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STIGMATISING ATTITUDES TOWARD EMPLOYEES WITH MENTAL HEALTH CHALLENGES: THE EFFECT OF DEMOGRAPHIC DIFFERENCES AND MENTAL HEALTH LITERACY.

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Declaration

This research project is submitted in partial fulfilment of the requirements for the degree of Master of Arts by Coursework and Research Report in the field of Organisational Psychology in the Faculty of Humanities, University of the Witwatersrand, Johannesburg on 12 July 2019.

I declare that this research report is my own, unaided work. It has not been submitted before for any degree or examination at this or any other university.

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Introduction

Work is highly meaningful to people (Schreuder & Coetzee, 2011; Stewart, Ward, & Purvis, 2004). In fact, working is one of the most meaningful and time-consuming activities that a person could engage in (Schreuder & Coetzee, 2011; Stuart, 2004, 2006). People see work as a means to earn a living, to apply oneself to a vocation, or to fulfil a passion (Schreuder & Coetzee, 2011; Stewart et al., 2004; Wrzesniewski, McCauley, Rozin, & Schwartz, 1997). The work that people do becomes a part of who they are – it becomes a part of their identity (Stewart et al., 2004). For people that have mental health challenges, work is even more important as it can facilitate recovery by creating opportunities for social interaction and support, giving one a sense of purpose and routine, and increasing one's self-efficacy and self-worth (Anthony & Blanch, 1987; Honey, 2005; Kirsh, 2000; Stuart, 2004, 2006).

The relationship between the world of work and the mental health of the worker is complex and is influenced by a combination of several factors (Dewa, Lesage, Goering, & Caveen, 2004; Marcotte, 2004; Service, 2004; Warr, 1987). This could be because mental health challenges affect people of all genders, races, and socio-economic statuses (World Health Organisation [WHO] & International Labour Organisation [ILO], 2000). Additionally, mental health conditions vary in their triggers and ages of onset (Durand & Barlow, 2010). As such, they can affect people that are already in the labour market as well as people that are trying to join the labour market. People that are already in the world of work may develop a mental health challenge due to the nature of their work (ILO, 2000) whilst as previously mentioned, people with mental health challenges stand to benefit from joining the world of work (Stuart, 2004, 2006). Therefore, while work has been said to have positive meaning for people, that is not always the case; "depending on the conditions and nature of work, the well-being of individuals can be enhanced, reduced, or remain unaffected..." (Stewart et al., 2004, p. 329).

Furthermore, mental health is not merely the absence of a mental health challenge; it is a state of psychological well-being (WHO, 2013). A mentally healthy individual has an accurate estimate of their own ability and is able to cope with daily stressors and to make contributions at work and in society (WHO, 2013). Therefore, the ability to function at work and within society is determined by the nature and severity of the mental health challenge (Durand & Barlow, 2010).

Decades of research have shown that mental health challenges are complex and that no single definition can adequately capture and encapsulate the manifestation and presentation of all mental health conditions (American Psychiatric Association ([APA], 2013). However, in their paper about mental health and the workplace, the ILO (2000) made a distinction between a mental health problem and mental illness or mental disorder. Mental health problems are the milder form of mental health issues; these are usually alleviated by social support and in some cases certain levels of professional help (ILO, 2000). Contrastingly, mental illnesses or mental disorders are more severe and usually require both clinical and psychotherapeutic intervention (ILO, 2000). According to the APA (2013, p. 20):

> A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above.

For the purposes of this paper, the term *mental health challenge* (MHC) is used as an umbrella term to refer to all mental health issues; mental health problems and mental illnesses or mental disorders as per the distinction made by the ILO (2000). Furthermore, the term *mental health* has positive connotations; so using *mental health challenges* as the opposite of *mental health* has a euphemistic function (Pilgram, 2014). As such, having the term *mental health* as a prefix to *challenges* would arguably be less offensive and less stigmatising than the use of terms such as *mental illness* or *mental disorder* (Pilgram, 2014). I will, however, use terms such as *mental illness* or *mental disorder* where it is necessary to be specific about the severity of the mental health challenge.

On the global scale, mental health challenges make one of the largest contributions to the burden of disease and disability (WHO & ILO, 2000). They are equally costly and prevalent in all types of societies and communities (WHO & ILO, 2000). In fact, depression, a mental disorder, surpasses physical diseases and physical disabilities as the largest contributor to disability worldwide (WHO, 2017). In 2015, it was estimated that more than 300 million people in the world had depression (WHO, 2017). In the same period, more than 29 million and 9 million people were estimated to have depression in Africa and Southern Africa respectively (WHO, 2017).

Similar to depression in terms of prevalence are anxiety disorders (WHO, 2017). It is for that reason that anxiety disorders and depressive disorders are called the most common mental disorders (WHO, 2017). Anxiety disorders were estimated at more than 25 million in Africa and 7 million in Southern Africa in 2015 (WHO, 2017). In 2009, anxiety disorders as a category were the found to be the most prevalent in South Africa with a 12-month prevalence of 8.1% (Herman, et al., 2009). Major depressive disorder was found to be the most prevalent disorder at an estimate of 4.9% (Herman et al, 2009; Tomlinson, Grimsrud, Stein, Williams, & Myer, 2009). From the statistics, it can be seen that mental health challenges, such as anxiety and depressive disorders, are as pervasive in Africa and the Southern African region as they are globally. Unlike in other regions of the world, however, there may be more stigmatising attitudes against MHCs in Africa because MHC stigma has been reported to be higher in developing rather than in developed countries (Alonso et al., 2008 as cited in Aromaa, 2011).

There has been debate about whether people with MHCs ever were and continue to be stigmatised against (Byrne, 2000; Pescosolido, 2013). Byrne (2000) attributes the basis of this debate to the lack of a single-word term that refers to stigma against people that have mental health issues (unlike, for example, racism or homophobia). However, it is well established that the lay population holds stigmatising attitudes against people living with MHCs (Corrigan et al., 2002; Pescosolido, 2013) and always have (Felix, 1967; Wig, 1997). In fact, it has been said that "Stigma against mental illness is probably as old as civilisation itself" (Wig, 1997, p.187) and that the stigma against people with MHCs is the ultimate stigma (Falk, 2001 as cited in Thornicroft et al., 2009). Furthermore, despite the strides made in mental health professions and

the understanding of mental health issues in general, public views of MHC have continued to be stigmatising and in some cases have worsened (Angermeyer, Matschinger, & Schomerus, 2013; Fitzpatrick, 2012; Rüsch, Angermeyer, & Corrigan, 2005).

This research report will explore the complexities of mental health issues in the world of work as well as the unfortunate issue of stigma that is held against people that have mental health challenges. It will look into the factors associated with the levels of stigma against MHCs amongst employees working in South Africa and in Botswana.

Stigma against People with Mental Health Challenges

Goffman (1963) explained the origin of the word 'stigma' – it is a Greek term referring to the skin marks made on the bodies of the socially rejected. However, rather than referring only to physical marks, Goffman (1963) conceptualized stigma as a shameful attribute given to those deemed to be undesirably different from those that do not possess the same attribute. In other words, Goffman (1963) further defined a stigma as a mark on one's character. Recently, stigma has been defined as negative beliefs and feelings about undesired groups of people that may or may not lead to negative or discriminatory behaviour towards said groups by people who do not share the undesired qualities (e.g., Baldwin & Marcus, 2006: Overton & Medina, 2008; Stuart, 2006). There are many different types of stigmas based on race, gender, sexuality, physical appearance, as well as physical and intellectual ability (Byrne, 2000; Goffman, 1963).

The stigmas held against MHCs are mostly a consequence of the belief that people that have mental health challenges are physically violent or dangerous (Corrigan et al., 2002; Harai & Clum, 2000; Overton & Medina, 2008; Wig, 1997), are socially and personally incompetent (Harai & Clum, 2000; Corrigan, Watson, & Ottati, 2003), are personally responsible for developing a mental health challenge (Corrigan et al., 2002b; Corrigan, Markowitz, et al., 2003; Overton & Medina, 2008), and that they will always be affected by their mental health challenge (Harai & Clum, 2000). Corrigan, Watson and Ottati (2003) set out explore the why the public holds these specific beliefs and not others (such as, according to Corrigan, Watson, et al. (2003), that people living with MHCs are lazy or deceitful). They (2003) proposed that the specific stereotypes of incompetence, weakness, and dangerousness exist because of the way that society

has treated people with mental health conditions over time. Historically, people with MHCs were imprisoned and separated from society so the natural conclusion was that they are dangerous (Corrigan, Watson, et al., 2003). Later they were treated in asylums which then implied that they were helpless or incompetent hence requiring full time care (Corrigan, Watson, et al., 2003). In recent times, the high number of mental health challenged people in the prisons following the de-institutionalised care of mental patients further propagated the dangerousness stereotype (Corrigan et al., 2003).

The Outcomes of MHC Stigma

Regardless of the questions surrounding it, stigma against people with MHCs has grave implications for their quality of life (Corrigan, 2004; Markowitz, 1998; Overton & Medina, 2008; Stuart, 2004, 2006); a quality of life that is already negatively affected by the symptoms of their mental health condition (Aromaa, 2011; Byrne, 2000; Hocking, 2003; Rüsch, Angermeyer, & Corrigan, 2005). In the words of Jamison (2006), "Stigma can kill" (p. 533). As a matter of fact, people affected by mental health conditions have indicated that diminishing stigma would be the one factor to significantly improve their quality of life (Hocking, 2003). In the following section, outcomes of MHC stigma such as self-stigma, reduced treatment seeking and adherence, marginalization, and economic hardship are discussed.

Self-stigma

Self-stigma occurs when people with MHCs internalize the stigmatising beliefs that society has of them and they start to see themselves in the same light (Overton & Medina, 2008). There is a shame associated with having a mental health condition (Byrne, 2000) and this results in low self-regard among people living with MHCs (Rüsch et al., 2005; Rüsch, Corrigan, Todd, & Bodenhausen, 2010). According to Rüsch et al. (2010), self-stigma can manifest both explicitly and implicitly. Explicit self-stigma is known to the individual (I think I am bad because people with mental health issues are said to be bad and I have a mental health issue) whereas implicit self-stigma is mostly unconscious and automatic (Rüsch et al., 2010). Their study (2010) found that both types of stigma are independently predictive of reduced quality of life.

Decreased help-seeking and adherence to treatment

In order to avoid being stigmatised for having a mental health condition, people will choose to not seek (Rüsch et al., 2011) or adhere to the treatment they require (Corrigan, 2004; Wig, 1997). They recognize that there are negative outcomes of being labelled as someone that needs mental health treatment so they opt to not adhere to treatment after initially seeking help or they do not seek help at all (Cooper, Corrigan, & Watson, 2003). And the statistics are disconcerting. As many as 70% of people who require mental health treatment around the world do not seek it and MHC stigma is one of the major reasons for this (Thornicraft, 2007 as cited in Henderson, Evans-Lacko, & Thornicraft, 2013).

Marginalization and social withdrawal

People who stigmatize people with MHCs create social distance between themselves and those they suspect to have an MHC (Byrne, 2000). There is a separation between *us*, people not living with MHCs, and *them*, people living with MHCs (Byrne, 2000). As a result, individuals with MHCs will alienate themselves from the society that has rejected them (Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003; Stuart, 2004).

Furthermore, families and close friends of people living with MHCs are also subjected to stigma by association (Byrne, 2000; Phelan, Bromet & Link, 1998) - what Goffman (1963) referred to as *courtesy stigma*. Courtesy stigma results in the family being neglected, isolated, and marginalised as though they are no longer part of the community (Nxumalo & Mchunu, 2017). To avoid experiencing such outcomes, families conceal the hospitalization of a member living with an MHC (Phelan, 1998) or they do not reveal the fact that they have a family member or family members living with a mental health challenge (Koschorke et al., 2017; Tsang et al., 2003). The family as a unit can internalise the stigma and result in them feeling ashamed (Corrigan & Miller, 2004). The amount of shame felt by these families can be so strong that they are embarrassed to be seen in public with their affected family members (Tsang et al., 2003). There are also instances where the family members themselves are stigmatising (Freeman, 1961). In a study conducted in the Limpopo province of South Africa, participants living with MHCs reported that they found being treated in a patronising manner by family caregivers to be particularly vexing (Khumalo et al., 2015).

Economic hardship

With reduced employment opportunities, people with mental health conditions are more likely to struggle financially (ILO, 2000; Overton & Medina, 2008; Stuart, 2000). Moreover, it has been shown that they are at greater risk of losing their jobs during economic recessions (Evans-Lacko et al., 2013) so they have to contend with lower job security. As such, it is highly likely that people living with MHCs will experience economic hardship due to stigmatising attitudes.

All of these outcomes of stigma lead to the exacerbation of the symptoms of MHCs and they can worsen the course of MHCs (Corrigan et al, 2003). As a result, a lot of people that have a mental health condition do not disclose their condition even to people that are in their close social circle such as family members, friends and co-workers (Dinos, Stevens, Serfaty, Weich, & King, 2004; Jones, 2011). To avoid the unnecessary affliction of stigma, anti-stigma interventions have been designed and implemented over the years (Kakuma et al., 2010).

Interventions to Reduce Stigma

Around the world, there have been attempts made to reduce MHC stigma for well over half a century (Arboleda-Flórez & Sartorius, 2008 as cited in Corrigan et al., 2012). Kakuma and colleagues (2010) found a number of interventions designed to educate the public on mental health issues and to eliminate MHC stigma in South Africa. These included early education aimed at children, public awareness campaigns through the media, national awareness weeks of different mental disorders such anxiety disorders in October and intellectual disability in March, as well as sensitizing the community on caring for individuals living with mental health conditions (Kakuma et al., 2010). In fact, it would seem that the most common types of interventions designed to tackle MHC stigma are education and contact based (Corrigan & O'Shaugnessy, 2007; Thornicroft et al., 2016).

Contact-based Interventions

Based on the literature that has found that contact with people living with MHCs have less MHC stigma (Corrigan, Edwards et al., 2001; Corrigan, Green et al., 2001; Couture & Penn, 2003), providing exposure to and contact with people that have MHCs has been used as an intervention

against stigma (Thornicroft et al., 2016). Some scholars have called it the most effective type of intervention (e.g., Corrigan & O'Shaughnessy, 2007) while others have found it to be effective only under certain conditions (e.g. Corrigan et al., 2002b; Thornicroft et al., 2016; Wallach, 2004; Whaley, 1997). For example, Corrigan and colleagues (2012) found that contact as intervention is most effective at reducing stigma if done in person rather than through watching a recording on film. Furthermore, contact as an intervention is best when targeted towards adults rather than adolescents (Corrigan et al., 2012; Rao, Feinglass, & Corrigan, 2007). Thornicroft et al. (2016) found that contact with someone that has a mental health condition only reduced MHC stigma in the short-term but not in the long-term. This is further supported by Wallach (2004) who found that contact with people living with MHC should occur for an extended period of time in order to effectively combat MHC stigma.

Another factor that may have an impact on the efficacy of contact based anti-stigma interventions is race (Whaley, 1997). It was found that Black people are more likely than White people to maintain their stigmatising beliefs even after a contact-based intervention (Whaley, 1997; Rao et al., 2007). In addition, others suggest that designing interventions against MHC stigma that allow the general public to have contact with people living with MHCs is not effective for all MHCs – the people exposed to the intervention may lose stigma against the specific mental health conditions they had been exposed to but still remain stigmatizing towards other mental health conditions (Corrigan et al., 2000). Based on all these findings, it is clear there is a lot of consideration that needs to go into contact-based anti-stigma interventions and the section of the population that they target in order for the intervention to be effective.

Education-based Interventions

Education based interventions focus on increasing the mental health literacy of the public and replacing misconceptions and stereotypes about mental health conditions with fact-based information about the aetiology and treatment of MHCs (Corrigan et al., 2012; Watson et al., 2004). However, like interventions based on contact, education has been found to be effective only under certain conditions. In a meta-analysis of studies investigating the efficacy of MHC stigma interventions, Corrigan et al. (2012) found that young people responded more positively

to education about mental illness and the aetiology of the different mental disorders than they did to contact with someone living with an MHC (Corrigan et al., 2012).

In fact, education has been used with school children as an early intervention against MHC stigma (Oduguwa, Adedokun, & Omigbodun, 2017; Watson et al., 2004). The belief is that if MHC stigma can be eradicated in people while they are young then they will grow up with a more positive view of MHC (Corrigan et al., 2012) and thus reduce the levels of MHC stigma in the population as a whole (Oduguwa et al., 2017). Watson et al. (2004) found that increasing the mental health literacy of children did reduce their initially negative perception of MHCs most particularly if the children's' negative perceptions were pronounced.

Other researchers, however, do not believe that education used on its own is effective: "...education alone cannot change centuries of folklore and prejudice" (Byrne, 2000, p.68). Keane (1990, 1991) said that using education as an intervention to increase mental health literacy and to eliminate stigma might not be entirely effective for all forms of stigma against MHCs (as cited in Corrigan et al., 2000). Interventions that focus on educating people on the biological causes of mental health conditions have similarly been found to eliminate certain stereotypes (for example, people with MHCs are not to blame for their condition) while reinforcing others (for example, if the condition has biological causes then that means it is unpredictable and so people with MHCs are unstable and dangerous) (Corrigan & Watson, 2004). Corrigan et al. (2012) recommended that additional research be conducted to establish the factors that may play a role in determining the efficacy of education based interventions against MHC stigma.

