



UNIVERSIDADE  
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"DO THEY TRULY CARE?": PERCEIVED ORGANIZATIONAL  
SUPPORT, PSYCHOLOGICAL WELL-BEING AND THE  
MEDIATING ROLE OF INTERNALIZED STIGMA AMONG  
PORTUGUESE WORKERS

Dissertation to Universidade Católica Portuguesa to obtain  
a Master's Degree in Psychology in Business and  
Economics

By

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Universidade Católica Portuguesa de Lisboa

September 2024



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## Abstract

**Background:** Recently, mental health and employee well-being have become a growing concern within organizations. However, research on the impact of organizational support on workers' psychological well-being remains relatively limited, and studies on the potential experience of stigmatization in the workplace are even scarcer, highlighting the need for further exploration of this phenomenon.

**Objectives:** To investigate how the perception of organizational support (POS) influences the psychological well-being (PWB) of Portuguese workers. Additionally, to propose a model in which internalized stigma mediates the relationship between POS and PWB in workers with a mental health condition.

**Method:** After informed consent, two correlational studies were conducted. In Study 1, measures of POS and PWB were applied to 278 workers (219 women and 58 men, aged between 18 and 66 years [ $M=37.05$ ,  $SD=13.18$ ]). The sample for Study 2 involved 109 workers (92 women and 17 men, aged between 18 and 63 years [ $M=36.39$ ,  $SD=12.93$ ]), who were also assessed for internalized stigma (ISMI).

**Results:** The results of Study 1 revealed a significant positive relationship between POS and PWB, indicating that workers who perceive greater organizational support report higher psychological well-being. The results of Study 2 showed that ISMI was negatively associated with PWB, but did not mediate the relationship between POS and PWB.

**Conclusion:** These findings highlight the negative impact of the stigmatization experience on the psychological well-being of workers with mental health conditions. Future research should investigate other factors that might influence the relationship between POS and ISMI. Practical implications include the development of organizational interventions to strengthen support systems and combat the internalization of stigma related to mental health.

**Keywords:** Perceived Organizational Support; Psychological Well-Being; Internalized Stigma; Mental Health

## Resumo

**Enquadramento:** Recentemente, a saúde mental e o bem-estar dos trabalhadores têm-se tornado uma preocupação crescente nas organizações. No entanto, a investigação sobre o impacto do suporte organizacional no bem-estar psicológico dos trabalhadores permanece relativamente limitada, e estudos sobre a potencial experiência da estigmatização em contexto de trabalho são ainda mais escassos, sublinhando a necessidade de explorar mais aprofundadamente este fenómeno.

**Objetivos:** Investigar como a perceção de suporte organizacional (PSO) influencia o bem-estar psicológico (BEP) em trabalhadores portugueses. Adicionalmente, propor um modelo no qual o estigma internalizado atua como mediadora na relação entre a PSO e o BEP, em trabalhadores com um problema de saúde mental.

**Método:** Após consentimento informado, foram efetuados dois estudos do tipo correlacional. Para o estudo 1, aplicaram-se medidas de avaliação do PSO e BEP a 278 trabalhadores (219 mulheres e 58 homens, com idades entre os 18 e os 66 anos [ $M=37.05$ ,  $DP=13.18$ ]); A amostra do estudo 2 envolveu 109 trabalhadores (92 mulheres e 17 homens, com idades entre os 18 e os 63 anos [ $M=36.39$ ,  $DP=12.93$ ]) tendo também sido avaliados quanto ao estigma internalizado (ISMI).

**Resultados:** Os resultados do Estudo 1 revelaram uma relação positiva e significativa entre a PSO e o BEP, indicando que os trabalhadores que percecionam maior suporte organizacional relatam maior bem-estar psicológico. Os resultados do Estudo 2 evidenciaram que o ISMI se associou negativamente ao BEP, contudo, não mediou a relação entre a PSO e o BEP dos trabalhadores.

