MHA through their organisation, in support of the global SDGs for workplace MHP (Omigbodun et al., 2023). Employee stressors are also linked to leadership decisions on EVP, including remuneration, recognition, and rewards such as promotion, as well as working conditions, including flexitime. Good leadership improves employee engagement and well-being, resulting in low staff turnover and increased productivity, which translates to high profitability of the business. Ultimately, leadership plays a critical role in setting the work environment or organisational culture and how this impacts employees' mental health (Chinyamurindi, 2019; Chinyamurindi & Shava, 2022; Hobson, 2019; Milner et al., 2015; Van de Voorde et al., 2011; Warr, 2007).

5.4 Personal or Individual Interventions

Spirituality and mental health

Prayer or workplace spirituality should be encouraged by HR policymakers and practitioners as a form of human expression since most people ascribe to religion or Christianity; for example, an executive in this study encourages his employees to pray through difficult situations (stressors or job demands) which reduces emotional fatigue or burnout, and heightens job satisfaction, thereby mitigating MHCs (Chirico et al., 2023; Chirico et al., 2020; LaBarbera & Hetzel, 2016; Mirshahi & Barani, 2016).

The interrelation between mental and physical health

HBP was the most prevalent physical health condition, reported by several participants in the study, as MHCs have a psychological impact, which leads to a physical reaction. HBP can also lead to other complications, such as migraines, experienced by one participant; stroke; and heart attack, as with the lady executive's health scare (Niedhammer et al., 2021). The JD-R model also indicates that physical well-being provides resources by buffering against MHCs and building resilience, boosting energy levels, morale, and productivity. Physical activity is therefore encouraged, as there is evidence that exercise improves mental health (Bakker & Demerouti, 2007; Bischoff et al., 2019; Gerber & Pühse, 2009; Heuel et al., 2024).

AI and MHIs

AI presents phenomenal mechanisms for managing MHCs due to its accessibility and rapid uptake in the global community; however, this was only utilised by a minority of participants in this study, and the low usage rate can be ascribed to the slow rate of adoption of new technology in South Africa (Mindu et al., 2023). This technology can be adapted from clinical use to organisational/HR systems to efficiently and timely facilitate AI stress detection and personalised interventions, with the advantage of chatbot impartiality and objectivity in addressing employees with MHCs (Gan et al., 2022; Huschens et al., 2023; Liu et al., 2024; Yue et al., 2022).

Gaming can also be adapted to MHI for CBT and relaxation techniques (Ferrari et al., 2022; Ren, 2020).

5.5 Summary of Findings

The results indicate that both OI and PI are being utilised at a high adoption rate by employees in this research. Leadership is a key factor in mental health, and participants who receive organisational support through mental health training, counselling, flexitime, career development, and fair remuneration have more resources to meet their job demands. Most participants rely on prayer or spirituality and exercise or physical activity to manage MHCs, which also impact their physical health. Technology, such as AI and digital gaming, can be adapted to improve employee well-being and increase the adoption of MHIs.

CHAPTER 6. CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

The purpose of this study was to explore the implementation of MHIs through qualitative research using interviews to determine the accessibility, acceptability, and adoption of these strategies by individual employees in the South African workplace, with special focus on the financial services industry.

This section provides a conclusion and presents recommendations emanating from the findings of the research.

6.2 Conclusion

This study of a sample of qualified professionals in the financial services sector in South Africa demonstrates the relationship between organisational and personal mental health interventions, confirming that strong organisational support leads to a higher rate of adoption of MHIs at a personal level, resulting in positive mental health in employees. It reveals that good leadership and people management skills are the backbone of good mental health practices, by ensuring that employees have access to multiple interventions, while bad leadership impedes progress in this area. Based on the JD-R model, this research reveals that individuals who use available MHIs are equipped with resources to manage MHCs and can overcome their job demands through preferred interventions like prayer and exercise while taking advantage of breaks or flexitime opportunities. Disruptive technological advancements like AI can also aid the efficacy and adoption of MHIs through gaming or chatbots.

These results can help organisations to take a more focused strategic approach towards MHA programmes or MHP, with the goal of offering effective MHIs to their employees, while individuals can draw from specific interventions to mitigate or handle MHCs.

6.3 Limitations

This research was conducted among participants in the LSM 8-10 category of the Living Standards Measure in South Africa and did not include the views of blue-collar employees in the LSM 5-7 group.