Mental Health Challenges and the Workplace

The work environment is one of the places with the highest impact on employees' mental health (Wang, 2006; WHO & ILO, 2000). In order to better appreciate the issue of mental health stigma in the workplace, one must gain an understanding of the issue of mental health in the workplace. The workplace can have both a negative and a positive impact; either enhancing or hindering mental wellbeing (ILO, 2000; Pilgrim, 2014; Stewart et al., 2004). On the one hand, the workplace has become more cognitively demanding and socially diverse; presenting workers with the opportunity to challenge themselves and to enhance their skills and abilities (Schreuder

& Coetzee, 2011). On the other hand, such high levels of demand on mental resources could account for the onset and the exacerbation of mental disorders at work (Chopra, 2009; Wang, Lesage, Schmitz, & Drapeau, 2008). Furthermore, mental health conditions have implications for job and organisational performance (Kelloway & Day, 2005a).

The Impact of Job/Work Conditions on Mental Health

While the workplace can have a positive impact on one's life, and while the etiology of mental health issues is complex and rarely the result of a single factor (Durand & Barlow, 2010; APA, 2013; ILO, 2000), judging by the increase in the incidence and prevalence of mental health issues in the workplace (ILO, 2000; Sanderson & Andrews, 2006; Wang et al., 2008; WHO & ILO, 2000), it can be argued that the workplace presents unique risk factors for the trigger of mental health challenges (ILO, 2000). In literature, there are a number well-known theories that identify workplace factors that have implications for mental health.

Karasek's (1979) demands-control model of job strain

According to this model, mental strain is determined by the rate of job demands relative to the level of control afforded the employee (Karasek, 1979). The highest level of job strain, and greatest threat to health, occurs when there is a high level of demand on an employee who has little control over how they do their job (Karasek, 1979). This model has implications for the interaction between time pressures relative to workloads and autonomy in job designs (Karasek, 1979; Wall, Jackson, Mullarkey, & Parker, 1996). Autonomy or discretion on the job allows employees to deal with the demands of their job in a manner they consider fit – thus limiting psychological strain (Karasek, 1979). High job demands are not harmful in and of themselves but they are if the job design excessively limits employee autonomy (Walls et al., 1996). This was established by Walls et al. (1996) in a study they conducted to test for the significant interaction between demands and control on employee well-being.

Warr's (1987) vitamin model

Warr's (1987) vitamin model posits that certain workplace environmental factors have an influence on mental health just like vitamins have an influence on physical health. There are nine *vitamins;* the opportunity for control, the opportunity for skill use, externally generated goals,

variety, environmental clarity, the availability of money, physical security, the opportunity for interpersonal contact, and valued social position (Warr, 1987).

The first five vitamins seem to refer to the characteristics of the job. A job design is good for mental health if it allows the employee to use their discretion (opportunity for control) and expertise (opportunity for skills use), if the job demands and conflicts are balanced (externally generated goals), if there is sufficient variety in the work that is done and how it is done as well as low levels of ambiguity (environmental clarity) (Warr, 1987, 2009). The last four vitamins could be said to refer to the characteristics of the work environment and conditions of employment. They refer to pay (availability of money), occupational health and safety (physical security) and positive social interactions and standing (opportunity for interpersonal contact and valued social position) (Warr, 1987, 2009).

Similar to the influence of vitamins on physical health, too few a presence of any of these in the workplace leads to a deficiency in mental well-being whereas too high a level in any of them does not result in additional benefit and may even lead to toxicity (Warr, 1987, 2009). As such, it is important that workplaces offer these vitamins to their employees in adequate amounts to promote the mental well-being of workers (Warr, 1987).

Demerouti and colleagues' (2001) job demands-resources model

In this model, burnout is characterised by exhaustion and depersonalisation (Bakker & Demerouti, 2007; Demerouti, Bakker, Nachreiner, and Schaufeli, 2001). Exhaustion refers to stress reactions such as physical fatigue and psychological strain and it can result from high *job demands* such as workloads and time pressures (Demerouti et al., 2001). Depersonalisation is disengagement from the job and occurs as a result of low *job resources* (Demerouti et al., 2001). Job resources are the "physical, psychological, social, or organizational aspects of the job that may do any of the following: (a) be functional in achieving work goals, (b) reduce job demands at the associated physiological and psychological costs; (c) stimulate personal growth and development (Demerouti et al., 2001, p. 501).

Therefore, burnout occurs in situations where there are both high job demands and low job resources (Bakker & Demerouti, 2007; Bakker, Demerouti & Euwema, 2005; Demerouti et al., 2001). Exhaustion occurs first as a result of high job demands and is in the long-term followed by depersonalisation if there are not enough job resources to offset the effect of the high job demands (Bakker & Demerouti, 2007; Bakker et al., 2005; Demerouti et al., 2001). As with Karasek's model, there is empirical support for this model (Bakker & Demrouti, 2007; Demerouti et al., 2001).

In sum, these models posit that there job and workplace conditions that facilitate mental well-being. These job and workplace conditions include autonomy, adequate levels of job demands, low role conflict and ambiguity, and social support structures (Bakker & Demerouti, 2007; Demerouti et al., 2001; Karasek, 1979; Warr, 1987, 2009). This supports Kelloway & Day's (2005a) definition of a healthy workplace: a workplace that not only limits stressors but one that provides employees with the resources to manage life and job stress that occurs regardless. Without these job and environmental factors, it has been argued and shown that employees are placed at greater risk of developing MHCs at work.

In addition, according to Chopra (2009), stressful and/or workplace environments that are detrimental to mental health are most likely to be in developing countries because there are higher incidences of temporary and informal employment in such countries. Such work conditions are substantially more stressful than fair work conditions because they are characterised by low stability and job security (Chopra, 2009). Furthermore, Sieberhagen, Rothmann and Pienaar (2009) argue that employee health and wellness, particularly mental health, is more prioritised in developed than in developing countries. Africa consists mainly, if not completely, of developing countries. It is, therefore, possible that African workplaces are more detrimental to employees' mental health than those in the Western world. "Minimising work-related stress, enhancing quality of life and improving well-being is perhaps even more important in the developing world especially Africa where poverty levels are much higher than in the more developed countries" (Gbadamosi, 2009, p. 496). Therefore, it is important for employee wellness to be prioritised in Africa. There are interventions that organisations,

including African organisations, can put in place to prevent mental health challenges and to promote mental health.

Preventing Mental Health Challenges in the Workplace

In response to the workplace outcomes of mental health challenges, organisations are increasingly implementing different forms of interventions to address mental health issues in the workplace (ILO, 2000; Kelloway & Day, 2005b; Millar, 1990). According to the ILO (2000), between 40 and 60 percent of medium-sized companies in Western countries have some form of mental health programme in place. Most of these interventions are aimed at reducing work-related stressors through teaching stress and time management, disease prevention, and health promotion (ILO, 2000). Workplace health programmes should comprise both primary and tertiary interventions (Kelloway & Day, 2005b). Primary interventions are geared towards creating healthy job designs and getting those in organisational leadership to model and encourage healthl work behaviour whilst tertiary interventions are carried out at a national level (Kelloway & Day, 2005b). Tertiary interventions include occupational health and safety laws as well as the implementation of national plans and strategies for public health.

Currently, there appears to be little information on mental health interventions in organisations based in a lot of African states. I have, however, found some information on organisational health programmes in South Africa and Botswana. At a national level, both countries have legislation [such as the Occupational Health and Safety Act no 85 of 1993 in South Africa (Department of Labour, 2004) and The Factories Act no 31 of 1973 in Botswana (Government of Botswana, 1979)] to provide guidance on the workplace health and safety of employees. However, it would seem that the focus of these pieces of legislations is more on physical health (for example protecting against harm from machinery, chemicals, fire and electricity, et cetera) than mental health (Sieberhagen et al., 2009). As such, it is up to individual organisations to see to the holistic well-being of their employees above and beyond labour law requirements through their own primary interventions (Seiberhagen et al., 2009).

According to Naidoo and Jano (2003), less than half of the top 100 companies in South Africa have employee wellness programmes (as cited in Seiberhagen, Pienaar, & Els, 2011). Of those

that have implemented an employee wellness programme many did not seem to prioritise the programme and its outcomes (Sieberhagen et al., 2011). As such, the argument that employee wellness is not highly priorotised in African states (Chopra, 2009; Seiberhagen et al., 2009) is further supported. However, employees wish that employer would be more interested and supportive of their holistic health and wellness (Gbadamosi, 2009). In addition, a study from Botswana reported that employees who participated in employee wellness programmes reported fewer incidences of burnout and depersonalisation (Ledikwe et al., 2018). As such, companies in Africa would do well to prioritise the mental and holistic well-being of their employees.

In sum, working conditions can have an adverse impact on workers' mental health and workplace interventions to curb such impact must be prioritised. However, stigma against MHCs is a factor that can increase incidence of mental health challenges in the workplace and undermine the efficacy of interventions implemented to eradicate such incidences. It could do so because as mentioned, MHC stigma carries with it a sense of shame due to the false perceptions surrounding MHCs. Therefore, for example, employees who need to be afforded resources to better cope with the demands of their job may fear to ask for such resources for fear of being seen as weak or lacking will to handle the demands made on them. And they may, as a result, endure working conditions that jeopardise their mental well-being rather than ask for help or participate in interventions designed to promote their mental health.

The Impact of Mental Health Challenges on Work Performance

Just as work has an impact on mental health, mental health also has an impact on work. Many studies report that mental disorders, especially the common ones such as depressive and anxiety disorders, negatively affect individual functioning and work performance (e.g., Bender, 2008; Chopra, 2009; ILO, 2000; Sanderson & Andrews, 2006; Wang et al., 2008). At an organisational level, this mostly manifests in lost productivity and medically-related costs (Bender, 2008; Dewa & Lin, 2000; Haslam, Atkinson, Brown, & Haslam, 2005; WHO & ILO, 2000). Employees with mental health challenges are more likely to engage in absenteeism, presenteeism (present at work but not productive), and be involved in workplace accidents (Bender & Kennedy, 2004; Dewa et al., 2004; Haslam et al., 2005; Marcotte, 2004) than employees who do not live with a mental health challenge.

Workplace support for employees living with MHCs

As previously mentioned, competitive work has been found to have profound benefit for people living with MHCs (Honey, 2005; Kirsh, 2000; Stuart, 2006, 2007). Perhaps the most paramount benefit of work is the positive effect it has on MHC symptoms. McGurk & Mueser (2003) found that having a job was predictive of reduced severity of symptoms and enhanced cognitive functioning in employees with MHCs. However, caution must be exercised because in her qualitative study exploring the meaning of work to people living with serious mental disorders, Kirsh (2000) found that there are certain conditions under which these people should work to derive the most benefit. Persons living with MHCs appreciate the benefits of engaging, challenging and fulfilling work even if they may sometimes be concerned about the level of demand such jobs may require because unemployment and underemployment is so much more detrimental to their recovery and quality of life (Kirsch, 2000). As such, employee support programmes and reasonable accommodation by the employer have to be based on the understanding that such employees require work that is competitive and commensurate with their abilities yet also flexible and open to restructuring according to these employees' limitations (Kirsh, 2000; McGurk & Mueser, 2003).

Employee support programmes were established on the philosophy that any employee, no matter their level and type of disability, can be an efficient and valuable employee provided that they are in the right job and afforded the right level of workplace support (Anthony & Blanch, 1987). In the years that have passed, employee support programmes for individuals with MHCs in Western countries have played a crucial role in the employment, integration, rehabilitation and retention of people with MHCs (Drake & Bond, 2008).

In South Africa, the *Code of Good Practice: Employment of People with Disabilities* in the Employment Equity Act 55 of 1998 (Juta's Statutes Editors, 2015) protects the right to fair employment of employees with MHCs (by South African labour law, employees with mental disorders are considered as people living with disability just like people that have physical disabilities). This Code of Good Practice gives employers guidelines on how to reasonably accommodate employees with MHCs while protecting those employees' rights to confidentiality

and protection from unconstitutional treatment (Juta's Statutes Editors, 2015). In line with this Code, employers should do as much as they can to reduce the limitations that an employee's health condition might impose on their ability to compete for the job and once hired, to perform the essential duties of the job (Juta's Statutes Editors, 2015). As such, depending on the severity of the condition, reasonable accommodation could be required at every stage from the recruitment and selection stage; to the job placement and performance management and evaluation (Juta's Statutes Editors, 2015).

It is important to note, however, that the type of mental health condition an employee presents with will determine how they can be supported and integrated into the workplace because the type of mental health challenge they have has implications for their level of dysfunction and consequently, their ability to work (ILO, 2000) and cost to the employer (Birnbaum et al., 2010). It has been found that the more severe a mental illness is, the higher the financial burden to the employer (Birnbaum et al., 2010).

However, this is not to suggest that all people living with a mental health condition cannot be as productive and valuable to organisations as those that do not. It is just that they may simply require personalised employee support or reasonable accommodation in competitive employment or they may need to otherwise be engaged in employment that is commensurate with their ability. What I argue against are instances where people living with MHCs are unemployed or underemployed simply because of stigmatising attitudes against them rather than a fair and accurate appraisal of their ability to adequately do the job. As such, while the mental health of an employee will affect their ability to do the job, the ideal is that people who act as the gate-keepers and decision-makers in organisations would not have MHC stigma so that people living with MHCs will have equal opportunity to gainful employment.

Stigma against People with Mental Health Challenges in the Workplace

People with MHCs identify the workplace as one of the most discriminatory environments they come across (Stuart, 2004). In fact, it has been found that those with MHCs will be discriminated against at work more than those with physical disabilities (Stuart, 2004) and that very few employees are keen on working under or reporting to someone living with an MHC

(Pescosolido, Medina, Martin & Long, 2013). This is unfortunate because the way that employees living with MHCs are treated by their co-workers and employers has a profound effect on their performance and retention on the job (Kirsh, 2000).

There are two types of stigma against people with MHCs in the workplace; stigma against those trying to enter the job market and stigma against those returning to work from an MHC episode (ILO, 2000). Stigma against people with MHCs that are trying to find a job is propelled by the general belief that job candidates with MHCs will be less productive due to their disorders (Baldwin & Marcus, 2006). According to Stuart (2006), people tend to think that there is very little that can be expected of people with MHCs. Employers are especially concerned that people with MHCs might lack the social skills (Hipes, Lucas, Phelan, & White, 2016), self-motivation and accountability required in any job (Hand & Trysenaar, 2006). These negative expectations could be the reason why people with mental health issues experience difficulties with gaining competitive employment that is commensurate with their knowledge, skills and abilities (Baldwin & Marcus, 2006; Overton & Medina, 2008; Stuart, 2004, 2006).

Those that return to work after having taken leave due to an MHC episode find that their colleagues and managers treat them differently (Andersen, Nielsen, & Brinkmann, 2012; ILO, 2000; Stuart, 2004). Once their mental health condition is known, employees with MHCs have to contend with wage disparities for equal work done (Baldwin & Marcus, 2006), and limited career advancement opportunities (Stuart, 2006). It is for this reason that employees living with MHCs experience what is commonly referred to as the *dilemma of disclosure* (Kirsh, 2000). In order to benefit from reasonable accommodation and employee assistance programmes (Kirsh, 2000), as well to feel relieved and accepted for who they truly are (Honey, 2005), employees that have an MHC feel the need to disclose their condition (Kirsh, 2000). However, there is always the threat of being stigmatised against by employers and co-workers following disclosure (Honey, 2005; Kirsh, 2000). As a result, people living with MHCs struggle in resolving this dilemma (Honey, 2005; Kirsh, 2000). This dilemma is considered one of the major drawbacks of having a job as a person living with an MHC (Honey, 2005).

The way that people with MHCs are treated at work is predictive of whether or not working will improve their mental health (Butterworth, Leach, McManus, & Stanfeld, 2013). Poor psychosocial working conditions undermine the benefits of employment on mental health to the point where employment under such conditions is as bad as unemployment (Butterworth et al., 2013). It is clear that one of the most consequential impacts of stigma in the workplace is that of marginalization; hindering employees with MHCs' access to social support in the workplace (Kirsh, 2000). Yet the quality of the psychosocial conditions in the workplace is one of the determinants of whether a person with MHC will benefit from working or not (Butterworth et al., 2013; Kirsh, 2000).

In addition to direct MHC stigma, employees are subjected to stigma-by-association (courtesy stigma). Kulik, Bainbridge, and Cregan (2008) developed a model of stigma-by-association in the workplace. According to this model, employees who have been linked to persons living with MHCs are at risk of being marginalised by their co-workers (Kulik et al., 2008) further undermining access that people living with MHCs have to a positive psychosocial work environment. Based on this model, it would seem, once more, that MHC stigma is so pervasive that it is not only employees who live with MHCs that have to contend with it but so too do the employees that are known to be familiar with or family to individuals living with MHCs (Kulik et al., 2008). Furthermore, this could further limit the access that employees living with MHCs have to social support in the workplace as co-workers might be wary of the courtesy stigma that could result from supporting employees living with MHCs.