**Conclusão:** Estes dados evidenciam o impacto negativo da experiência de estigmatização no bem-estar psicológico de trabalhadores com problemas de saúde mental. Investigações futuras devem investigar outros fatores que possam influenciar a relação entre a PSO e o ISMI. As implicações práticas incluem o desenvolvimento de intervenções organizacionais para reforçar o apoio e combater o estigma associado à saúde mental.

**Palavras-chave:** Perceção de Suporte Organizacional; Bem-Estar Psicológico; Estigma Internalizado; Saúde Mental

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## 1. Introduction

Mental health has become one of the most concerning issues in modern society. According to the National Institutes of Mental Health (NIMH), anxiety disorders are the most common mental health condition among adults in the United States, affecting 19.1% of the population each year. These disorders include a variety of conditions such as generalized anxiety disorder, panic disorder, social anxiety disorder, and specific phobias. Major depression is the second most common mental illness, with 21 million adults, or 8.3% of the population, reporting at least one episode of major depression in 2021. Likewise, and according to Caldas de Almeida and Xavier (2013), more than one-fifth of the Portuguese population suffers from a psychiatric disorder. This makes Portugal the country with the second-highest prevalence of psychiatric illnesses in Europe, with anxiety disorders also being the most common (16.5%).

These findings reinforce the growing awareness of mental health issues not only in society at large but particularly in the workplace (NIMH, 2022). The prevalence of mental health problems in the workplace has been on the rise in recent years (LaMontagne et al., 2014), leading to increased awareness of the importance of mental health in the workplace. According to Strudwick and others (2023), depressive and anxiety disorders are also the leading cause of overall health problems affecting people of working age, while Joyce and coworkers (2016) state that these conditions pose significant economic, social, and personal costs to employees, employers, and society.

Globally, workplace mental health is gaining attention, with organizations like the World Health Organization (WHO) calling for integrated mental health support systems. As stress levels in the workplace increase and mental health receives more attention worldwide, many other organizations are gradually realizing the importance of psychological well-being in relation to work performance and organizational success (Haddon, 2018). This has led researchers to recognize the workplace as an important setting for implementing mental health prevention programs and improving access to treatment, which can benefit both employees and employers (Carolan et al., 2017), as well as to explore what types of interventions may be beneficial in creating a supportive environment for employees (Joyce et al., 2016).

Given the amount of time employees spend at work, it's not surprising that work-related factors, particularly how organizations treat and value their employees, have a

strong impact on their mental health, both at work and in their personal lives (Caesens et al., 2021). This global context further highlights the importance of understanding how factors, such as organizational support and mental health stigma, impact different cultural settings, like the Portuguese workforce.

In a recent study in Portugal, where this research is based, Lopes (2024) reported some findings from the "Consumer Sentiment Survey 2023", revealing that 23% of Portuguese workers described feeling psychologically unstable or somewhat unstable in the workplace. Given these statistics, it's vital to explore the role of organizational support in addressing mental health concerns in the workplace.

With the growing recognition of the need to support employee mental health in workplaces around the world, understanding the relationship between perceived organizational support and mental health stigma becomes essential. Despite growing awareness of mental health issues, internal barriers such as stigma continue to prevent individuals from feeling psychologically well, especially those with mental illness (Drapalski et al., 2013; Pérez-Garín et al., 2015). Therefore, increasing awareness and understanding of mental health among all workers could help in reducing the stigma of mental illness and creating a supportive work culture.

Knowing how stigma affects employees in their respective workplaces is key to building better support systems, as organizations become more sensitive to the psychological needs of their employees. Few studies have focused on this particular population or investigated whether reducing internalized stigma could increase the positive effects of perceived organizational support on employee psychological well-being. Therefore, this research may contribute to a better understanding of the impact of perceived organizational support on the psychological well-being of employees and, in addition, investigate the impact of internalized stigma of mental illness on those dealing with it.

The research questions guiding this study are:

- 1) What is the relationship between Portuguese employees' perceptions of organizational support and their psychological well-being?
- 2) What is the relationship between perceptions of organizational support and psychological well-being among Portuguese employees with mental illness?