6.4 Recommendations

Recommendations and action plans for organisations

At the onset, it is pertinent for HRM to facilitate mental health and EI training for company leadership or senior management to enable them to employ good people management practices, thereby facilitating MHA and MHP.

Leaders should demonstrate their concern for employee welfare by proactively identifying and tackling the *root cause* of employee stressors or job demands, rather than reactively solving for MHCs through MHIs, since “prevention is better than cure”. Creating a positive work environment will foster mental health, rather than cause undue pressure, toxicity, or bullying. Employees also require a clear vision or goals and objectives from their leaders, coupled with an empathetic, nurturing, or empowering spirit to drive performance and results. Ensuring the right job fit, according to employee strengths and weaknesses, is another way of managing this.

Organisations can also incentivise employees to attend gyms or spas to improve their mental and physical stamina, in addition to offering flexitime or mandatory breaks, while harnessing innovations such as AI bots and gaming to improve employee adoption of MHIs, achieving a wider reach to a digitally advanced workforce.

Organisations should ensure consistency in their mental health initiatives, as start-stop interventions will not benefit employees in the long term, since some participants indicated that they have forgotten and cannot utilise interventions that they were taught years ago, for instance, through once-off training provided during the COVID pandemic.

It is also beneficial for HRM to tailor MHIs to suit individuals rather than mass-producing or taking a blanket approach, where mental health communication flows one way to employees, but they cannot put their hand up to receive individual assistance with MHCs when necessary. This can be facilitated through AI stress detection and personalised interventions.

Recommendations and action plans for individuals

Employees are encouraged to practise prayer or spirituality, as well as self-management through physical activities, such as exercise, and self-care, including a healthy diet or mindfulness. They can attend the gym or spa regularly to improve their mental and physical stamina, or use AI bots and gaming to manage stress. They should also use flexitime opportunities and be intentional about taking breaks during working hours. They can approach their HRM or mental health ambassadors to obtain counselling or information on MHIs, and where possible, they can draw on peer support.

Recommendations for future studies

Future studies may focus on the implementation, adoption, and impact of prayer or spirituality on mental health in the workplace. This study may investigate whether employees are accepting and using this intervention effectively to cope with MHCs.

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APPENDIX A

Table 2. Effects of various interventions and their delivery mechanisms (Phillips et al., 2019; Proper & van Oostrom, 2019)

Intervention	Mechanism	Effects
Lifestyle Interventions	Archer et al. studied health education or wellness programmes, plus incentivised and non-incentivised behavioural practices, including physical activities (Archer et al., 2011; Odgaard-Jensen et al., 2011).	Overall enhanced mental health, positive attitude, and resilience.
Physical Interventions	Ergonomics, fitness or exercise programmes, and weight loss initiatives studied by Conn et al. (Conn et al., 2009; Spek et al., 2007).	Reduce depression, anxiety and job stress (Andersson & Cuijpers, 2009; Richards & Richardson, 2012).
Physical activity and diet	Cardiovascular risk indicators, comprising body mass index (BMI), body fat percentage, waist size, glucose levels and blood pressure. (Proper & van Oostrom, 2019)	Positive weight-related outcomes.
Resistance exercise training by Van Eerd et al. (Borness et al., 2013; Van Eerd et al., 2016)	Verbeek et al. studied the effect on back pain including, duration, frequency, and intensity (Tulbure, 2011; Verbeek et al., 2011).	Prevention of musculoskeletal disorders.
Psychological interventions or behavioural changes	EAP, counselling and rehabilitation, stress management training, conflict management training, and coping skills training (Tetrack & Winslow, 2015). Carolan et al. studied Cognitive behavioural therapy (CBT) techniques delivered through e-health (internet, mobile apps, or computers) (Carolan et al., 2017; Kuester et al., 2016).	Prevention of depression and reduction of anxiety problems (Kuster et al., 2017).