Interventions to Reduce Stigma in the Workplace

Unlike in the general population, programmes aimed at addressing and alleviating stigma against mental health challenges in the workplace are few in number (Angermeyer, 2004; Malachowski & Kirsh, 2013; Szeto & Dobson, 2010). This is the case even though the effect that stigma against people with mental health condition at work has on the health and recovery of these people has been argued to be as damaging as the mental health challenge itself (Angermeyer, 2004; Overton & Medina, 2008) and highly costly to the organisation (Gelb & Corrigan, 2008; Szeto & Dobson, 2011). Zhang et al. (1999) found that employees who receive the appropriate level of treatment for their mental health challenge cost the organisation less compared to

employees who do not receive treatment (as cited in Gelb & Corrigan, 2008). In addition, alleviating MHC stigma in the workplace can improve return on investment of employee assistance programmes (Hanisch, 2016). Therefore, since MHC stigma hinders the use of employee assistance programmes (Hanisch, 2016), reduces MHC treatment adherence, and therefore negatively affects organisational productivity, workplace interventions against MHC stigma are financially advantageous and in the interest of business (Hanisch, 2016; Szeto & Dobson, 2010). Based on this realisation, more and more organisations have recently begun implementing anti-stigma programmes in the workplace (Malachowski & Kirsh, 2013; Szeto & Dobson, 2010).

Similar to general population anti-stigma interventions, workplace interventions are based on contact and education approaches. However, unlike general population interventions, these interventions have better attendance numbers, are more targeted in their approach (Hanisch et al., 2016), and can thus produce more sustainable outcomes (Szeto & Dobson, 2010). Furthermore, Szeto and Dobson (2010) argued that because MHC stigma can be context specific, it is possible that only workplace MHC stigma interventions can be effective against MHC stigma in the workplace (Szeto & Dobson, 2010). Hanisch et al. (2016) found workplace interventions to be rather effective against MHC stigma as they were shown to increase mental health literacy in the workplace, to change how employees treated colleagues living with MHC, and to change their beliefs about MHCs in some instances.

In their study of anti-stigma interventions in the workplace, Malachowski and Kirsh (2013) reported that most of the interventions they reviewed were education-based and were delivered through formats such as workshops and learning modules. But according to Gelb and Corrigan (2008), the educational approach is not the best solution for alleviating MHC stigma in the workplace. In fact, Batastini et al. (2014) found that using psycho-education to change discriminatory hiring practices was not effective for job applicants with mental health challenges. As such, Gelb and Corrigan (2008) recommended contact-based interventions in which employees living with MHCs discuss living with MHCs in a manner that emphasises similarities between physical and mental health difficulties. They (2008) recommended that, for example, “Mark can talk about positive effects of [psycho-pharmaceutical] medication and the

fact that... Jennifer will be taking them over a long period of time, [just like]... Paul will be taking asthma medication for many years" (Gelb & Corrigan, 2008, p. 296). Such a contact-based approach could create positive and accurate associations between MHCs and what is known and considered acceptable about physical health conditions (Gelb & Corrigan, 2008). They (2008) had suggested that employees recruited for the purposes of these contact-based interventions could be attracted and rewarded with incentives such as additional workplace accommodation.

However, Malachowski and Kirsh (2013) reasoned that such an approach could prove to be impractical and expensive to execute. It is difficult to organise contact-based interventions in the workplace because a large number of resources are involved in recruiting people willing to discuss their MHCs as well as in training and compensating these people to head the intervention on a long-term basis whereas education-based interventions are easier to organise and can be delivered in a number of different formats (Malachowski & Kirsh, 2013). Therefore, similar to population-based interventions, workplace interventions have to be tailored to the specific organisation in question in order to be effective (Malachowski & Kirsh, 2013).

In sum, mental health challenges are one of the most stigmatised challenges. People living MHCs are said to be dangerous and unpredictable (Corrigan et al., 2002; Harai & Clum, 2000; Overton & Medina, 2008; Wig, 1997), responsible for their condition (Corrigan et al., 2002b; Corrigan, Markowitz, et al., 2003; Overton & Medina, 2008), and that they lack basic social and work skills (Harai & Clum, 2000; Corrigan, Watson, & Ottati, 2003). As a result of these stereotypes, people that do not live with MHCs have been found to respond with fear, pity, or anger towards people living with MHCs (Angermeyer et al., 2010; Corrigan et al., 2002b; Corrigan, Markowitz et al., 2003; Link et al., 2004; Yang et al., 2013). In addition, such people avoid and distance themselves from people living with mental health challenges (Corrigan, Markowitz et al., 2003). All these stigmas against MHCs are detrimental and disadvantage people living with MHCs (Corrigan, 2004; Markowitz, 1998; Overton & Medina, 2008; Stuart, 2004, 2006). People living with MHCs internalise the stigma (Overton & Medina, 2008), they do not seek or adhere to treatment (Cooper et al., 2003; Corrigan, 2004; Rüsch et al., 2011; Wig, 1997), they are marginalised and afforded minimal social support (Byrne, 2000; Nxumalo &

Mchunu, 2017; Stuart, 2004), and in instances where their mental health challenge is suspected or known, they are denied access to competitive employment that is commensurate with their knowledge, skills, and abilities (Overton & Medina, 2008; Stuart, 2004, 2006).

Due to the significantly negative outcomes of stigma against people living with MHCs, a substantial number of general population anti-stigma interventions have been designed and implemented over the years (Kakuma et al., 2010). Most the interventions use the education-based and contact-based approaches (Corrigan et al., 2012; Corrigan & O'Shaughnessy, 2007; Thornicroft et al., 2016). However, general population interventions have been found to be limited in their reach, impact, and application in specific populations like the workplace (Hanisch et al., 2016; Szeto & Dobson, 2010). Therefore education-based and contact-based interventions have been tailored for use in the workplace (Malachowski & Kirsh, 2013). Similar to general population interventions, however, there are mixed results concerning the efficacy of workplace anti-stigma interventions (Hanisch et al., 2016; Malachowski and Kirsh, 2013). There are conditions under which workplace anti-stigma interventions are effective because MHC stigma is determined by different factors and is manifested and expressed differently across different populations (Malachowki & Kirsh, 2013). As a result, it is important to gain an understanding of what contributes to MHC stigma in a specific population in order to know how to best eradicate such stigma. The current research will investigate the levels of stigma against MHCs and its predictors amongst employees that work in South Africa and in Botswana. The following section outlines the theoretical framework that guided the research.

Theoretical Framework

This section outlines the theoretical framework for the proposed study and culminates in a schematic model and an outline of the research variables and research questions in the proposed study.

Rosenberg and Hovland's (1960): Cognitive, Affective, and Behavioural Components of Attitudes

According to Rosenberg and Hovland (1960), attitudes can be divided into three components. Firstly, the cognitive component, which refers to the beliefs or opinions about the attitude object. Secondly, the feelings toward the attitude object, which denote the affective component. Lastly,

the behavioural component - the behavior towards or around attitude object (Rosenberg & Hovland, 1960). In their model (refer to Figure 1 below), attitudes are defined as intervening variables in the relationship between the attitude object and the responses that they elicit.

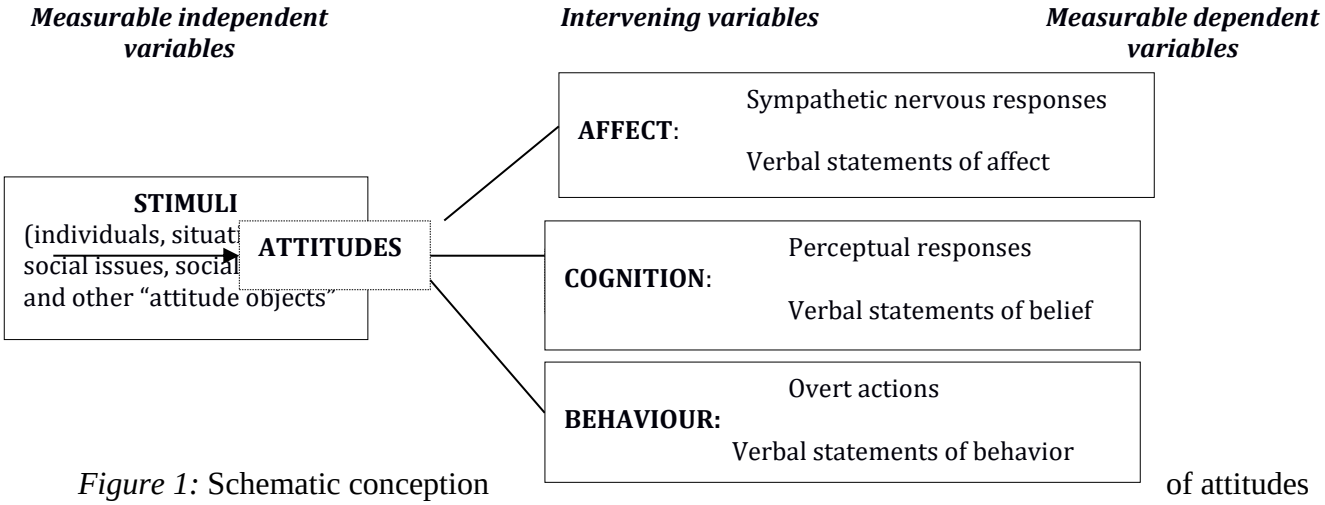


Figure 1: Schematic conception of attitudes

(Rosenberg & Hovland, 1960)

Link and Phelan (2001): Components of Stigma

Link and Phelan (2001) divided the concept of stigma against MHCs into four components. The components are "labeling", "stereotyping", "separation", as well as "status loss" and "discrimination" (Link & Phelan, 2001, p. 367). Link, Yang, Phelan, and Collins (2004) added the emotional reactions component of stigma to the earlier conceptualization of stigma that was proposed by Link and Phelan years before. It is interesting how the *stereotyping and separation*, *emotional reactions*, and *discrimination* components of stigma proposed by Link and colleagues (2001, 2004) fit into the cognitive, affective, and behavioural divisions of Rosenberg and Hovland's (1960) model of attitudes respectively. This suggests that stigma against mental health challenges can be conceptualised and measured and like attitudes as proposed by Rosenberg and Hovland (1960).

This is also the case with another model, the social cognitive model of stigma, which lists the components of stigma as stereotypes, prejudice, and discrimination (Corrigan, Watson et al., 2003) as well as the knowledge, prejudice, and discrimination elements of stigma suggested by Thornicraft et al. (2007). Similarly, the attribution models developed by Corrigan and colleagues

(2002b, 2003) further support the notion of the cognitive, emotional, and behavioural components of stigma. According to these two models, which are based on Weiner's (1995) attribution-affect-model, what an individual thinks about people living with MHCs predicts how they are likely to feel about such people and how they will respond to such people (Corrigan et al., 2002b; Corrigan, Markowitz et al., 2003). For example, if a person believes that people living with MHCs are to blame for their condition, then that person will feel anger towards these people and will be less likely to engage in helpful behaviour (Corrigan et al., 2002b; Corrigan, Markowitz et al., 2003). In contrast, if a person feels that people with MHCs cannot be blamed for their condition then that person will feel moved to offer help to people that have MHCs (Corrigan et al., 2002b; Corrigan, Markowitz et al., 2003).

Cognitive stigma: Stereotyping and separating

Stereotypes are the negative thoughts that people have about people different from themselves (Corrigan, 2004; Link et al., 2004). Separation refers to the distinction that people make between themselves and the out-group (Link et al., 2004; Link & Phelan, 2001; Schomerus, Matschinger, & Angermeyer, 2013). Both these components of stigma are associated with cognitive processes (Link et al., 2004; Link & Phelan, 2001). As such, these will comprise the cognitive component of stigmatising attitudes against employees with MHCs in the current study.

There is an argument that stereotypes form because there is what is referred to as a "kernel of truth" (p. 145) in them (Corrigan, Watson et al., 2003). So, if people have observed mentally challenged individuals to be more dangerous, socially challenged, and incompetent than people without such challenges, then the stereotypes they hold against people with MHCs are seen to be warranted (Corrigan, Watson et al., 2003). This then would mean that the stereotypes are somewhat accurate and true (Corrigan, Watson et al., 2003). In her appeal for frank discourse on the roots of MHC stigma, Jamison (2006) claims that it is undeniable that untreated mental health conditions can result in symptoms including physical violence. As such, this reality could arguably contribute to the dangerousness stereotype. This particular stereotype, that people with mental health issues are usually dangerous or physically aggressive and violent, is one of the most pervasive (Corrigan et al, 2002b; Harai & Clum, 2000; Overton & Medina, 2008; Whaley, 1997) and is the most resistant to change (Tsang et al., 2003). In fact, Gureje et al. (2005) found

that up to 96.5% of the Nigerian sample in their study believed that people with MHCs are dangerous.

However, the issue that I have with this argument is that research has shown that the stereotypes held against people with MHCs are an exaggerated generalisation (Corrigan, Watson et al., 2003). It is reported that people living with MHCs are involved in only three to five percent of all incidents of violence (Fitzpatrick, 2015). Furthermore, even with increased access to information about mental health issues (Crisp et al, 2005 as cited in Thornicroft, Rose, Kassam, & Sartorius, 2007), a large number of lay people get their information on mental health issues from popular media (Wig, 1997) most especially film and television (Wahl, 1992). It is well established that popular media sensationalises mental health conditions and mostly depicts people living with MHCs as unstable (Hocking, 2003; Wahl & Lefkowits, 1989) as well as dangerous and violent (Dinos et al., 2004; Hocking, 2003; Thornton & Wahl, 1996; Wahl & Lefkowits, 1989). Therefore, it is easy to disqualify the argument that stereotypes against MHCs comprise a kernel of truth when such *truth* is based on sensationalised misinformation created to entertain and shock rather than to educate.

The other common inaccurate belief about people living with MHCs is that they are personally to blame for their condition (Corrigan et al., 2002b; Corrigan, Markowitz et al., 2003). As previously mentioned, according to the personal responsibility attribution model by Corrigan and colleagues (2002b, 2003), people either believe that people have MHCs as a result of their own behaviour and through a lack of strong will (for example, “he drank too much that is why he has a substance-related disorder”) or they believe that people with MHCs cannot help that they have a mental health condition (for example “the causes of mental disorders include biological factors so it’s not his fault that he has a mental health challenge”). Those that blame people with MHCs for their condition will respond in anger and deny help when needed while those that do not will respond with pity and a willingness to help (Corrigan et al., 2002b; Corrigan, Markowitz, 2003). In addition, the second model suggested by Corrigan and colleagues (2002b, 2003), the dangerousness attribution model, posits that the belief that a person with a mental health issue is dangerous leads to a fearful response and avoidance behaviour. I think, however, these two models might not always translate to African communities. It is a common belief in Africa that

mental illness is a result of witchcraft (Abbo et al., 2008; Akyeampong, 2015) or possession by spirits (Kabir, Iliyasu, Abubakar, & Aliyu, 2004; Laher, 2014). In this case, the person with an MHC will not be held responsible for their condition. However, because withcraft and malevolent spirits or demons are feared, then the responses to persons with MHCs will be that of fear and avoidance. As such, the outcomes of the beliefs - personal responsibility and dangerousness - might trade places in the African context. More research regarding the attribution models of MHC stigma is needed in Africa.

Stereotyping and separating can contribute to the two other components of MHC stigma; emotional reactions and discrimination. Not all people believe the stereotypes about people living with MHCs. But those that believe the stereotypes are more likely to be prejudiced against people living with MHCs (Corrigan, Markowitz, et al., 2003). Prejudice comprises negative feelings about a group of people (Corrigan, Markowitz, et al., 2003). Therefore, individuals that are prejudiced against people living with MHC would respond towards such people in an emotionally negative way (Corrigan, Markowitz, et al., 2003) and could consequently discriminate against them (Corrigan et al., 2002b).

Affective stigma: Emotional reactions

As the name suggests, emotional reactions towards people with MHCs will fall under the affective component of stigmatising attitudes towards employees with MHC. It has been found that the public may respond with feelings of fear, anger, and/or pity towards people with MHCs (Angermeyer, Holzinger, & Matschinger, 2010; Corrigan et al., 2002b; Corrigan, Markowitz et al., 2003; Link et al., 2004; Yang et al., 2013). Affective stigma is the least researched component of stigma but it has strong implications for the stigma process as a whole (Angermeyer et al., 2010) and may be a stronger determinant of discrimination than cognitive stigma (Thornicroft et al., 2007). Of all three components of stigma, emotional reactions are perhaps the most conspicuous and can easily reveal stigmatization to the stigmatised (Angermeyer et al., 2010). This could be because beliefs about people living with MHCs cannot be directly observed and the reasons behind discriminating against people living with MHCs could be easily concealed while emotional reactions are usually revealed by facial expressions

which are universal and thus easily interpretable. As a result, affective stigma perhaps contributes the most to self-stigma (Angermeyer et al., 2010).