- 3) Does internalized stigma negatively impact the psychological well-being of these workers?
- 4) Does internalized stigma mediate the relationship between perceived organizational support and psychological well-being among employees with mental illness?

With this, the present research aims to better understand how organizational support, internalized stigma, and psychological well-being interact in the workplace context. In addition to providing academic insights, this research may provide practical recommendations for organizations to better support employees with mental health needs.

This dissertation consists of four main sections. The first section includes a detailed literature review that presents the current state of the art, as well as the hypotheses and conceptual framework of this thesis. The second section, the methods section, presents the empirical part of the dissertation, including two studies. It explains the research methods, the characteristics of the participants, the data collection process, and the statistical analysis used. In the third section, the results of the two empirical studies are presented. It is followed by the fourth section, the discussion, in which the main results are discussed and interpreted in light of findings from previous research. This section also includes a review of the study's limitations and implications for future research, as well as practical recommendations for organizational practice.

## **2. Literature Review**

This section presents the literature review, which provides a comprehensive overview of the key concepts explored in this thesis: perceived organizational support, psychological well-being, and internalized stigma of mental illness.

The review addresses the existing research on perceived organizational support and psychological well-being, and the relationship between them in the workplace context, and highlights the potential mediating role of internalized stigma.

Afterwards, the aims and objectives of the dissertation will be presented, as well as the conceptual framework and hypothesis guiding this empirical research.

### **2.1. Perceived Organizational Support**

Perceived Organizational Support, a construct first introduced by Eisenberger and colleagues (1986), refers to employees' global perceptions of the extent to which their organization values their contributions and is concerned about their well-being. This concept also includes the beliefs and expectations that individuals have about the organization's recognition of their work efforts (Santos & Gonçalves, 2010). According to Eisenberger and colleagues (2020), perceived organizational support has been widely researched because of its significant antecedents and consequences, including positive employee attitudes, performance, and well-being.

The main goal of Eisenberger et al. (1986) when exploring this concept was to understand what links employees to a particular organization, realizing that the factors that stood out the most were affective and economic ones. This research led to the development of the “Organizational Support Theory”, which posits that employees tend to personify their organization, attributing humanlike qualities such as intent and purpose to it (Eisenberger et al., 1986; Rhoades & Eisenberger, 2002; Santos & Gonçalves, 2010; Eisenberger et al., 2020).

This theory is grounded in Levinson's (1965) Social Exchange Theory, which suggests that employees, frequently, tend to view actions by agents of the organization as actions of the organization itself (Eisenberger et al., 1986; Rhoades & Eisenberger, 2002). Levinson (1965) also suggested that the personification of the organization is supported by numerous factors, such as: (a) the legal, moral, and financial responsibility of the organization for the actions of its agents; (b) the organizational policies, norms, and culture that provide continuity and propose role behaviors; and (c) the power that the

organization's agents wield over individual employees (Eisenberger et al., 1986; Rhoades & Eisenberger, 2002). Based on the personification of the organization, employees perceive their favorable or unfavorable treatment as an indication that the organization is favoring or disfavoring them (Rhoades & Eisenberger, 2002).

In this way, the "Organizational Support Theory" explains the psychological processes behind the effects of perceived organizational support. It suggests that perceived organizational support is developed not only to indicate the organization's willingness to reward employees for their efforts, but also to fulfill employees' socioemotional needs, like recognition and approval (Eisenberger et al., 1986; Eisenberger et al., 2020). Perceived organizational support should elicit a norm of reciprocity, where employees feel obligated to support organizational goals in exchange for recognition and rewards, resulting in greater effort and performance (Eisenberger et al., 2020).

Furthermore, the care, recognition, and respect that employees associate with perceived organizational support fulfill their socioemotional needs, leading to a greater identification with and commitment to the organization, as well as a desire to help the organization achieve success, and increased psychological well-being (Kurtessis et al., 2017; Rhoades & Eisenberger, 2002). These processes should produce positive results for both the employees (*e.g.*, increased job satisfaction and positive mood) and the organization (*e.g.*, increased affective commitment and performance, reduced turnover) (Rhoades & Eisenberger, 2002).