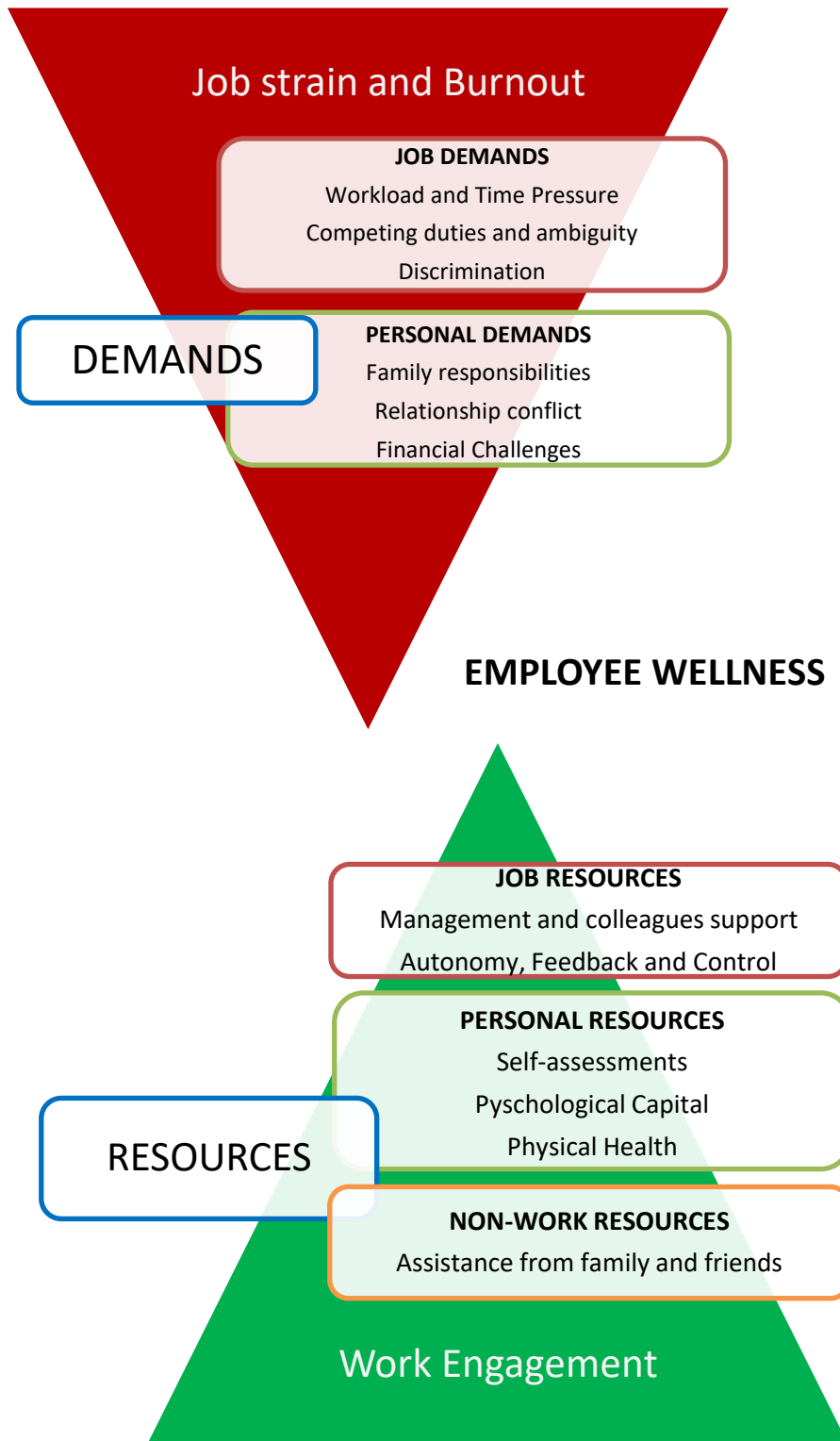
APPENDIX B

Table 3. Green cape Interventions for individual MHIs (Tetrick & Winslow, 2015)

Green cape Intervention	Description
Gratitude or social ties and connectedness	An experimental group focused on what they were grateful for at work, and increasing social contact with colleagues through email and conversations. Those in the gratitude group displayed improved wellness, while there was reduced absenteeism due to illness in both groups (Kaplan et al., 2013).
Positive reflection exercise	Did not reduce employees' blood pressure and it was not beneficial in buffering them from negative work experiences, however, it deflected the harmful impact of mental health and hypertension resulting from work-family conflict (Bono et al., 2013; Tetrick & Winslow, 2015).
Psychological capital (PsyCap),	This intervention focuses on resilience, optimism, and self-efficacy (Luthans et al., 2008).
Cognitive-behavioural interventions	CBTs which are more proactive and highly effective compared to relaxation interventions which are explored more frequently and their technique encourages individuals to release their tension rather than shift their cognition (Richardson & Rothstein, 2008).
Relaxation interventions	Reduce tension and create mental calm, for example, breathing exercises, mindfulness meditation, and prayer (Harvard Health, 2022; Hassard et al., 2011).
Social Interventions	Focus on attaining mental health through self-care such as regular exercise, moderate diet and alcohol intake, and refraining from tobacco and drug use (Pfeffer & Williams, 2020).