According to Angermeyer et al. (2010), participants from all over the world tended to report that they emotionally react in a manner that is considered *positive* to people living with MHCs. Respondents indicated that they responded with emotions such as empathy and pity (Angermeyer, 2010). Negative emotion such as fear and uneasiness followed the positive emotions in frequency whilst the least indicated emotions were anger and annoyance (Angermeyer, 2010). Furthermore, it seems as though some forms of affective stigma have changed over the years (Angermeyer & Matschinger, 2004; Angermeyer et al., 2010). Angermeyer and Matschinger (2004) found that while both pity and anger towards people living with depression increased between the years of 1990 and 2001, the level of fear towards people with depression in the samples of 1990 and 2001 remained unchanged during that period. Furthermore, Angermeyer et al. (2010) replicated a study that was conducted by Angermeyer and Matschinger in 2004 in the same study samples. Angermeyer et al. (2010) found that while there was no increase in positive emotions such as empathy towards people living with schizophrenia, there was an increase in feelings of anger and fear towards said people. These findings suggest that in instances where affective stigma against people living with different mental health challenges has not changed, it has increased (Angermeyer et al., 2010).

Behavioural stigma: Discrimination

Discrimination is the behavioural element of stigma. It refers to behaviour that results in the rejection and exclusion of people that are stigmatized (Link et al., 2004). According to Corrigan, Markowitz, and others (2003), this occurs through behaviours such as avoidance, coercion, segregation, and denying assistance.

In contrast to the conceptualisation by Corrigan, Markowitz, et al. (2003), Thornicroft et al. (2009) conceptualised behavioural stigma as one being treated differently from others because of one's MHC diagnosis. Therefore, in their (2009) research, discrimination could be both negative (for example, being avoided or segregated) and positive (having an advantage over others due to having a mental health condition). However, they found that people living with MHCs rarely

experienced positive discrimination and if they did it was from expected parties such as family members and welfare programmes (Thornicroft et al., 2009). As such, discrimination mostly manifests negatively in that people living with MHCs are marginalized and denied access to community support and acceptance and is therefore conceptualised as such in most research including this one.

In summary, I have discussed the attribution models created by Corrigan and colleagues (2002b, 2003) under the previous sections because they consist of pathways from cognitive stigma to affective stigma culminating in behavioural stigma. As discussed, what people believe about the causes of MHCs determine how they feel and whether they help or avoid individuals living with MHCs (Corrigan et al., 2002b; Corrigan, Markowitz et al., 2003). Feldman & Crandall (2007) replicated the work by Corrigan and colleagues (2002b, 2003) and found similar results; blaming people with MHC for their condition and thinking that people with MHCs are dangerous was associated with desire for social distance. Based on these models and findings, it would seem that behavioural stigma occurs only if preceded by cognitive stigma, affective stigma or both one after the other.

By studying MHC stigma in all its three components, the current research confers a richer understanding of stigma. It is no longer enough to state that a population has stigma against people living with MHCs as that does little to inform policy makers about the type of intervention that will be effective in eradicating it. Researchers have to study the predictors of MHC stigma in all its dimensions and manifestations so as to better understand how to eradicate it. Another unique contribution that this research makes to the literature is that it studied MHC stigma in all its three components in the Southern African workplace.

Research Variables

Outcome Variable: Stigmatising Attitudes

In the proposed study, Rosenberg and Hovland's (1960) model of attitudes will be adapted to stigmatising attitudes towards mentally-challenged employees in the workplace through the components of stigma as postulated by Link and colleagues (2001, 2004). Rosenberg and Hovland (1960) labelled attitudes and their components as intervening variables. They do,

however, go on to say that because attitudes are predispositions, they cannot be directly measured or observed (Rosenberg & Hovland, 1960). Therefore, attitudes can only measured by the overt indications of their components (Rosenberg & Hovland, 1960). Consequently, in this study, stigmatising attitudes will not be considered as an intervening variable but as an outcome variable measured by the manifestations of its components. That is to say that levels of stereotyping and separating (cognitive stigma), emotional reactions (affective stigma), and discrimination (behavioural stigma), will be measures of levels of stigmatising attitudes against employees with MHCs.

Population studies from around the world have reported that negative perceptions and attitudes against MHC stigma are prevalent in the general public persist to this day (Corrigan et al., 2002; Harai & Clum, 2000; Stier & Hinshaw, 2007). Closer to home, there is stigma concerning mental health issues in Botswana (Pheko, Chilisa, Balogun, & Kgathi, 2011), South Africa (Hugo et al., 2003; Mavundla & Uys, 1997), and at especially high levels in Ghana (Barke, Nyarko, & Klecha, 2011) and Nigeria (Gureje et al., 2005). As such, it is expected that there will be levels of cognitive, emotional, and behavioural stigma in this study's sample.

Predictor Variables

Demographic differences

Little research has investigated the influence of variables such as age, gender and occupational level on stigmatising attitudes against people with MHCs. As such, I could not make evidence based hypotheses on the effect of these variables on MHC stigma. Nonetheless, it would be valuable to know the effect of these variables on MHC stigma. In contrast, there has been more research investigating the effect of race and nationality (national culture) on attitudes towards mental health challenges.

Race has been found to be predictive of stigma against MHCs (Abdullah & Brown, 2011; Anglin, Link, & Phelan, 2006; Rao, Feinglass, & Corrigan, 2007). It has been found that African Americans have higher levels of stigmatising attitudes than Caucasian Americans (Abdullah & Brown, 2011; Anglin et al., 2006; Rao et al., 2007; Whaley, 1997). As such, it was hypothesised in this study that non-Caucasian individuals will hold more stigmatising attitudes than

Caucasians. In addition, a study by Griffiths et al. (2006) suggested that people of different nationalities could differ in their levels of stigmatising attitudes towards MHCs. This difference was attributed to whether the dominant culture in the nation is individualistic or collectivist (Griffiths et al., 2006). According to Papadopoulas, Foster, and Caldwell (2013) and Griffiths et al. (2006), collectivist cultures are more conscious of differences from the norm. Therefore, because people living with MHCs tend to deviate from the norm, collectivist cultures are more likely to have MHC stigma (Papadopoulas et al., 2013). I hypothesised that there will be a difference between South Africans level of stigmatising attitudes and that of Non-South Africans depending on which group has higher levels of collectivism.

Level of contact with MHCs

Level of contact with MHCs, or familiarity with MHCs, can occur at different levels, including but not limited to: personally having a mental health condition, having a family member or social relations with someone who has an MHC, and working with people living with MHCs (Corrigan, Green, Lundin, Kubiak, & Penn, 2001). According to Angermeyer and Matschinger (1996), as well as Alexander and Link (2003), people that are familiar with MHCs are more likely to respond in a pro-social manner towards people with MHCs than people who are not familiar with MHCs. Corrigan et al. (2001) found that familiarity with MHCs contributed to people being less likely to believe that people with mental health conditions are dangerous, thus less likely to fear them, and in turn, they are less likely to create social distance between themselves and people with MHCs. Angermeyer, Matschinger, and Corrigan (2004) found similar results in a different population when they replicated the study by Corrigan et al. (2001). These findings suggest that familiarity with MHCs affects stigma against MHCs through the cognitive (dangerousness stereotype), affective (responding in fear), and behavioural (social distancing) components.

However, not all forms of contact are equally effective at diminishing stigmatising attitudes (Wallach, 2004). In addition, Tsang et al. (2003) found that negative perspectives such as the belief that people living with MHCs have limited social skills were not reduced but increased with exposure to people living with mental health conditions. It is possible that knowing and understanding the nature of mental health issues through meeting people living with such conditions make the public pity such people but it does not make them more accepting of them

(Tsang et al., 2003). Due to the mixed results, I could not hypothesise what the effect of level of contact will be on MHC stigma in this study.

Mental health literacy

A lot of research has associated knowledge about mental health issues with less stigmatising attitudes (e.g. O'Connor & Casey, 2015; Papadopoulos, Leavey, & Vincent, 2002). In South Africa, it was found that people are not knowledgeable about mental health conditions and so this could contribute to stigmatising attitudes against MHCs (Hugo, Boshoff, Traut, Zungu-Dirwayi, & Stein, 2003). According to Evans-Lacko and colleagues (2010), knowing where to seek professional help, how effective treatments for mental health conditions are, how to recognize the symptoms of mental health conditions, and how people with MHCs relate to employment can improve attitudes towards mental health challenges.

However, it has been found that public MHC stigma has grown worse over the years even with increased public awareness about mental illness and mental health issues (Pescosolido et al. 1999 as cited in Corrigan et al., 2002). For example, Angermeyer, Holzinger, and Matschinger (2009) found that increased mental health literacy either had no impact or increased levels of stigmatising attitudes against people living with MHCs. In addition, there are contrary findings about mental illness stigma amongst mental health professionals; some held stigmatising attitudes (Hansson, Jormfeldt, Svedberg & Svensson, 2011) while others did not as a result of their professional knowledge of mental health issues (Kingdon, Sharma, & Hart, 2004). Thus it is clear that there are mixed results in literature on the impact of mental health literacy on MHC stigma and I did not propose a hypothesis of what its impact will be in this study as a result.

All these variables culminate in the conceptual model of stigmatising attitudes against employees with mental health challenges as depicted in Figure 2 overleaf.

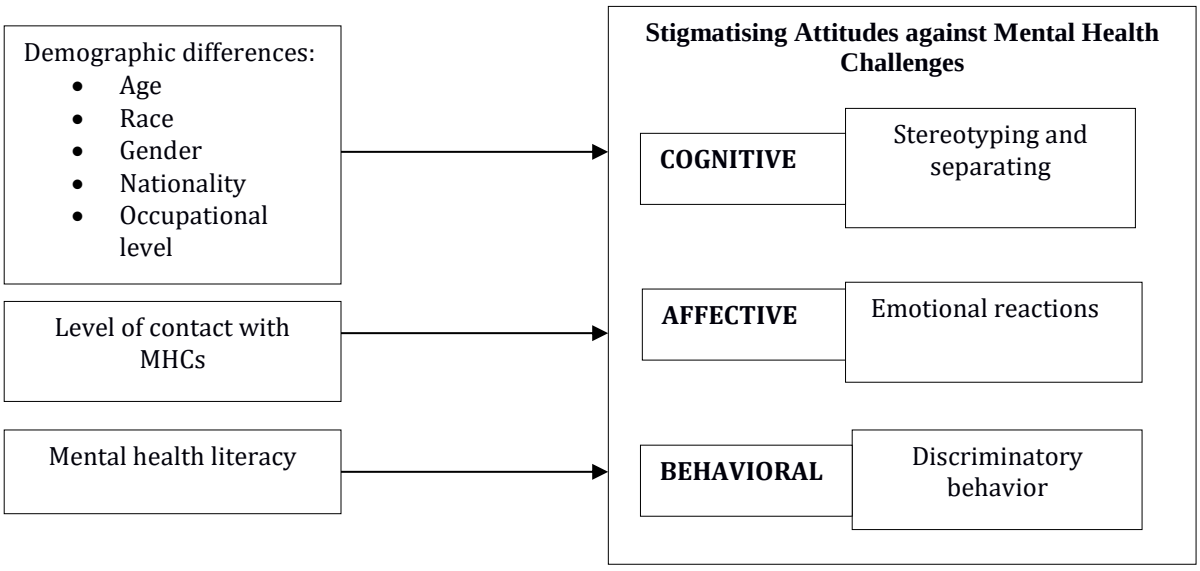


Figure 2: Conceptual model of stigmatising attitudes

Research Questions

While the literature indicates that there are stigmatising attitudes towards those with mental challenges in the Western workplace (e.g., Corrigan, 2003; ILO, 2000; Overton & Medina, 2008) it appears that little research has been conducted to investigate stigmatising attitudes against people with MHCs in workplaces in Botswana and in South Africa. In addition, it appears that little research has been conducted to explore if demographics, level of contact (LOC), and mental health literacy (MHL) influence attitudes towards mental health challenges in workplaces in Botswana and in South Africa. Knowing the factors that influence attitudes towards those with mental health challenges, particularly in the workplace, would inform workplace interventions aimed at mitigating negative attitudes against MHCs and ensuring equal opportunity and quality work life for those living with MHCs (Angermeyer, 2004).

The aim of this study is to answer the following questions:

1. What are the levels of stigmatising attitudes towards employees with mental health challenges?
2. Is there a difference in stigmatising attitudes amongst the different demographic groups in the workplace?
3. Is there a difference in stigmatising attitudes among people with different levels of LOC?
4. Is there a difference in stigmatising attitudes among people with different levels of MHL?

Methodology

This study was guided by the aim to investigate the research questions outlined in the preceding section of this research report. Included in this section are more details of the research design, sampling procedure, data collection procedure, the measuring instruments, statistical analyses, and the ethical considerations of the study.

Research Design

The research design is the approach or plan that guides how the research is conducted (Babbie & Mouton, 2001; Wilson & MacLean, 2011). The research design of a study is decided upon based on the nature of the problem and the best response to the problem (Babbie & Mouton, 2001). As such, this study used an ex-post facto correlational design because I was not able to manipulate or to directly control the independent variables in this study (Kerlinger, 1973). The inferences I have made about the associations between the variables in the study resulted from the subsequent variation in the independent and dependent variables without my intervention as is the case in an ex-post facto correlational design (Kerlinger, 1973). In addition, the current study was quantitative in its approach.

Sampling Procedure

Non-probability sampling methods (convenience sampling and snowballing) were used. At the beginning of data collection, I started out with convenience sampling. In order to recruit participants, I contacted a number of major corporations within Johannesburg (through their respective Human Resources (HR) departments) and invited them to participate in the study. The HR officers approached were given a copy of the letter requesting organisational access and a copy of ethical clearance (refer to Appendix A and Appendix B) so that they could give their permission before the survey was distributed among their members of staff. However, of all the organisations I approached, only one organisation granted me organisational access. The organisations that did not grant me access said that they did so because the organisation does not participate in scholarly research or that the research I was conducting that is not in the interest of their business or in the interest of the organisation.

However, the sample acquired from the one organisation I had attained access to was quite small. As such, I began to conduct snowball sampling. I invited individual professionals I knew (based in both South Africa and Botswana) to participate in the study and to then invite their co-workers and other professionals they knew to participate in the study. Even after this, my sample size was not adequate and I needed to recruit more people. As a result, I went back to convenience sampling and invited people to participate through use of social media sites such as LinkedIn and Facebook. It is through using these different sampling procedures that I acquired my final sample.

Data Collection Method

Survey research was the elected data collection procedure for this study. Specifically, this study made use of a computerized self-administered questionnaire (CSAQ) disseminated through the web-based survey site Survey Monkey. The CSAQ was delivered as a link through email for sampling in the organisation I had access to as well as for snowballing and it was uploaded as a link for convenience sampling through Facebook and LinkedIn. The respondents who choose to participate in the study clicked on the link, completed the survey, and submitted it.

Measuring Instruments

In addition to the collection of demographic information (refer to Appendix C)**,** the survey used different measuring instruments to assess the levels of stigmatising attitudes in its three components, the level of contact with people living with MHCs, and the level of mental health literacy (MHL) in the sample. All of the measuring instruments selected were identified to be valid and reliable measures (Corrigan et al., 2002a, 2002b; Harai & Clum, 2000; Holmes et al., 1999b; Royal & Thompson, 2013) and they are all freely available in the public domain.

Stigmatising attitudes

As mentioned in the preceding section, stigma against MHC comprises cognitive, affective, and behavioural components (Link et al., 2004; Link & Phelan, 2001). Therefore, the level of stigmatising attitudes will be assessed through measures that tap into these three components.

Cognitive stigma (stereotyping and separating):

The cognitive aspect of stigmatising attitudes towards mental health challenges was measured through the use of the Beliefs toward Mental Illness Scale (Harai & Clum, 2000) (refer to Appendix D). The scale comprises three subscales denoting popular stereotypes of mental disorders; *dangerousness* (α = .75), *poor social skills* (α = .84), and *incurability* (α = .82) (Harai & Clum, 2000). The scale has 21 items and an overall Cronbach's alpha of .91 (Harai & Clum, 2000).

Example items in the scale are "A mentally ill person is more likely to harm others than a normal person" (dangerousness), "A person with a psychological disorder should hold a job with minor responsibilities" (poor social skills), and "I do not believe that a psychological disorder is ever completely cured" (incurability). The response scale is Likert-type ranging from 0 = "Completely disagree" and 5 = "Completely agree". The responses on the scale were summed to create a score. The higher the score, the higher the level of negative beliefs against MHCs and thus, the higher the level of cognitive stigma.

Affective and behavioural stigma (emotional reactions and discriminations):

The Attribution Questionnaire (AQ-27) developed by Corrigan and colleagues (2002a, 2002b) has 27 questions that measure the different emotional reactions (blaming, anger, fear, pity) and discriminatory behaviour (withholding help, avoidance, segregation, and coercion) that people with stigmatising attitudes against MHCs might engage in (refer to Appendix E). As such, it was used as a measure of affective and behavioural stigma in this study.