Some important antecedents of perceived organizational support include organizational fairness, leadership support, human resource practices, and favorable work conditions (Kurtessis et al. 2017; Rhoades & Eisenberger, 2002). In terms of its main consequences, these include both employee performance and well-being. As suggested by Eisenberger and colleagues (2020), employees who perceive high levels of organizational support are more likely to engage in behaviors that are consistent with their job responsibilities (in-role performance) and to take on additional tasks that benefit the organization beyond their standard tasks (extra-role behaviors). In addition, perceived organizational support helps mitigating harmful practices, such as counterproductive work behaviors that could negatively impact the organization. Beyond performance and behavior, perceived organizational support contributes to improved employee well-being, including greater job satisfaction and better work-life balance.

Allen and colleagues (2003) highlight that human resources practices such as autonomy, job security, training, participation in decision-making, and opportunities for career growth positively influence perceived organizational support, as they reflect organizational investment in employees. However, organizations must ensure these practices are perceived as genuine and voluntary by employees to truly foster a sense of support, rather than being seen as externally imposed.

## **2.2. Psychological Well-Being**

The concept of well-being has become increasingly important in recent research, as it is relevant to various areas, including psychology, sociology, management, education, and health; however, due to its interdisciplinary nature, reaching a universal definition remains a challenge (Dodge et al., 2012). While the concept of well-being encompasses a variety of definitions, two central themes emerge across disciplines: well-being as subjective happiness and optimal functioning.

The World Health Organization (WHO) defines well-being as “*a positive state in which individuals can realize their potential, cope with the normal stresses of life, work productively, and contribute to their communities*”. This view emphasizes the impact of social, economic, and environmental factors on well-being. Similarly, the American Psychological Association (APA) (2018) considers well-being as a state of happiness and contentment, characterized by low levels of distress, good physical and mental health, and a level of quality of life globally high.

In contrast, Deci and Ryan (2008) define well-being as an optimal state of experience and psychological functioning. Warr (2002) also proposes a definition for well-being, which can be understood from two perspectives: a "context-free" view, which refers to people's overall feelings about life without focusing on specific areas, and a context-specific view, particularly related to the workplace, named as "job-related" or "job-specific" well-being. These definitions highlight the complexity of defining well-being, making it essential to understand its historical development to arrive at a more accurate and comprehensive definition.

Historical research on well-being in the social sciences began with investigations in the 1960s and 1970s aimed at assessing population well-being and improving social policies (Westerhof & Keyes, 2010). Currently, research on well-being is divided into two

main conceptual approaches: the hedonic perspective and the eudaimonic perspective (Ryan & Deci, 2001; Keyes et al., 2002).

According to Soares and others (2018), the hedonic approach views well-being as a subjective experience, where one evaluates their feelings of well-being, interpreting them in terms of pleasure and happiness. Moreover, this perspective also incorporates three interrelated components such as life satisfaction, pleasant affect, and unpleasant affect, usually summarized as happiness (Deci & Ryan, 2001). While affect refers to positive and negative moods and emotions, life satisfaction refers to the cognitive evaluation that one makes about their satisfaction with life (Diener & Suh, 1997). In short, Deci and Ryan (2008) explain that subjective well-being is determined by high levels of positive affect, low levels of negative affect, and a high level of satisfaction with life. This perspective allows well-being to be measured by evaluating the frequency and intensity with which someone experiences positive and negative emotions, such as happiness, sadness, anger, and joy (Diener et al., 2018).

During the 1980s and 1990s, there was a growing recognition of the need to move beyond the hedonic approach to focus more on overall life satisfaction and mental health. Therefore, psychologists started to further study this concept, especially in the context of individual objectives and optimal functioning, leading to the development and research of a new approach to well-being, known as eudaimonic well-being (Ryff, 1989; Waterman, 1993; Westerhof & Keyes, 2010).