APPENDIX C

Figure 1. Theoretical framework based on the JD-R model (Bakker & Demerouti, 2007)



APPENDIX D

Table 6: Emerging Themes from Thematic Analysis

	THEMES	Codes
Awareness	Global Trend	Africa (Witchcraft)
		Modern or younger generation
		COVID
	MEDIA	Reading, Social media
	First-hand exposure	Work, Personal or family experience
Causes (Stressors or demands)	LEADERSHIP	Leadership impact
	Working conditions	Remuneration
		Pressure – workload & Deadlines
	Family Responsibilities	Finances, Children & Gender roles
Personal Experience	MHCs	Stress, Anxiety, Insomnia
		PRESENTEEISM
	Physical conditions	High Blood pressure (hypertension)
		Ergonomics – back pain (long hours)
		Obesity
Personal Interventions	Self-management or self-care	Exercise, diet and relaxation activities
	Religion	Prayer
	Technology	Gaming / App
	Recreation	Hobbies
Organisational Interventions	Employee Value Proposition (EVP)	Mental Health Training
		Counselling / ICAS
		FLEXIBILITY & Breaks
		Well-being teams / Ambassadors
	Peer Support	Support Groups
		One-on-one support - through
		Talk Therapy or Referrals

APPENDIX E

Research Instrument

Interview Guide	
Demographics	
1.	Please advise your Gender, Age, and Race (African, Coloured, Indian, or White).
2.	What is your highest level of Education? (Diploma, Bachelor, Master's, or Doctorate (PhD))
Employment Background	
3.	How many years of work experience do you have up to date?
4.	Which sector of the Financial Services Industry do you work for, between the Banking, Investment, and Insurance sectors?
5.	Please share your Job Title and briefly describe your current role in the organisation that you work for.
6.	Which level are you at within the organisation? (Skilled employee, Middle management, Senior Management, or Executive)
7.	Do you lead a team, and how many employees do you have under your supervision?
Awareness of Mental Health	
8.	What is your understanding of the subject of mental health and the impact that mental health issues have on individuals? How have you acquired this knowledge?
Mental Health Promotion / Organisational Support	
9.	Have you ever received mental health training (talks, seminars, presentations, or formal training) and been advised of the available interventions, for example, emotional intelligence training, physical activities, meditation, online programmes, etc.?
Causes of Mental Health Conditions	
10.	How would you describe your current work environment in terms of the working conditions, including changing roles and responsibilities, as well as relationships amongst colleagues and management?
11.	What aspects of your job do you find to be the most stressful, for instance, heavy workload, tight deadlines, reward-effort imbalances, poor career advancement, and job insecurity (stressors or job demands)?
12.	How do personal demands, such as family responsibilities, impact your work-life balance?
Personal Experience / Employee Wellness	
13.	Describe how these demands impact your mental health in relation to stress, anxiety, insomnia, depression, and burnout, as well as your physical health (for example, hypertension or musculoskeletal issues).

14.	Describe the subsequent effects that you have experienced due to these conditions, such as time management issues, absenteeism, presenteeism, or mistakes. Which of these effects has had the most impact on you?
15.	Have you had any positive work experiences, such as work flexibility, excellent relationships, training, and career advancement, and do they outweigh the stressors or job demands?
Mental Health Interventions	
16.	How does your organisation support you in addressing your mental health challenges? For example, do they offer any Organisational Interventions such as EAP, counselling and rehabilitation, stress management training, conflict management training, coping skills training, as well as Cognitive behavioural therapy (CBT) techniques on the internet, mobile apps, or computers?
17.	Have you found these Organisational interventions empowering, and do you make use of them in times of distress?
18.	What Personal interventions or wellness activities do you use to prevent or cope with stress, anxiety, insomnia, depression, and burnout? (Have you sought help?) For example, diet and physical exercise, relaxation techniques (breathing exercises, meditation, and prayer), and other self-care activities.
19.	Which mental health intervention do you consider to be most effective in addressing these conditions (stress, anxiety, insomnia, depression, and burnout)?
20.	Have you observed any mental health conditions or challenges (MHCs) that individuals in your team may be experiencing, and how do you support them with dealing with these issues?