The scale presents a short vignette of a man called Harry (adapted in this study to the culture and gender neutral TM), a person with schizophrenia. Following which are questions asking how the participants feel and would behave around TM on a 9-point Likert-type scale where 1 = "Not at all", "Not very likely", "Definitely would not help" and "None at all" whereas 9 = "Very much", "Very likely", and "Definitely would help" depending on the question. Example items include "I would feel aggravated by TM", "How likely is it that you help TM?" and "I think it would be best for TM's community if he were put away in a hospital". The scale has been found by other researchers to have a Cronbach's alpha ranging from .60 to .93 (Brown, 2008).

Each of the nine emotional reactions and discriminatory behaviours has its own subscale comprising three questions. The responses on the whole scale were summed to give a score (the *avoidance* subscale is reverse scored before summation). Based on the response scale, the higher score the higher the level of emotional and behavioural stigma.

Level of contact

The Level of Contact Report (Holmes, Corrigan, Williams, Canar, & Kubiak, 1999b) was used to measure the level of familiarity with MHCs (refer to Appendix F). It consists of 12 items that depict different levels of contact with people that have MHCs (Holmes et al., 1999a). The items are rated from one to twelve with increasing levels of intimacy Holmes et al., 1999a). Experts on psychiatric conditions rated the items on levels of intimacy and the measure was found to have inter-rater reliability of .83 (Holmes et al., 1999a). For example, the least intimate experience is rated one and therefore given a score of one ("I have never observed a person that I was aware had a severe mental illness"), whilst the most intimate, rated 12, is given a score of 12 ("I have a severe mental illness") (Holmes et al., 1999a). As such, the higher the score, the higher the level of contact. According to Holmes et al. (1999a), if a respondent ticks more than one item, indicating that they have had more than one type of contact with people living MHCs, then they have to be scored on their most intimate experience. Using the Level of Contact Report is advantageous in that it provided the researcher with a continuous measure of contact rather than the simple categorical result of *no contact with people living with MHC* versus *some contact with people living with MHC* (Holmes et al., 1999b).

Mental health literacy

The Mental Health Literacy Measure (MHLM) developed by Jung, Von Sternberg and Davis (2016a) has a total of 26 items (KR-20 = .83) that consist of 12 items to measure knowledge-based mental health literacy (*knowledge-based* subscale), 10 items to measure belief-based mental health literacy (*belief-based* subscale) and four items to measure resource-based mental health literacy (*resource-based* subscale) (refer to Appendix G). The first two subscales have a 5-point Likert response scale where 1 = "Strongly agree" and 5 = "Strongly disagree" as well as an "I don't know" response option (Jung et al., 2016a, 2016b). In this study, the "I don't know" response item was included as the sixth point on the response scale (6 ="I don't know"). The

items in the *resource-based* subscale have a yes or no response format where "Yes" = 1 and "No" = 0 (Jung et al., 2016a, 2016b).

The *knowledge-based* subscale (KR-20 = .76) has items such as "Counselling is a helpful treatment for depression" and "A person with schizophrenia may see things that are not really there" (Jung et al., 2016a). The *belief-based* subscale (KR-20 = .77) includes items like "A highly religious/spiritual person does not develop mental illnesses" and "Depression is a sign of personal weakness" whilst the *resource-based* subscale comprises items such as "I know where to go to receive mental health services" and "I know where to get useful information about mental illness" (Jung et al., 2016a).

In order to score and analyse the results, Jung et al. (2016a, 2016b) instructed that each response in the first two subscales be dichotomized and coded into 1 (having MHL) and 0 (not adequate MHL). Where "Strongly agree" (1) and "Agree" (2) indicate having MHL and are therefore coded into 1 and the rest of the response items "Neutral" (3), "Disagree" (4), "Strongly disagree" (5), and "I don't know" (6) indicate not having adequate MHL and are thusly coded into 0 (Jung et al., 2016a, 2016b). While Jung et al. (2016a, 2016b) do not mention that the responses in the *belief-based* subscale require reverse-scoring, it is clear from the phrasing of the items in the subscale that they go in a different direction from the rest of the scale so I reverse scored the items in the *belief-based* subscale before coding its responses into 1 and 0. The responses were summed to give a score – the higher the score the higher the level of MHL.

Statistical Analyses

The data collected will be analysed through different types of statistical analyses using the Statistical Package for Social Sciences version 25 (IBM Inc, 2017). These different types of statistical analyses will be used to answer the research questions of this study as follows:

Research question one

What are the levels of stigmatising attitudes towards employees with mental health challenges?

The mean, a measure of central tendency, provides the average score of all participants on a psychological measure (Wilson & MacLean, 2011). Therefore the mean score on all measures of stigma was calculated to get the average levels of stigmatising attitudes.

In addition, frequency distributions were used to analyse the responses on all the items on the stigma measures. Frequency distributions are the "arrangement of scores or categories with the frequency of each score or category shown" (Wilson & MacLean, 2011, p.677). Thus they were used because they provided deeper insight into the participants' beliefs about, emotional reactions to, and behaviours around people living with MHCs.

Research question two

Is there a difference in stigmatising attitudes amongst different demographic groups in the workplace?

Age

The relationships between age and levels of stigmatising attitudes were assessed through Kendall's tau-b. I was going to run Pearson's correlation but the scatterplot revealed a non-linear relationship, (a linear relationship is required (Laerd Statistics, 2016b)), between age and cognitive stigma as well as between age and emotional and behavioural stigma). The alternative was to run Spearman's correlation as it does not require a linear relationship between the variables (Laerd Statistics, 2018; Wilson & MacLean, 2011). Spearman's correlation, however, requires a monotonic relationship; a relationship that goes in one direction (Laerd Statistics, 2018; Wilson & MacLean, 2011). The scatterplot indicated no clear monotonic relationship between age and the dependent variables. As such, the data was not eligible for Spearman's correlation. Therefore, I opted to run Kendall's tau-b. While a monotonic relationship is desired for Kendall's tau-b, it is not a strict assumption (Laerd Statistics, 2016). Thus I tested for the relationship between age and the dependent variables through Kendall's tau-b. The hypotheses are:

H_A: there is a relationship between age and the stigmas against mental health challenges
H_0: there is no relationship between age and the stigmas against mental health challenges

Gender

An independent samples *t*-test was used to test for differences in stigma between males and females. The hypotheses are as follows:

H_A: $\mu_1 \neq \mu_2$, the population means of the female and male groups are not equal
H_0: $\mu_1 = \mu_2$, the population means of the female and male groups are equal

In testing for the assumptions, boxplots revealed two cases of outliers on the cognitive stigma score. The two cases were identified and excluded from analysis. Furthermore, on emotional and behavioural stigma, the kurtosis was above 1 and the Shapiro-Wilk test of normality was significant ($p < .05$) for the female group and so the variable was log transformed. Following the log transformation of the emotional and behavioural stigma variable, the kurtosis, tests of normality, histogram, and Normal Q-Q Plots were improved and suggested normal distribution. However, the assumption of homogeneity of variances on the cognitive stigma scores was violated, as assessed by Levene's test for equality of variances ($p = .04$). In contrast, there was homogeneity of variances on the emotional and behavioural stigma scores as assessed by Levene's test for equality of variances ($p = .82$).

Race

An independent samples *t*-test was used to test for differences in stigma between Whites and Black racial groups. The initial intention was to test for differences across all groups of race (Black, Whites, Coloured, Indian, Asian, and Other). However, because the Coloured, Indian, and Asian groups had low membership, I combined them with the Black (African) group to make a combined Black group. Thus the hypotheses are as follows:

H_A: $\mu_1 \neq \mu_2$, the population means of the Whites and Blacks groups are not equal
H_0: $\mu_1 = \mu_2$, the population means of the Whites and Blacks groups are equal

There were no significant outliers on any of the dependent variables. Furthermore, the kurtosis was above 1 and the Shapiro-Wilk test of normality was significant ($p < .05$) for the Blacks group on the affective and behavioural stigma variable and so it was log transformed. Following the

log transformation of the variable, the kurtosis, tests of normality, the histogram and Normal Q-Q Plots were improved and suggested normal distribution. In addition, there was homogeneity of variances on the cognitive stigma and emotional and behavioural stigma scores for both groups as assessed by Levene's test of homogeneity, (p = .53) and (p = .99) respectively.

Nationality

An independent samples *t*-test was used to test for differences in stigma between South Africans and Non-South Africans. The hypotheses are as follows:

H_A: $\mu_1 \neq \mu_2$, the population means of the South Africans and Non-South Africans groups are not equal

H_0: $\mu_1 = \mu_2$, the population means of the South Africans and Non-South Africans groups are equal

The boxplots indicated three cases of outliers on the emotional and behavioural stigma variable. Consequently, these cases were excluded from analysis. The kurtosis of the emotional and behavioural stigma was out of range but the skewness, tests of normality, histograms and Normal Q-Q Plots suggested approximate normality and so it was kept the same for analysis. In addition, Levene's test of homogeneity confirmed that there was homogeneity of variances for the two scores of both groups; (p = .33) on cognitive stigma and (p = .25) on emotional and behavioural stigma.

Occupational level

I ran a one-way ANOVA to test for differences in stigma between the five occupational groups. The hypotheses were as follows:

H_A: the population means are not all equal

H_0: all group population means are equal ($\mu_1 = \mu_2 = \mu_3 = ... = \mu_5$)

Similar to the independent-samples *t*-test, I checked for assumptions of non-significant outliers, normality, and homogeneity of variances. I found only five cases of outliers amongst the

dependent variables and excluded them from analysis. All common indicators of normality suggested that the data approximates normality. Furthermore, Levene's test for equality of variances was assessed to check if the assumption of homogeneity of variances was met and it was.

Research question three

Is there a relationship between stigmatising attitudes towards MHCS and the level of contact with people living with MHCs?

Kendall's tau-b was used to assess the relationship between level of contact and the levels of stigmatising attitudes. I was going to run Pearson's correlation but the scatterplot revealed a non-linear relationship, (a linear relationship is required (Laerd Statistics, 2016b), between contact level and cognitive stigma as well as between contact level and affective and behavioural stigma). The alternative was to run Spearman's correlation as it does not require a linear relationship between the variables (Laerd Statistics, 2018; Wilson & MacLean, 2011). Spearman's correlation, however, requires a monotonic relationship; a relationship that goes in one direction (Laerd Statistics, 2018; Wilson & MacLean, 2011). The scatterplot indicated no clear monotonic relationship between level of contact and the dependent variables. Therefore the data was not eligible for Spearman's correlation. As a result, I ran Kendall's tau-b. While a monotonic relationship is desired for Kendall's tau-b, it is not a strict assumption (Laerd Statistics, 2016). Thus I tested for the relationship between the level of contact and the dependent variables through Kendall's tau-b. The hypotheses are:

H_A: there is a relationship between level of contact and the stigmas against mental health challenges
H_0: there is no relationship between level of contact and the stigmas against mental health challenges

Research question four

Is there a difference in stigmatising attitudes towards mental health challenges between people that have mental health literacy and those that do not?

An independent samples *t*-test was used to test for differences in stigma between people that had knowledge-based, belief-based, and resource-based mental health literacy and those that did not have these forms of mental health literacy. The hypotheses are as follows:

H_A: $\mu_1 \neq \mu_2$, the population means of people that have MHL and those that do not are unequal
H_0: $\mu_1 = \mu_2$, the population means of people that have MHL and those that do not are equal

The boxplots revealed two similar cases of outliers on cognitive stigma on all types of MHL and one more case on affective and behavioural stigma common to all types of MHL. As such, these three cases were excluded from analysis. In addition, the skewness, kurtosis, and tests of normality were past the limit on emotional and behavioural stigma on all types of MHL so the variable was log transformed. Similarly, cognitive stigma was log transformed as I found it to be positively skewed. Following the log transformation of the affective and behavioural stigma variable, the skewness and kurtosis were still above the limit of 1 for the group with no adequate knowledge-based MHL. However, the tests of normality, and Normal Q-Q Plots were improved. Contrastingly, the log transformation of the cognitive stigma variable did not improve normality, so I used the data that was not transformed. In addition, there was homogeneity of variances for the cognitive stigma and emotional and behavioural stigma scores for all groups as assessed by Levene's test of homogeneity.

In sum, the analyses I ran in this study were Kendall's tau-b, independent samples *t*-test, and one-way ANOVA to test for the effect of demographic variables, level of contact and mental health literacy on stigma against employees with mental health challenges.

Ethical Considerations

Ethical considerations are imperative in psychological research because they encourage integrity, respect for participants, and the continued effort to avoid any foreseeable harm (Wilson & MacLean, 2011). The following ethical considerations were observed in this study.

Informed consent

In order to enable the participants to give informed consent, the first page of the CSAQ was a participant information sheet (PIS). The PIS included information such as the purpose of the

research, what participation entailed, if there was compensation for participation, how research results will be used and disseminated, who the researcher is, what their rights as participants are and how they can get in touch with the researcher or counselling professionals should they need such assistance (refer to Appendix H).

Permission for organisational access

Applications for access to organisations were made to respective management or HR offices of the approached organisations before the survey is administered to all employees within those organisations (refer to Appendix A). Only one organisation granted organisational access and so the survey was disseminated to all employees in that one organisation.

Confidentiality and anonymity

The participants were not asked to give any identifying information and their responses will be kept confidential. Furthermore, the organisation whose employees participated in the study will not be named or implied in this paper or in any presentation based on this research.

Volunteerism and withdrawal

The participants took part in this study on a fully voluntary basis. They were made aware of their right to choose to not participate and to withdraw at any point before final submission of the survey if they had initially decided to participate.

Ethical clearance

Ethical clearance was attained from the Wits University Human Research Ethics Committee (Non-Medical) before the study was conducted (refer to Appendix B)

Results

Instrument Reliabilities

The internal consistency reliability of a measuring instrument as indicated by Cronbach's alpha is the degree of association between the items in the instrument (Wilson & MacLean, 2011). The closer the value is to 1, the higher the degree of association between the items and internal consistency reliability (Wilson & MacLean, 2011).

Beliefs toward Mental Illness Scale

The *dangerousness* subscale's internal consistency reliability was low in this study (α = .62). Contrastingly, the overall scale had a high reliability (α = .84) and so I used the overall scale score when conducting the statistical analyses.

Attribution Questionnaire

Of all the nine subscales in the measure the *blame* (α = .35), *coercion* (α = .41), *pity* (α = .60) and *avoidance* (α = .63) subscales had very low to low internal consistency reliabilities. Therefore, I used the overall scale (α = .79) score when running the analyses.

Mental Health Literacy Measure

The internal consistency reliability of this measure was indicated by the Kuder-Richardson Formula 20 (KR-20) because the of its dichotomous response items (Jung et al., 2016). The KR-20 is the internal consistency reliability measure for dichotomous items but it is measured and interpreted in a manner similar to Cronbach's alpha. While the overall scale had a KR-20 of .70, all three of the subscales in the measure had acceptable levels of internal consistency reliability; *knowledge-based* had .66, *belief-based* had .79, and *resource-based* had .75. Consequently, I used the subscales in analysis.

Participants

The final sample consisted of 153 employed and self-employed individuals over the age of 18 with ages ranging from 18 to 69 (M = 35.39, SD = 9.39) and mostly female n = 102 (72.3%). A majority of the sample identified as South African, n = 113 (74.8%), followed by Batswana, n = 27 (17.9%), people from other African states n = 7 (4.6%), and lastly n = 4 (2.6%) individuals from non-African states. The sample was mostly White n = 77 (51.0%) while the Black races such as Black (African), Coloured, Indian, and Asian added up to n = 74 (49.0%). Forty people (26.3%) in the sample were in the administrative occupational level, n = 26 (17.1%) in junior management, n = 36 (23.7%) in middle management, n = 38 (25.0%) in senior management and n = 12 (7.9%) indicated other levels such as technician and entrepreneur.

Research Results

Below are the results from the statistical analyses that were run to answer the research questions.

Research question one

What are the levels of stigmatising attitudes towards mental health challenges?

Cognitive stigma

The results suggested that there was cognitive stigma (M = 35.98, SD = 15.08) against people living with MHCs in workplaces in South Africa and in Botswana. However, responses to the items on the cognitive stigma measure showed mixed beliefs concerning MHCs (refer to Table 1 overleaf). Some responses suggested that a majority of the respondents were less likely to endorse the dangerousness stereotypes. For example, 52.9% of the participants indicted that they "Completely disagree" that "It may be a good idea to stay away from people who have a psychological disorder because their behaviour is dangerous" and 53.6% selected "Completely disagree" to the item "I am afraid of people who are suffering from a psychological disorder because they may harm me". However, a majority of the respondents (51%) indicated that they were in agreement ("Completely agree" = 11.1%, "Agree" = 10.5% and "Somewhat agree" = 29.4%) with the statement that "A mentally ill person is more likely to harm others than a normal person".