While the hedonic tradition highlights general life satisfaction and positive emotions, the eudaimonic tradition takes a more existential approach, focusing on human development and life's challenges (Keyes et al., 2002). According to this perspective, true psychological well-being involves more than just feeling happy or experiencing positive emotions; it also requires reaching one's full potential and achieving a sense of purpose and fulfillment (Ryan & Deci, 2001, 2008). This eudaimonic perspective defends that true well-being is achieved by fulfilling one's *daimon*, or "true self", representing a person's unique potential that, when reached, results in the most profound fulfillment in life (Waterman, 1993).

Ryff's (1989) eudaimonic model of psychological well-being is consistent with this perspective and provides a multidimensional framework for understanding well-being. By conducting an extensive literature review on optimal psychological functioning, she

synthesized insights from humanistic-existential theories, human development, and mental health, resulting in the formulation of the dimensions of this construct (Machado & Bandeira, 2012). The resulting model highlights the pursuit of personal excellence, where psychological well-being is identified through cognitive, emotional, and affective resources inherent to the individual. These aspects are included within six central dimensions of positive psychological functioning (Pereira et al., 2018; Westerhof & Keyes, 2010; Ryff, 1989):

a) Self-acceptance: an essential component of mental health and a sign of maturity, self-actualization, and optimal functioning. It involves keeping an optimistic and accepting perspective of oneself, both past and present.

b) Purpose in life: refers to having goals and beliefs that give life direction and meaning. Individuals who function positively typically have clear goals, intentions, and a sense of purpose, that contribute to the perception that life is meaningful.

c) Autonomy: Demonstrates self-direction guided by socially accepted internal standards, along with self-determination, independence, and self-regulation.

d) Positive relations with others: Involves maintaining satisfying personal relationships characterized by empathy, affection, and intimacy.

e) Environmental mastery: Refers to effectively manage and adapt to the surrounding environment to meet personal needs. The ability to choose or create environments that suit one's psychological conditions is seen as a sign of mental health.

f) Personal growth: Involves recognizing and striving towards one's potential for self-improvement and development. Optimal psychological functioning involves not only achieving the previously mentioned characteristics but also continuously growing and expanding as an individual, aligning closely with Aristotle's concept of eudaimonia.

In this way, Ryff's model offers a more comprehensive view of well-being than the traditional hedonic approach, by emphasizing personal growth and self-acceptance. Empirical studies have used these dimensions in many different contexts, demonstrating the model's versatility and links to positive mental health and personal development outcomes. For example, Ryff's dimensions have been used in the workplace to examine the impact of well-being on job satisfaction and productivity. Wright et al. (2007) investigated the moderating role of employee well-being in the job satisfaction-performance relationship, finding that well-being strengthens this relationship. In clinical populations,

Ryff's model has been used to assess psychological well-being in individuals with depression, anxiety, and chronic illness. For instance, Wood and Joseph (2010) conducted a ten-year cohort study showing that the absence of eudaimonic well-being was a significant risk factor for depression, highlighting its protective role. In line with this, Ruini et al. (2003) examined the relationship between psychological well-being, distress, and personality traits, demonstrating that higher levels of well-being are associated with less distress and healthier personality profiles. This wide application across contexts reinforces the robust nature of Ryff's model in assessing well-being and stresses the importance of fostering psychological well-being for both personal and professional growth.

However, while some research sees well-being as a complex construct with multiple definitions depending on theoretical perspectives (Wood & Joseph, 2010), an integrative approach that includes both hedonic and eudaimonic perspectives may offer a more holistic understanding.

Well-being, in Ryan and Deci's (2001) perspective, is best understood as multidimensional, combining subjective experiences of happiness (hedonic) with self-actualization and personal fulfillment (eudaimonic). For instance, Ryan and Frederick (1997) demonstrated that subjective vitality, an important aspect of eudaimonic well-being, is strongly linked to psychological factors such as autonomy and relatedness, as well as physical health.

Warr (1978) conceptualizes psychological well-being as a spectrum of affective experiences, from negative feelings such as dissatisfaction and worry to positive emotions that mean more than just the absence of negativity. This spectrum reflects both the hedonic dimension (feeling good) and the eudaimonic dimension (functioning well), aligning with broader definitions of well-being. In the same way, Deci and Ryan (2008) argue that psychological well-being involves both positive emotional states (hedonic) and effective functioning in personal and social contexts (eudaimonic).