Similarly, there were mixed responses with regards to the incurability stereotype. Some of the responses suggested that a majority of the respondents were more likely to endorse some stereotypes about MHCs not being curable. For example, 58.6% of the respondents agreed in some degree ("Completely agree" = 15.1%, "Agree" = 22.4% and "Somewhat agree" = 21.1%) that "Individuals diagnosed as mentally ill will suffer from its symptoms throughout their life" and 60.8% indicated varying degrees of agreement ("Completely agree" = 13.1%, "Agree" = 22.9% and "Somewhat agree" = 24.8%) with the item "People who have once received psychological treatment are likely to need further treatment in the future". However, 72.5% of the respondents indicated varying levels of disagreement ("Completely disagree" = 35.9%, "Disagree" = 23.5% and "Somewhat disagree" = 13.1%) with the statement "Psychological disorder is unlikely to be cured regardless of treatment".

Table 1: Cognitive Stigma Results (Beliefs towards Mental Illness Scale)

	Frequency (%)					
	Completely disagree 0	**1**	**2**	**3**	**4**	**Completely agree 5**
Dangerousness						
A mentally ill person is more likely to harm others than a normal person	27.5	10.5	11.1	29.4	10.5	11.1
It may be a good idea to stay away from people who have a psychological disorder because their behaviour is dangerous	52.9	19.0	9.8	13.1	3.3	2.0
Mentally-ill people are more likely to be criminals	68.6	11.1	9.2	7.8	2.0	1.3
I am afraid of people who are suffering from a psychological disorder because they may harm me	53.6	19.0	10.5	11.1	3.9	2.0
Poor interpersonal and social skills						
The term "psychological disorder" makes me feel embarrassed	50.3	17.6	7.2	11.1	6.5	7.2
I am afraid of what my boss, friends, and others would think if I were diagnosed as having a psychological disorder	20.0	12.7	14.7	13.3	18.7	20.7
It might be difficult for mentally-ill people to follow social rules such as being punctual or keeping promises	29.4	12.4	17.6	19.6	14.4	6.5
I would be embarrassed if people knew that I dated a person who once received psychological treatment	66.4	16.4	7.9	4.6	2.6	2.0
A person with psychological disorder is less likely to function well as a parent	34.0	19.6	21.6	17.0	5.2	2.6
I would be embarrassed if a person in my family became mentally ill	80.3	8.6	7.9	2.0	0.0	1.3
Mentally-ill people are unlikely to be able to live by themselves because they are unable to assume responsibilities	49.7	14.4	12.4	14.4	4.6	4.6

Most people would not knowingly be friends with a mentally-ill person	34.0	12.4	11.8	15.7	15.7	10.5
	Frequency (%)					
	Completely disagree 0	**1**	**2**	**3**	**4**	**Completely agree 5**
The behavior of people who have psychological disorders is unpredictable	14.6	14.6	18.5	27.2	9.3	15.9
I would not trust the work of a mentally-ill person assigned to my work team	52.6	19.1	12.5	13.2	2.0	0.7
Incurability						
Mental disorder would require a much longer period of time to be cured than would other general diseases	13.2	15.1	15.1	19.1	14.5	23.0
Psychological disorder is recurrent	11.9	9.8	20.3	33.8	17.2	6.6
Individuals diagnosed as mentally ill will suffer from its symptoms throughout their life	14.5	11.2	15.8	21.1	22.4	15.1
People who have once received psychological treatment are likely to need further treatment in the future	8.5	9.2	21.6	24.8	22.9	13.1
I do not believe that psychological disorder is ever completely cured	26.5	11.3	15.2	17.9	15.9	13.2
Psychological disorder is unlikely to be cured regardless of treatment	35.9	23.5	13.1	14.4	8.5	4.6

In contrast, respondents responded similarly on all items measuring the stereotype that people living with MHCs have poor work and social skills. The results suggested that a majority of the participants did not endorse this stereotype. For example, 52.6% of the participants "Completely disagree" with the statement "I would not trust the work of a mentally-ill person assigned to my work team" and 68.5% of respondents selected response items indicating disagreement ("Completely disagree" = 37.1%, "Disagree" = 18.3% and "Somewhat disagree" = 13.1%) to the item "A person with psychological disorder should have a job with minor responsibilities". Additionally, 59.4% of the participants selected various degrees of disagreement ("Completely disagree" = 29.4%, "Disagree" = 12.4% and "Somewhat disagree" = 17.6%) to the item "It

might be difficult for mentally-ill people to follow social rules such as being punctual or keeping promises".

Affective and behavioural stigma

Similar to cognitive stigma, the results indicated that there was affective and behavioural stigma (M = 111.79, SD = 23.66) against people living with MHCs amongst employees working in South Africa and Botswana (refer to Table 2 overleaf). However, when it comes to affective stigma, the responses to most of the items measuring it suggested that a majority of the participants were less likely to respond in emotionally negative ways towards people living with MHCs. For example, in response to the item "TM would terrify me", 79.2% of the participants responded in the negative. In addition, 56.4% selected "Not at all" in response to "How angry would you feel at TM". This response pattern was consistent throughout items measuring anger and fear. However, a majority of the respondents (55.7%) indicated that they "...would feel pity for TM" and this was consistent across items that tapped into the emotion of pity. So while the participants indicated that they would be less likely to respond in fear and anger, a majority of the participants indicated that they would respond with pity to people living with MHC.

In the case of behavioural stigma, the same results were observed. The responses to most of the items measuring behavioural stigma suggested that a majority of the respondents were less likely to treat people living with MHCs in an untoward manner. For example, in response to "If I were an employer, I would interview TM for a job", 53.4% of the research participants responded in the affirmative and this pattern was observed in items concerning avoidant behaviour. Similarly, a majority of respondents (54.4%) selected "Not at all" in response to the item "How much do you think an asylum, where TM can be kept away from his neighbours, is the best place for him/her?" and 51.7% selected "Very much" to the item "I would be willing to talk to TM about his/her problems". A majority of the participants responded similarly across all items measuring segregating and helping behaviour. However, the result suggested that a majority of the respondents endorsed coercive behaviour towards people living with MHCs if it concerns their treatment as indicated by the affirmative responses to the items "If I were in charge of TM's treatment I would require him to take his medication" and "How much do you agree that TM should be forced into treatment with his/her doctor even if (s)he (TM) does not want to?". So

while a majority of the respondents indicated that they were more likely to help and less likely to avoid and segregate people living with MHCs from those that do not, a majority of them also indicated that they were more likely to coerce people living with MHC into receiving treatment against their own free will.

Table 2: Affective and Behavioural Stigma Results (AQ-27)

	Frequency (%)								
	"Not at all" (1)	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**"Very much" (9)**
Anger									
I would feel aggravated by TM.	34.5	10.8	16.2	12.2	13.5	3.4	3.4	1.4	4.7
How angry would you feel at TM?	56.4	16.1	12.8	5.4	4.0	4.0	.0	.0	1.3
How irritated would you feel by Harry?	39.6	22.1	14.8	6.7	11.4	4.0	.0	0.7	0.7
Pity									
I would feel pity for TM.	11.4	2.7	8.1	8.7	13.4	16.1	8.7	6.7	24.2
How much sympathy would you feel for TM?	3.3	.0	2.6	2.6	9.2	9.9	17.1	16.4	38.8
How much concern would you feel for TM?	.7	.7	2.0	5.3	11.2	15.1	17.8	7.9	39.5
Fear									
TM would terrify me.	41.6	14.1	14.8	8.7	8.7	5.4	3.4	1.3	2.0
How scared of TM would you feel?	39.2	19.0	17.0	11.1	4.6	4.6	3.3	0.0	1.3
How frightened of TM would you feel?	40.8	17.8	13.8	8.6	9.2	3.3	4.6	.7	1.3
Blame									
I would think that it was TM's fault for present condition	87.9	3.4	3.4	2.0	1.3	.0	1.3	.7	.0
How controllable... is the cause of TM's present condition	28.9	9.4	10.1	12.1	16.1	6.7	7.4	4.0	5.4
How responsible... is TM for present condition	45.1	8.5	9.2	3.9	11.8	5.2	5.9	1.3	9.2
Dangerousness									
I would feel unsafe around TM.	30.4	15.5	16.2	8.1	12.2	6.1	3.4	4.1	4.1
How dangerous would you feel TM is?	26.2	16.8	20.8	12.8	10.1	6.7	4.7	0.7	1.3

	Frequency (%)								
	"Not at all" (1)	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**"Very much" (9)**
Hw dangerous would you feel TM is?	26.2	16.8	20.8	12.8	10.1	6.7	4.7	0.7	1.3
I would feel threatened by TM.	44.7	16.7	12.0	10.0	8.7	2.0	4.0	0.0	2.0
Help									
I would be willing to talk to TM about his problems.	4.7	.7	3.4	2.7	6.7	8.7	12.1	9.4	51.7
How likely is it that you would help TM?	2.6	1.3	2.6	3.9	9.2	8.5	15.0	11.1	45.8
How certain would you feel that you would help TM?	5.3	1.3	4.6	8.6	5.3	15.1	11.2	8.6	40.1
Avoidance									
If I were an employer, I would interview Harry for a job.	26.4	4.7	14.2	8.1	12.8	7.4	9.5	4.1	12.8
I would share a car pool with TM every day.	22.0	6.7	12.0	11.3	14.7	8.0	10.0	6.0	9.3
If I were a landlord, I probably would rent apartment to TM	26.1	7.8	13.7	9.2	13.1	4.6	8.5	5.9	11.1
Coercion									
If I were in charge of TM's treatment, I would require him/her to take his/her medication	2.7	2.7	2.7	2.7	3.4	1.3	8.7	6.0	69.8
How much do you agree TM should be forced into treatment...?	12.8	7.4	4.7	6.1	13.5	10.8	10.8	8.8	25.0
If I were in charge of TM's treatment, I would force him/her to live in a group home.	39.7	14.6	8.6	4.0	19.9	4.6	3.3	2.6	2.6
Segregation									
I think TM poses a risk to his/her neighbours unless he is hospitalized.	33.8	18.2	16.9	12.8	7.4	4.1	3.4	1.4	2.0
I think it would be best for TM's community if (s)he were put away in a psychiatric hospital.	50.7	17.3	14.7	3.3	9.3	.7	1.3	1.3	1.3
How much do you think an asylum...is the best place for TM?	54.4	13.4	14.8	3.4	7.4	2.7	1.3	.7	2.0

Research question two

Is there a difference in stigmatising attitudes amongst different demographic groups in the workplace?

Age

A Kendall's tau-b correlation was run to determine the relationship between age and the different types of stigmas against MHCs. There was a very weak, negative association between age and cognitive stigma (τ_b = -.036) that was not statistically significant (p = .521). Similarly, the association between age and affective and behavioural stigma was weak, negative and not statistically significant (τ_b = -.038, p = .504). As such, I failed to reject the null hypothesis.

Gender

There were 100 female and 37 male participants on the cognitive stigma measure. The female cognitive stigma score (M = 36.76, SD = 1.37) was higher than the male cognitive stigma score (M = 34.69, SD = 2.74). However, the mean difference in cognitive stigma scores between females and males was not statistically significant, t(54.98) = .67, p = .50.

There were 98 female and 37 male participants on the affective and behavioural stigma measure. In contrast to the cognitive stigma score, the male participants scored higher (M = 2.05, SD = .09) than the female participants (M = 2.04, SD = .09). However, the mean difference in emotional and behavioural stigma scores between the two groups was not statistically significant, t(133) = -.82, p = .41. As a result, I failed to reject the null hypothesis.

Race

The Black group had 74 participants while the White group had 77 participants. The Black group scored higher on cognitive stigma (M = 39.17, SD = 15.39) than the White group (M = 32.81, SD = 14.33). The mean difference was statistically significant, M = 6.36, 95% CI [1.58, 11.15], t(149) = 2.63, p = .009, d = .43.

On the emotional and behavioural stigma measure, there were 70 Black participants and 77 White participants. The Black group scored higher (M = 2.05, SD = .09) than the White group (M = 2.02, SD = .09). However, the mean difference in affective and behavioural stigma between

Blacks and Whites was not statistically significant, $t(145) = 1.97$, $p = .051$. As such, I could only partially accept the alternate hypothesis.

Nationality

The South African group had 113 participants and the Non-South African group had 38 participants on the cognitive stigma measure. The Non-South African group reported more cognitive stigma ($M = 42.67$, $SD = 16.53$) than the South African group ($M = 33.49$, $SD = 13.92$). There was a statistically significant mean difference, $M = -9.18$ 95% CI [-14.59 to -3.46], $t(149) =$, $p = .001$, $d = .63$.

On the affective and behavioural stigma measure, the South African group had 109 participants and the Non-South African group comprised 35 participants. The Non-South African group reported more affective and behavioural stigma ($M = 117.22$, $SD = 22.83$) than the South African group ($M = 107.75$, $SD = 20.32$). There was a statistically significant mean difference, $M = -9.47$, 95% CI [-17.52 to -1.43], $t(142) = -2.33$, $p = .02$, $d = .45$.

Occupational level

A one-way ANOVA was conducted to find out if the cognitive stigma differed across different occupational groups. Participants were classified into five groups: administrative ($n = 40$), junior management ($n = 25$), middle management ($n = 36$), senior management ($n = 37$), and other ($n = 12$). There was homogeneity of variances as assessed by Levene's test of homogeneity of variances ($p = .73$). The cognitive stigma score increased from senior management ($M = 31.10$, $SD = 15.73$), to middle management ($M = 35.79$, $SD = 13.36$), to administrative ($M = 36.06$, $SD = 12.48$), to junior management ($M = 37.49$, $SD = 15.03$), and to other ($M = 40$, $SD = 16.60$) in that order. However, there were no statistically significant differences in cognitive stigma scores between the groups, $F(4, 145) = 1.31$, $p = .27$.

Similarly, one-way ANOVA was run to determine if affective and behavioural stigma differed across occupational groups. Participants were classified into five groups: administrative ($n = 36$), junior management ($n = 24$), middle management ($n = 35$), senior management ($n = 38$), and other ($n = 12$). There was homogeneity of variances as assessed by Levene's test of homogeneity

of variances (p = .69). The affective and behavioural stigma score increased from senior management (M = 2.011, SD = .074), to middle management (M = 2.024, SD = .092), to junior management (M = 2.041, SD = .078), to administrative (M = 2.044, SD = .074), and to other (M = 2.082, SD = .109) in that order. However, there were no statistically significant differences in affective and behavioural stigma scores between the groups, $F(4, 140) = 2.03$, p = .09.

Research question three

Is there a difference in stigmatising attitudes towards MHCS amongst people with different levels of contact with people living with MHCs?

A Kendall's tau-b correlation was run to determine the relationship between age and the different types of stigmas against MHCs. There was a very weak, negative association between level of contact and cognitive stigma (τ_b = -.067) that was not statistically significant (p = .259). Similarly, the association between level of contact and affective and behavioural stigma was very weak, negative and not statistically significant (τ_b = -.007, p = .906). I therefore failed to reject the null hypothesis.

Research question four

Is there a difference in stigmatising attitudes towards mental health challenges between people that have mental health literacy and those that do not?

Knowledge-based mental health literacy

On the cognitive stigma measure, there were 11 people in the group that did not have adequate knowledge-based MHL (group 1) and there were 135 people in the group that had knowledge-based MHL (group 2). There was homogeneity of variances as assessed by Levene's test for equality of variances (p = .68). The group 2 cognitive stigma score (M = 35.81, SD = 14.68) was higher than that of group 2 (M = 31.45, SD = 11.98). However, the mean difference in cognitive stigma scores between the group of people that had knowledge-based mental health literacy and the group of those that did not was not statistically significant, $t(144) = .-.96$, p = .34.

For affective and behavioural stigma, there were 11 people in the group that did not have adequate knowledge-based MHL (group 1) and there were 132 people in the group that had knowledge-based MHL (group 2). There was homogeneity of variances as assessed by Levene's test for equality of variances (p = .52). The group 2 participants scored higher (M = 2.04, SD = .09) than the group 1 participants (M = 2.03, SD = .07). However, the mean difference in affective and behavioural stigma scores between the two groups was not statistically significant, $t(141) = -.39$, p = .69. As a result, I failed to reject the null hypothesis.

Belief-based mental health literacy

On the cognitive stigma measure, there were 68 people in the group that did not have adequate belief-based MHL (group 1) and there were 76 people in the group that had knowledge-based MHL (group 2). There was homogeneity of variances as assessed by Levene's test for equality of variances (p = .29). The group 1 cognitive stigma score (M = 35.92, SD = 14.85) was higher than that of group 2 (M = 34.39, SD = 13.96). However, the mean difference in cognitive stigma scores between the group of people that had belief-based mental health literacy and the group of those that did not was not statistically significant, $t(142) = .64$, p = .53.

For affective and behavioural stigma, there were 65 people in the group that did not have adequate belief-based MHL (group 1) and there were 79 people in the group that had belief-based MHL (group 2). There was homogeneity of variances as assessed by Levene's test for equality of variances (p = .35). The group 1 participants scored higher (M = 2.05, SD = .09) than the group 2 participants (M = 2.03, SD = .08). However, the mean difference in affective and behavioural stigma scores between the two groups was not statistically significant, $t(139) = 1.89$, p = .06. As a result, I failed to reject the null hypothesis.

Resource-based mental health literacy

On the cognitive stigma measure, there were 40 people in the group that did not have adequate resource-based MHL (group 1) and there were 108 people in the group that had knowledge-based MHL (group 2). There was homogeneity of variances as assessed by Levene's test for equality of variances (p = .37). The group 1 cognitive stigma score (M = 37.66, SD = 15.82) was higher than that of group 2 (M = 34.93, SD = 13.79). However, the mean difference in cognitive

stigma scores between the group of people that had knowledge-based mental health literacy and the group of those that did not was not statistically significant, $t(146) = 1.03$, $p = .31$.

For affective and behavioural stigma, there were 39 people in the group that did not have adequate belief-based MHL (group 1) and there were 107 people in the group that had belief-based MHL (group 2). There was homogeneity of variances as assessed by Levene's test for equality of variances ($p = .52$). The group 1 participants scored higher ($M = 2.039$, $SD = .093$) than the group 2 participants ($M = 2.038$, $SD = .085$). However, the mean difference in affective and behavioural stigma scores between the two groups was not statistically significant, $t(144) = .08$, $p = .94$. As a result, I failed to reject the null hypothesis.

Discussion

The Level of Stigma

Cognitive stigma

Similar to previous research, I found that on average, there was cognitive stigma against people living with MHCs. According to previous research, the most highly endorsed stereotypes MHCs are those of dangerousness (Corrigan et al, 2002b; Harai & Clum, 2000; Overton & Medina, 2008; Whaley, 1997), incurability (Harai & Clum, 2000), poor social skills (Harai & Clum, 2000; Hipes et al., 2016) and low employability (Baldwin & Marcus, 2006; Hand & Trysenaar, 2006; Stuart, 2006).

However, in the current research, the results suggested that the participants either partially endorsed these stereotypes or rejected them altogether. For example, an examination of the responses on the items measuring the endorsement of the dangerousness stereotypes suggested that most of the respondents did not believe that people living with MHCs are dangerous. However, most of them did indicate that they think that people living with MHCs are more dangerous than people that do not have MHCs. So it would seem that while they do not believe that people living with MHCs are dangerous in general, they believe that people living with MHCs have a higher propensity for violence compared to other people. This could be because while an MHC diagnosis does not imply an inclination for violence, when a person engages in

dangerous and/or violent behaviour, they are automatically labelled as *crazy*, *mad,* or *mentally disturbed* by the lay population.

Another partially endorsed the stereotype was that of MHC incurability. The responses to the items measuring endorsement of the incurability suggested that a majority of the respondents believed that MHCs are lifelong conditions and cannot be cured. However, a majority of the respondents also indicted that they believed that MHCs cannot be cured without treatment. Perhaps what they believed was that while MHCs cannot be cured in general, those that could be cured cannot be so without treatment. In contrast to these other stereotypes, the results suggested that majority of the respondents do not support the stereotype that people living with have poor social and work skills. For example, most of them indicted that they would trust the work of a co-worker living with MHCs and that people living with MHCs should not be relegated and limited to minor job roles simply because of an MHC diagnosis. This is in contradiction with previous research that has found the workplace to be one the most stigmatising and discriminatory environments for people living with MHCs (Stuart, 2004).

Affective and behavioural stigma

Similar to cognitive stigma, the results indicated that there was both affective and behavioural stigma in the population. And also similar to cognitive stigma results there was mixed results on affective and behavioural stigma. The inspection of individual items measuring affective stigma revealed that a majority of participants responded in a manner that indicated that they would not respond with fear or anger towards people living with MHCs but that they would respond with pity. This is in support of the research by Angermeyer et al. (2010) in which respondents had indicated positive emotional responses including pity. Feeling pity for people living with MHCs is, however, just as stigmatising as responding in anger or fear. While it might be considered as showing concern for people living with MHCs, feeling pity for people living with MHCs is stigmatising because it implies that they are lacking in some way and are not like everyone else. As such, while the results suggested that a majority of the respondents did not affectively stigmatise by way of anger or fear, they did affectively stigmatise against people living with MHCs by pitying them.

In a similar vein, the respondents were behaviourally stigmatising in some ways but not all. For example, a majority of them indicated that they would not engage in avoidant behaviour and do something like interview someone living with MHCs for a job. This is in line with the finding in the current study that a majority of the respondents did not believe that people living with MHCs would be incompetent at work due to their diagnosis and is in contrast with previous research because it has found that people who disclose that they are living with an MHC are less likely to be considered for employment (Batastini et al., 2014; Overton & Medina, 2008). Similarly, majority of the respondents indicated that that they were against the segregation of people living with MHCs and that they would be helpful towards them. The reason for this could, however, be negative. As mentioned before, a majority of the respondents had indicated that they felt pity towards people living with MHCs and so they could be helpful towards people living with MHCs because they feel pity for them. Following feelings of pity in the personal responsibility attribution model is a willingness to help (Corrigan et al., 2002b; Corrigan, Markowitz et al., 2003). In addition, a majority of the respondents indicated that they have behavioural stigma when it came to the forced institutionalisation and treatment of people living with MHCs.

The findings in this study provided a richer understanding of MHC stigma in the population. It further confirms the complexity of MHC stigma. So while the results showed that there is cognitive, affective, and behavioural stigma in the population, it showed that these stigmas are not present in their entirety. For example, while the respondents might not have endorsed some stereotypes, they did endorse others and even then not fully (such as the dangerousness stereotype). Or while they might have intimated that they do not feel anger or fear towards people living with MHCs, they did indicate that they pity them. Furthermore, while they might have suggested that they were accepting and helpful towards people with MHCs they also indicated that they would force them into treatment.

Demographic Variables and Stigmatising Attitudes

Age, gender, and occupational Level

The results showed that there are no statistically significant differences in stigmatising attitudes against MHC amongst people of different ages, gender, and occupational levels. Little research has investigated the influence of variables such as age, gender and occupational level on

stigmatising attitudes against people with MHCs and the findings in the current research suggested that these three demographic variables had no effect on the stigmas against MHCs.

Race

There were differences with a moderate effect size in cognitive stigmatising attitudes against people with mental health challenges along racial lines. People that identified as being members of a race that is not White had a higher level of cognitive stigma than people that identified as White. This means that Black people are more likely to stereotype against and to separate themselves from people that live with MHCs than White people are. Rao et al. (2007) attributed this difference to differences in culture. Black, particularly African, communities are thought to be more collectivist than White communities (e.g. Eaton & Louw, 2000). In collectivist cultures, those who deviate from the norm set by the group are more easily recognised and set apart from the rest of the group (Griffiths et al., 2006; Papadopoulas et al., 2013). This is no different when it comes to mental health challenges. Papadopoulas et al. (2013) found that communities that identify with the collectivist culture are more likely to stigmatize MHCs than those who identify as individualistic. So collectivism could explain why Black people in this sample were more likely to stereotype and separate themselves from people living with MHCs. Furthermore, Whaley (1997) and Rao et al. (2007) found that people of African descent, who made up 84% of the Black group, believe in the stereotype that people with MHCs are dangerous and that they have a high likelihood of engaging in violent behaviour. As such, this group may desire social distance and wish to separate themselves from people living with MHCs more than White people.

In contrast, there was no statistically significant difference in affective and behavioural stigma along racial lines. One would expect that since the Black group was more likely to stereotype and separate themselves from people living with MHCs then they would also be more likely to engage in negative emotional responses or to discriminate against people living with MHCs. However, it is possible that cognitive stigma does not predict the other types of stigma and vice versa. Anglin et al. (2006) found that even though African-Americans were more likely than White people to believe that people living with MHC are dangerous, they were behaviourally more lenient towards people living with MHCs. So African-Americans were both more

cognitively stigmatising and simultaneously less behaviourally stigmatising when compared to the other racial group (Anglin et al., 2006). This might explain what is observed in the current study. Because these are three separate components of stigmatising attitudes (Link & Phelan, 2001; Link et al., 2004), it is possible that there are different mechanisms that contribute to their formation.

Nationality

Similar to the case of race, there were differences with a moderate effect size in cognitive stigmatising attitudes between South Africans and Non-South Africans. Non-South Africans had a higher level of cognitive stigma than South Africans. Differences in race, and therefore culture, could be a contributing factor to these differences. Cross-tabulation revealed that the South African group had majority Whites (63.4%) while the Non-South African group had majority Blacks (86.8%). As such, the Non-South African group could have been the more collectivist group and therefore more stigmatising as collectivist cultures have been purported to be (Papadopoulas et al., 2013).

Similarly, the results suggested that non-South Africans had a higher level of affective and behavioural stigma than South Africans. It is possible that people from South Africa were less likely to emotionally and behaviourally respond in a negative manner towards people living with MHCs than people from other nations because of South Africa's unique history with discrimination. The South African Constitution forbids discrimination on the basis of personal attributes such as disability and so it is possible that South Africans are now more accepting of differences including differences in mental health. However, little research has been conducted to explore differences in MHC stigma across different cultures and nations. It is possible that there are other factors that account for cross-cultural differences in MHC stigma in the Southern African or African context and so more research has to be conducted to establish these factors.

Level of Contact and Stigmatising Attitudes

It was highly unexpected that there would be no statistically significant relationship between the level of contact someone has had with a person living with MHC and stigmas against people living with MHC. Many of the studies in literature found that the more intimate the level of contact with MHCs or with people living with MHCs that an individual has had, the more likely

that individual is to be positive and open towards mental health issues and people that have them (e.g. Angermeyer and Matschinger, 1996; Angermeyer et al., 2004; Corrigan et al., 2001). However, factors such as race may make contact ineffective. Rao et al. (2007) found that even following interventions involving contact with someone living with MHCs, African Americans still held stigmatising attitudes against MHCs. Whaley (1997) even concluded that contact may not make a difference on stigmatising attitudes particularly in Black communities. Furthermore, if an individual has had contact with a person that has a specific MHC, that individual may maintain their stigmatising attitudes against people with other forms of MHC different from the one they had contact with (Corrigan et al., 2000). I propose that similar to how contact does not have an impact on MHC stigma across all races and across all mental health conditions in previous research; it is not related to all forms of stigma including the specific stigmatising attitudes held by the population in the current research. Further research should establish the relationship between the level of contact and familiarity with specific stigmas as manifested in stereotypes, emotional responses and behaviours towards people living with MHCs.

Mental Health Literacy and Stigmatising Attitudes

There were no statistically significant differences in mental health challenges stigmas among people with mental health literacy and those without. It could be expected that if someone knows and understands the aetiology, prognosis, treatment of mental health challenges and the complexities involved therein they would not have stigmatising attitudes while those that do not have such knowledge would be stigmatising. For example, in the current research, a majority of the respondents partially endorsed the stereotypes of dangerousness and incurability. They agreed with statements such as “A mentally ill person is more likely to harm others than a normal person” and “Individuals diagnosed as mentally ill will suffer from its symptoms throughout their life”. If they had the knowledge that people living with MHC are involved in only three to five percent of violent cases ((Fitzpatrick, 2015) and that recovery and remission is possible even in serious mental health challenges perhaps they would not have had such stigmatising beliefs.

However, it is possible that there are other factors that impact the association between mental health literacy and MHC stigma. In 2009, Angermeyer and colleagues found that interventions

that involved improving people's mental health literacy either had no impact on the level of stigma or it made the stigma worse. Corrigan and Watson (2004) found that while it may MHL may eliminate some stigmas it may also promote others. Furthermore, there have been studies that found that people in mental health professions, despite their high levels of mental health literacy, hold levels of stigmatising attitudes that equal to or higher than that of the general lay public (e.g. Hansson et al., 2011). Future qualitative research could uncover why people who have mental health literacy continue to be stigmatising against people with MHCs when they know better and this might explain how mental health literacy has no impact on MHC stigma in some instances.

Organisational Implications

Contrary to previous research (e.g., Stuart, 2004), the results in this study suggested that a majority of employees in South Africa and Botswana do not stigmatise against co-workers that live with MHCs. The responses endorsed by most of the participants to work-related items in the study indicated that they are open to working with, reporting to, and delegating work to people living with MHCs regardless of their diagnosis. They responded in varying degrees of disagreement to statements such as "I would not trust the work of a mentally-ill person assigned to my work team", and in agreement to items such as "If I were an employer, I would interview TM for a job". And while this is promising, there is still MHC stigma in the population and there were respondents who indicated work-related MHC stigma. Therefore, work-based interventions against MHC stigma are still required and encouraged.

Similar to some pieces of literature, the current research showed that mental health literacy and the level of contact with people that have MHCs are not predictive of all forms of MHC stigma. In fact, only race and nationality predicted MHC stigma in the current study. Thus workplace interventions against MHC stigma might have to go beyond being contact and education based. They might need to be tailored to the different races and nationalities found in organisations. Unless the specific predictors of MHC stigma along racial and cultural lines are uncovered and accounted for in MHC stigma workplace interventions, then one cannot trust that workplace interventions against MHC stigma will be effective.

Study Limitations

This study had a few limitations that need to be taken into consideration as they affect the interpretation of the results. Firstly, the sampling and data collection procedures present with limited generalisability and possible response biases. Convenience and snowball sampling methods result in a non-representative sample and a sample that is demographically skewed. As a result, these findings cannot be generalised to the whole population (i.e. people living in Botswana and in South Africa). While the online survey method has advantages such as limiting social desirability (Henderson, Evans-Lacko, Flach, & Thornicroft, 2012), the multiple ways in which it can be distributed for completion, timeliness, as well as convenience, it also results in a sample that is most likely educated, has access to the internet, e-mail, and social media and is at least computer literate and internet savvy (Evans & Mathur, 2005). This has excluded members of the working population that do not have access to these facilities and are not computer literate or internet savvy. Further research could be administered in pencil and paper so as to include a wider-range of members of the working population.

Secondly, the survey method with closed questions does not allow for elaboration on responses, and so a lot of nuance about how people think and feel about mental health challenges and people living with these challenges was missed. Mental health issues and the stigmas that are held against such issues are complex and multi-faceted, I recommend that future research should be qualitative in nature so as to capture the factors associated with these stigmas in greater detail. This will further allow for exploration into the type of stigmas held and the reasons behind them and the factors that determined them.

Lastly, the scales of measurements used in this study were not specific to the African context and to the African understanding of MHCs and MHC stigma. The scales used were developed and validated in Western countries. Further research could explore mental health challenges and the stigma against these challenges as understood by Africans and proceed to measure and study MHC stigma in the manner in which it is perceived by those living with MHCs and manifested by others. In addition, the scales were not specific to the work context. While they may have included some items applicable to the world of work, they were designed for use in the general population and so future research could measure stigma not just within the working population

but through the use of scales of measurement that comprise workplace themes and challenges insofar as MHC stigma at work is concerned.

Conclusion

Work is highly meaningful and beneficial to people, most particularly those living with mental health conditions (Honey, 2005; Stuart, 2004, 2006) and it is expected that there will be an increase in the prevalence of MHCs around the world (WHO, 2013, 2017) and that this increase will be observed in the workplace as well. As a result, it is important that research is focused on establishing and increasing the mechanisms of mental health in the workplace. The workplace, where a large number of the population spend a large amount of time should, and can be, an environment that promotes mental well-being rather than hinder it (Kelloway & Day, 2005a, 2005b).

Stigma against people living with MHCs is arguably a factor that hinders the recovery and quality of life, including work life, of people living with MHCs the most (Kirsch, 2000; Overton & Medina, 2008; Stuart, 2004, 2006). Stigmatisation limits, amongst other things, the access that people living with MHCs have to psychosocial support because it contributes to social exclusion (Byrne, 2000; Kulik et al., 2008; Nxumalo & Mchunu, 2017; Phelan et al., 1998). And yet psychosocial support in the workplace highly contributes to the productivity and well-being of employees living with MHCs (Kirsch, 2000).

Despite this, it seemed that not a lot of research has been conducted about the factors that contribute to MHC stigma in the work place. A lot of stigma research has focused on uncovering the attitudes towards MHCs of the general public. As such, this research was meant to fill that gap in the literature, especially in Southern Africa. The aim of this research was to investigate the effect of demographic variables of the working population - such as age, gender, race, and most particular to the work environment, occupational level - on stigma against employees with MHC. In addition, the aim was to investigate the effect of level of contact and level of mental health literacy on MHC stigma.

It was found that while there was cognitive, affective, and behavioural stigma in the population, not all types of stigma within these components were held by majority of the respondents. Cognitive stigma was manifested through the partial endorsement of the dangerousness and incurability stereotypes. Affective stigma was mostly indicated through pity and less through anger and fear. Lastly, a majority of the respondents supported behavioural stigma through coercion and not avoidant and unhelpful behaviour. It was found that only race and nationality had statistically significant effects on stigma against employees with MHCs. The Black group had more cognitive stigma against employees with MHC stigma than the White group and the Non-South African group had more cognitive, affective, and behavioural stigma than the South African group. Therefore, suggesting that in workplaces in South Africa and in Botswana only race and culture predicted MHC stigma while the other variables did not.