In the fields of psychology and sociology, well-being is often described through three dimensions. Guest (2017) explains that the psychological dimension focuses on well-being in terms of subjective experiences, differentiating between hedonic well-being—often linked to job satisfaction—and eudaimonic well-being, which emphasizes fulfilling one's potential and finding meaning in work. The physical dimension, on the other hand,

highlights bodily health, incorporating subjective health perceptions, energy levels, and negative aspects like fatigue and stress. Lastly, the social dimension views well-being in terms of relationships and community engagement, emphasizing interpersonal connections, social support, and fairness in treatment.

Huppert (2009) reinforces that psychological well-being involves leading a fulfilling life, combining positive emotions with effective functioning. Sustainable well-being requires not only positive affect but also meaningful engagement, self-realization, and maintaining strong relationships.

Although both hedonic and eudaimonic perspectives have evolved separately, evidence suggests they are interrelated, with each offering a distinct facet of general well-being (Keyes et al., 2002). An integrative approach that brings these two perspectives together provides a more holistic framework for assessing mental health and psychological well-being (Ring et al., 2007), allowing for a better understanding of what constitutes a "good life".

### **2.3. Perceived Organizational Support and Psychological Well-Being**

Early empirical research in industrial and occupational psychology led to the first studies and interest in well-being at work. In the 20<sup>th</sup> century, Hawthorne's studies revealed that employees who are more satisfied with their jobs tend to be more productive. This led to the opening of a whole new area of research in the study of the relationship between employee well-being and workplace performance.

In 1950, the World Health Organization (WHO) defined the concept of occupational health, which refers to the promotion and maintenance of high levels of physical, mental, and social well-being in all professions. Its main objectives include seeking the prevention of health problems caused by working conditions, protecting workers from exposure to risks, and a working environment adapted to employees, as referred by Silva and Tavares (2012).

As Grant and colleagues (2007) point out, work-related well-being isn't limited to a single dimension, such as job satisfaction; it can be conceptualized as a broader concept that includes the overall quality of an employee's experience and functioning at work. The authors continue to explain that this holistic definition of well-being is grounded in various disciplines, including healthcare, philosophy, psychology, and sociology. These fields

converge on three core dimensions of well-being: psychological (*e.g.*, satisfaction, self-respect, capabilities...), physical (*e.g.*, nourishment, shelter, healthcare, ...), and social (participating in the community, being accepted, helping people...).

Perceived organizational support has been linked to various aspects of psychological well-being, such as job satisfaction, stress reduction, and emotional resilience (Rhoades & Eisenberger, 2002). Employees who feel supported by their organization experience greater psychological well-being, leading to higher levels of engagement, motivation, and overall job performance (Kurtessis et al., 2017).

Research indicates that health and well-being at work are of great importance for organizations and are influenced by two types of factors: individual (*e.g.*, sociodemographic characteristics, personality, personal resources) and organizational (*e.g.*, work conditions, interpersonal relationships, the company's culture and climate as the managerial practices and politics) (Silva & Tavares, 2012).

Thus, promoting well-being has the potential to benefit both the employee and the organization. Employee well-being is essential to the success and sustainability of an organization because it affects costs associated with illness and health care, as well as other concerns such as absenteeism (Parks & Steelman, 2008), turnover, and discretionary effort; influences organizational citizenship behavior and overall job performance and productivity (Carmichael et al., 2016); and has been linked to several positive organizational attitudes, including team cohesion, job satisfaction (Parks & Steelman, 2008, and engagement (Grant et al., 2007; Keeman, et al., 2017).

Based on this, understanding the relationship between perceived organizational support and psychological well-being is of great importance for organizations seeking to assess how their work environments affect employee well-being. This understanding will enable organizations to implement interventions that employees will truly perceive as supportive, contributing to improved well-being and performance.