While there have been mixed results about the effects of contact (familiarity) and mental health literacy on MHC stigma, it was still unexpected that they would both have no statistically significant effect in this study. Both level of contact and mental health literacy have implications for two of the most popular anti-stigma interventions; contact-based and education-based interventions respectively. However, it has been found, in previous literature, that these interventions are effective only under certain conditions, in certain populations, and against certain types of stigmas. Further research could focus on uncovering the specific determinants of stigma across different populations so as to inform anti-stigma interventions against as many forms and facets of MHC stigma as possible in as many types of populations as possible.

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APPENDIX C

Biographical Survey
Please answer the following questions. They are for descriptive purposes only.

1. Indicate your age in years: _____

2. Indicate your gender:

☐ Female
☐ Male
☐ Not gender specific

3. Indicate your ethnic group:

☐ Black (African)
☐ Coloured
☐ Indian
☐ Asian
☐ White
☐ Other
Specify: _____

4. Indicate your nationality:_____

5. Indicate your occupational level:

☐ Administrative
☐ Junior management
☐ Middle management
☐ Senior management
☐ Other
Specify: _____

APPENDIX D

Beliefs towards Mental Illness (BMI) Scale (Harai & Clum, 2000)

1. A mentally ill person is more likely to harm others than a normal person.
   completely disagree **0 1 2 3 4 5** completely agree

2. Mental disorder would require a much longer period of time to be cured than would other general diseases.
   completely disagree **0 1 2 3 4 5** completely agree

3. It may be a good idea to stay away from people who have psychological disorder because their behavior is dangerous.
   completely disagree **0 1 2 3 4 5** completely agree

4. The term ‘‘Psychological disorder’’ makes me feel embarrassed.
   completely disagree **0 1 2 3 4 5** completely agree

5. A person with psychological disorder should have a job with minor responsibilities.
   completely disagree **0 1 2 3 4 5** completely agree

6. Mentally-ill people are more likely to be criminals.
   completely disagree **0 1 2 3 4 5** completely agree

7. Psychological disorder is recurrent.
   completely disagree **0 1 2 3 4 5** completely agree

8. I am afraid of what my boss, friends, and others would think if I were diagnosed as having a psychological disorder.
   completely disagree **0 1 2 3 4 5** completely agree

9. Individuals diagnosed as mentally ill will suffer from its symptoms throughout their life.

completely disagree **0 1 2 3 4 5** completely agree

10. People who have once received psychological treatment are likely to need further treatment in the future.

    completely disagree **0 1 2 3 4 5** completely agree

11. It might be difficult for mentally-ill people to follow social rules such as being punctual or keeping promises.

    completely disagree **0 1 2 3 4 5** completely agree

12. I would be embarrassed if people knew that I dated a person who once received psychological treatment.

    completely disagree **0 1 2 3 4 5** completely agree

13. I am afraid of people who are suffering from a psychological disorder because they may harm me.

    completely disagree **0 1 2 3 4 5** completely agree

14. A person with psychological disorder is less likely to function well as a parent.

    completely disagree **0 1 2 3 4 5** completely agree

15. I would be embarrassed if a person in my family became mentally ill.

    completely disagree **0 1 2 3 4 5** completely agree

16. I do not believe that psychological disorder is ever completely cured.

    completely disagree **0 1 2 3 4 5** completely agree

17. Mentally-ill people are unlikely to be able to live by themselves because they are unable to assume responsibilities.

    completely disagree **0 1 2 3 4 5** completely agree

18. Most people would not knowingly be friends with a mentally-ill person.

completely disagree **0 1 2 3 4 5** completely agree

19. The behavior of people who have psychological disorders is unpredictable.

completely disagree **0 1 2 3 4 5** completely agree

20. Psychological disorder is unlikely to be cured regardless of treatment.

completely disagree **0 1 2 3 4 5** completely agree

21. I would not trust the work of a mentally-ill person assigned to my work team.

completely disagree **0 1 2 3 4 5** completely agree

APPENDIX E

Attribution Questionnaire (AQ-27) (Corrigan et al., 2002)

Please read the following statement about TM:

TM is a 30 year-old single (wo)man with schizophrenia. Sometimes (s)he hears voices and becomes upset. (S)he lives alone in an apartment and works as a clerk at a large law firm. S(h)e had been hospitalized six times because of this illness.

Now answer each of the following questions about TM. Circle the number of the best answer to each question.

1. I would feel aggravated by TM.

   not at all **1 2 3 4 5 6 7 8 9** very much

2. I would feel unsafe around TM.

   not at all **1 2 3 4 5 6 7 8 9** very much

3. TM would terrify me.

   not at all **1 2 3 4 5 6 7 8 9** very much

4. How angry would you feel at TM?

   not at all **1 2 3 4 5 6 7 8 9** very much

5. If I were in charge of TM's treatment, I would require him/her to take his/her medication.

   not at all **1 2 3 4 5 6 7 8 9** very much

6. I think TM poses a risk to his/her neighbors unless (s)he is hospitalized.

   not at all **1 2 3 4 5 6 7 8 9** very much

7. If I were an employer, I would interview TM for a job.

not very likely **1 2 3 4 5 6 7 8 9** very likely

8. I would be willing to talk to TM about his/her problems.

not at all **1 2 3 4 5 6 7 8 9** very much

9. I would feel pity for TM.

not at all **1 2 3 4 5 6 7 8 9** very much

10. I would think that it was TM's own fault that (s)he is in the present condition.

not at all **1 2 3 4 5 6 7 8 9** very much

11. How controllable, do you think, is the cause of TM's present condition?

not at all under personal control **1 2 3 4 5 6 7 8 9** completely under personal control

12. How irritated would you feel by TM?

not at all **1 2 3 4 5 6 7 8 9** very much

13. How dangerous would you feel TM is?

not at all **1 2 3 4 5 6 7 8 9** very much

14. How much do you agree that TM should be forced into treatment with his/her doctor even if (s)he does not want to?

not at all **1 2 3 4 5 6 7 8 9** very much

15. I think it would be best for TM's community if (s)he were put away in a psychiatric hospital.

not at all **1 2 3 4 5 6 7 8 9** very much

16. I would share a car pool with TM every day.

not likely **1 2 3 4 5 6 7 8 9** very much likely

17. How much do you think an asylum, where TM can be kept away from his/her neighbors, is the best place for him?

not at all **1 2 3 4 5 6 7 8 9** very much

18. I would feel threatened by TM.

no, not at all **1 2 3 4 5 6 7 8 9** yes, very much

19. How scared of TM would you feel?

not at all **1 2 3 4 5 6 7 8 9** very much

20. How likely is it that you would help TM?

definitely would not help **1 2 3 4 5 6 7 8 9** definitely would help

21. How certain would you feel that you would help TM?

not at all certain **1 2 3 4 5 6 7 8 9** absolutely certain

22. How much sympathy would you feel for TM?

none at all **1 2 3 4 5 6 7 8 9** very much

23. How responsible, do you think, is TM for his/her present condition?

not at all responsible **1 2 3 4 5 6 7 8 9** very much responsible

24. How frightened of TM would you feel?

not at all **1 2 3 4 5 6 7 8 9** very much

25. If I were in charge of TM's treatment, I would force him/her to live in a group home.

not at all **1 2 3 4 5 6 7 8 9** very much

26. If I were a landlord, I probably would rent an apartment to TM
.

not likely **1 2 3 4 5 6 7 8 9** very likely

27. How much concern would you feel for TM?

none at all **1 2 3 4 5 6 7 8 9** very much

APPENDIX F

Level of Contact Report (Holmes et al., 199b)

Please read each of the following statements carefully. After you have read all the statements below, place a check by the statements that best depict your exposure to persons with a severe mental illness.

(3)___ I have watched a movie or television show in which a character depicted a person with mental illness.

(8)___ My job involves providing services/treatment for persons with a severe mental illness.

(2)___ I have observed, in passing, a person I believe may have had a severe mental illness.

(5)___ I have observed persons with a severe mental illness on a frequent basis.

(12)___ I have a severe mental illness.

(6)___ I have worked with a person who had a severe mental illness at my place of employment.

(1)___ I have never observed a person that I was aware had a severe mental illness.

(7)___ My job includes providing services to persons with a severe mental illness.

(9)___ A friend of the family has a severe mental illness.

(10)___ I have a relative who has a severe mental illness.

(4)___ I have watched a documentary on the television about severe mental illness.

(11)___I live with a person who has a severe mental illness.

APPENDIX G

Mental Health Literacy Measure (Jung et al., 2016b)
Please read the following statements and select one response.

1. Counseling is a helpful treatment for depression.
☐ Strongly agree
☐ Agree
☐ Neither agree nor disagree
☐ Disagree
☐ Strongly disagree
☐ I don't know

2. A person with schizophrenia may see things that are not really there.
☐ Strongly agree
☐ Agree
☐ Neither agree nor disagree
☐ Disagree
☐ Strongly disagree
☐ I don't know

3. Early diagnosis of a mental illness can improve chances of getting better.
☐ Strongly agree
☐ Agree
☐ Neither agree nor disagree
☐ Disagree
☐ Strongly disagree
☐ I don't know

4. Attending peer support groups helps recovery from mental illness.
☐ Strongly agree
☐ Agree
☐ Neither agree nor disagree
☐ Disagree
☐ Strongly disagree
☐ I don't know

5. Unexplained physical pain or fatigue can be a sign of depression.
☐ Strongly agree
☐ Agree
☐ Neither agree nor disagree
☐ Disagree
☐ Strongly disagree
☐ I don't know

6. Cognitive behavioral therapy can change the way a person thinks and reacts to stress.
☐ Strongly agree

☐ Agree
☐ Neither agree nor disagree
☐ Disagree
☐ Strongly disagree
☐ I don't know

7. A person with bipolar disorder may show a dramatic change in mood.
☐ Strongly agree
☐ Agree
☐ Neither agree nor disagree
☐ Disagree
☐ Strongly disagree
☐ I don't know

8. Taking prescribed medications for mental illness is effective.
☐ Strongly agree
☐ Agree
☐ Neither agree nor disagree
☐ Disagree
☐ Strongly disagree
☐ I don't know

9. When a person stops taking care of his or her appearance, it may be a sign of depression.
☐ Strongly agree
☐ Agree
☐ Neither agree nor disagree
☐ Disagree
☐ Strongly disagree
☐ I don't know

10. Drinking alcohol makes symptoms of mental illness worse.
☐ Strongly agree
☐ Agree
☐ Neither agree nor disagree
☐ Disagree
☐ Strongly disagree
☐ I don't know

11. A person with mental illness can receive treatment in a community setting.
☐ Strongly agree
☐ Agree
☐ Neither agree nor disagree
☐ Disagree
☐ Strongly disagree
☐ I don't know

12. A person with anxiety disorders has excessive anxiousness or fear.
☐ Strongly agree
☐ Agree
☐ Neither agree nor disagree
☐ Disagree
☐ Strongly disagree
☐ I don't know

13. A highly religious/spiritual person does not develop mental illnesses.
☐ Strongly agree
☐ Agree
☐ Neither agree nor disagree
☐ Disagree
☐ Strongly disagree
☐ I don't know

14. Depression is a sign of personal weakness.
☐ Strongly agree
☐ Agree
☐ Neither agree nor disagree
☐ Disagree
☐ Strongly disagree
☐ I don't know

15. Mental illness is a short-term disorder.
☐ Strongly agree
☐ Agree
☐ Neither agree nor disagree
☐ Disagree
☐ Strongly disagree
☐ I don't know

16. Recovery from mental illness is mostly dependent on chance or fate.
☐ Strongly agree
☐ Agree
☐ Neither agree nor disagree
☐ Disagree
☐ Strongly disagree
☐ I don't know

17. A person with depression should not be asked if he or she has thoughts of suicide.
☐ Strongly agree
☐ Agree
☐ Neither agree nor disagree

☐ Disagree
☐ Strongly disagree
☐ I don't know

18. Poor parenting causes schizophrenia.
☐ Strongly agree
☐ Agree
☐ Neither agree nor disagree
☐ Disagree
☐ Strongly disagree
☐ I don't know

19. Mental illness will improve with time, even without treatment.
☐ Strongly agree
☐ Agree
☐ Neither agree nor disagree
☐ Disagree
☐ Strongly disagree
☐ I don't know

20. Recovering from a mental illness is the same as being cured.
☐ Strongly agree
☐ Agree
☐ Neither agree nor disagree
☐ Disagree
☐ Strongly disagree
☐ I don't know

21. A person can stop hoarding whenever he/she wants to.
☐ Strongly agree
☐ Agree
☐ Neither agree nor disagree
☐ Disagree
☐ Strongly disagree
☐ I don't know

22. A person with depression will get better on his or her own without treatment.
☐ Strongly agree
☐ Agree
☐ Neither agree nor disagree
☐ Disagree
☐ Strongly disagree
☐ I don't know

23. I know where to go to receive mental health services.

☐ Yes
☐ No

24. I know how to get the number of a suicide prevention hotline.
☐ Yes
☐ No

25. I know where to get useful information about mental illness.
☐ Yes
☐ No

26. I know how to contact a mental health clinic in my area.
☐ Yes
☐ No

APPENDIX H

Psychology
School of Human & Community Development
University of the Witwatersrand
Private Bag 3, WITS, 2050
Tel: (011) 717 4500 Fax: (011) 717 4559

Participant Information Sheet

Hello

I am a Master of Arts (Organisational Psychology) student at the University of the Witwatersrand and I am conducting research to investigate how people in the workplace feel about employees that have mental health difficulties. I am really interested in what your viewpoints are on this matter. As such, I would like to invite you to participate in my study.

The survey takes about fifteen (15) minutes to complete. Your participation is completely voluntary; there is no compensation for participation nor is there will there be any negative consequences for non-participation.

I will not be asking you for identifying information such as your contact details, ID number, or employee numbers; your participation and your responses are completely anonymous. The biographical questions asked in the survey are for descriptive purposes only. Furthermore, confidentiality will be ensured as your response will be part of a data group and not in isolation. All the data collected will be kept in a password protected file and will only be utilized for research purposes.

In addition, you are free to withdraw your participation at any point in the survey before you click the "Submit" button. Once you have clicked that button, it is not possible to withdraw your responses because I will not be able to tell which one is yours (because, as previously mentioned, all responses are anonymous).

Completion of the survey will act as informed consent for me to use the data for research. This research will fulfill part of my course requirements and may be published in a journal article and/or

presented in a conference. Should you be interested in my findings, please feel free to let me know and I shall provide you with a summary once the study is complete.

If you feel that this research has raised issues that upset you, please contact the SA Depression and Anxiety group (SADAG) who will assist you in dealing with this. Their number is 011 234 4837 (Monday to Friday, 8am – 8pm).

Yours Sincerely,

LMM

Ms. Leonne Mfolwe.
Email: 1710142@students.wits.ac.za

KM
Supervisor: Prof. Karen Milner
Email: Karen.Milner@wits.ac.za

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

HUMAN RESEARCH ETHICS COMMITTEE (SCHOOL OF HUMAN & COMMUNITY DEVELOPMENT

CLEARANCE CERTIFICATE	**PROTOCOL NUMBER: MORG/18/007 IH**
PROJECT TITLE:	Stigmatising attitudes towards employees with mental health challenges: the effects of demographic differences and mental health literacy
INVESTIGATORS	Mfolwe Leonne
DEPARTMENT	Psychology
DATE CONSIDERED	28/06/18
DECISION OF COMMITTEE*	Approved

This ethical clearance is valid for 2 years and may be renewed upon application

DATE: 28 June 2018

CHAIRPERSON
(Dr Colleen Bernstein)

cc Supervisor:

Prof. Karen Milner
Psychology

DECLARATION OF INVESTIGATOR (S)

To be completed in duplicate and **one copy** returned to the Secretary, Room 100015, 10th floor, Senate House, University.

I/we fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure be contemplated from the research procedure, as approved, I/we undertake to submit a revised protocol to the Committee.

This ethical clearance will expire on 31 December 2020

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

Psychology
School of Human & Community Development
University of the Witwatersrand
Private Bag 3, WITS, 2050
Tel: (011) 717 4500 Fax: (011) 717 4559

To Whom It May Concern

Request for Organisational Access

I am a Master of Arts (Organisational Psychology) student at the University of the Witwatersrand and I am conducting research to investigate how people in the workplace feel about employees that have mental health challenges. As such, I ask that you grant me the permission to conduct this research among the employees in your organisation.

The survey is online based and should take about 15 minutes to complete. In order to distribute the survey, I would require their email addresses so as to send them the link to the survey. Participation in the study is completely voluntary (there is no compensation for participation nor is there consequence for non-participation) and confidential (no identifying information, such as the name of your organisation, will be disseminated). All the data collected will be kept in a password protected file and will only be utilized for research purposes.

This research will fulfil part of my course requirements and may be published in a journal article and/or presented in a conference. Should you be interested in my findings, please feel free to let me know and I shall provide you with a summary once the study is complete.

Yours sincerely,

LMM

Ms. Leonne Mfolwe
Email: 1710142@students.wits.ac.za

KM

Supervisor: Prof. Karen Milner
Email: Karen.Milner@wits.ac.za