#### **2.4. Stigma Of Mental Illness**

According to Link and Phelan (2001), the concept of stigma was introduced by Goffman in 1963 and remains widely referenced in contemporary literature. The author defined stigma as a social process in which one group assigns a negative or distinguishing label to another, often targeting minority groups, resulting in the deprivation of their

rightful privileges and opportunities. The authors continued to expand on this theory by conceptualizing stigma as a dynamic process involving labeling, stereotyping, separating, status loss, and discrimination.

In the context of mental illness, stigma represents a multidimensional phenomenon involving different emotions, attitudes, and behaviors that contribute to the exclusion and discrimination of those experiencing it (Overton & Medina, 2008). As stated by Caltaux (2003), the stigma surrounding mental illness has been a persistent and pervasive issue across different cultures and historical periods, mainly because mental illness is often seen as an undesirable form of "differentness".

As supported by the literature (Livingston & Boyd, 2010), a distinction can be made between three levels of stigma associated with mental illness: structural stigma, social stigma, and internalized stigma. Each of these operates at different levels, but together they contribute to a larger cycle of disadvantage. Rüsçh and colleagues (2005) add that the effects of stigma are cumulative, leading to long-term social exclusion and even affecting access to basic resources such as employment, health care, and housing.

#### ***2.4.1. Structural stigma***

Structural stigma, or institutional stigma, refers to the systematic exclusion of people with mental illness through policies, rules, and procedures within public and private institutions (Oliveira et al., 2015). Livingston and Boyd (2010) further explain that this form of stigma operates at the systemic or macro level, where cultural ideologies are integrated into institutional practices. This leads to power imbalances and reinforces disadvantage, which in turn perpetuates social exclusion by limiting opportunities for people with mental illness to access services, employment, or equal treatment.

#### ***2.4.2. Social Stigma***

Social stigma, also known as public or enacted stigma, refers to negative stereotypes, prejudice, and discrimination directed at individuals with mental health conditions, which generates the "us versus them" effect (Oliveira et al., 2015). This process operates at a group level and involves individuals in the general population internalizing beliefs, emotions, and negative behaviors that lead to discriminatory behaviors towards those known to have or be perceived as having a mental illness (Livingston & Boyd, 2010;

Corrigan & Bink, 2016; Michaels et al., 2012). These include, for example, beliefs that people with mental illness are dangerous and unpredictable, that they are responsible for their condition, unable to recover, or cannot contribute to society (West et al., 2011; Corrigan & Bink, 2016). In this sense, public stigma involves societal attitudes and behaviors that devalue and marginalize individuals with mental illness.

#### **2.4.3. Internalized stigma**

Internalized stigma, also known as self-stigma, occurs at the individual level where people with mental illness adopt and internalize society's negative stereotypes and apply them to themselves (Livingston & Boyd, 2010; Drapalski et al., 2013). This process involves the acceptance of stigmatizing beliefs as self-relevant, which can lead to the anticipation of rejection, self-deprecation, and the view of oneself as inferior or incapable of meeting societal standards (Corrigan et al., 2006). Link and Phelan (2001) suggest that stigma strongly influences the self-esteem of people who have mental illness.

It is also relevant to distinguish between felt stigma and self-stigma. Felt stigma refers to the awareness of societal prejudice and the expectation of discrimination, whereas self-stigma involves the assimilation of these negative views into one's self-identity and belief system (Livingston & Boyd, 2010).

Self-stigma can have serious psychological and social consequences. Individuals who internalize stigma frequently experience worsened depression, and social withdrawal, and engage in avoidant coping strategies. Moreover, internalized stigma has been linked to reduced self-esteem, diminished hope, and exacerbated psychiatric symptoms. These negative effects often discourage individuals from seeking help and limit their engagement with mental health services and support systems (Drapalski et al., 2013).

#### **2.5. The Internalized Stigma of Mental Illness and Psychological Well-Being**

The internalization of mental illness stigma has been a recent topic of research due to its impact on mental health and psychological well-being. A study by Pérez-Garín and colleagues (2015) proposes that internalized stigma is strongly associated with decreased psychological well-being. Individuals who internalize mental health stigma often experience lower life satisfaction and overall quality of life, which can result in increased symptoms of depression and anxiety (Pinto et al., 2023; Oliveira et al., 2016).

Internalized stigma significantly impacts cognitive mechanisms, leading to maladaptive thinking patterns across various mental health conditions. This phenomenon is characterized by the internalization of societal stereotypes, which fosters negative self-beliefs and diminished self-esteem. This negative cycle reflects how social stigma can be internalized, affecting self-perception and mental health outcomes (Catalano et al., 2021). Research suggests that internalized stigma reduces self-efficacy and hinders taking on important life roles, such as those related to employment, by reducing the individual's sense of control (Drapalski et al., 2013; Harkness et al., 2016). Additionally, internalized stigma can act as a barrier to seeking help, as individuals with higher levels of self-stigma are less likely to access mental health resources due to the fear of rejection and reinforced negative self-perceptions (Pearl et al., 2017). These patterns may vary across different cultural contexts, further complicating the experiences of those with mental health conditions globally (Yu et al., 2021). Therefore, addressing internalized stigma requires a multifaceted approach, considering both psychological and cultural factors.

In addition to its effects on personal well-being, internalized stigma extends to the professional domain, negatively impacting work performance. Individuals often experience lowered self-esteem, reduced productivity, and difficulties in forming positive interpersonal relationships in the workplace (Corrigan et al., 2012). This leads to a vicious cycle, where individuals internalize negative beliefs, leading to poorer work outcomes and reinforcing their feelings of inadequacy and failure.

However, addressing stigma in isolation may not be enough. If supportive work cultures are not actively fostered and mental health awareness is not promoted, stigma reduction interventions may not be able to create sustainable change (Hanisch et al., 2016). Efforts to reduce stigma should focus not only on individual-level interventions, such as promoting self-acceptance (Pérez-Garín et al., 2015) but also on organizational-level changes that foster inclusivity and support. These dual approaches could significantly improve both the psychological well-being and work performance of employees.

## **2.6. Perceived Organizational Support and the Internalized Stigma of Mental Illness**

As previously discussed, perceived organizational support reflects employees' perceptions of how much their organization values their contributions and cares about their well-being (Eisenberger et al., 1986). In contrast, internalized stigma involves the

internalization of negative beliefs about oneself that are often associated with mental health problems (Livingston & Boyd, 2010).

Mental health stigma remains a prevalent issue within the workplace, much like in society at large. For example, a study of 6,399 employees in workplaces, in the United States of America, found that while 62% of employees knew how to access resources for depression treatment, only 29% felt comfortable discussing their mental health issues with their supervisors (LaMontagne et al., 2014). This gap between awareness and comfort highlights the persistence of stigma surrounding mental health in professional settings, contributing to barriers to accessing help.

Research consistently shows that higher levels of perceived organizational support are associated with better mental health outcomes, including lower levels of stress, depression, and post-traumatic stress disorder (PTSD) symptoms (Kelley et al., 2014; Chatzittofis et al., 2021). A supportive organizational climate fosters a reduction in mental health stigma, encouraging employees to address their mental health needs without fear of judgment (Kelley et al., 2014).

In addition, perceived organizational support has been linked to improved psychological well-being and reduced feelings of job insecurity, further benefiting employee mental health and well-being (Panaccio & Vandenberghe, 2009). We can therefore expect that by improving employees' perceptions of organizational support, companies can mitigate the progression of mental health problems and prevent them from escalating into more severe conditions over time.

Despite this, many employees with mental illness still experience a lack of understanding from their employers, often influenced by stereotypes in the media. This perception can lead to negative responses from employers, such as rejection or condescending attitudes (Brohan et al., 2014).

In this way, perceived organizational support could be a way to significantly reduce internalized stigma and improve mental health outcomes for employees. A supportive workplace culture fosters reduced stigma, greater psychological well-being, and greater self-esteem. These improvements, in turn, contribute to better employee retention and mental health outcomes.

Therefore, understanding the relationship between perceived organizational support and internalized stigma within the workplace may be essential. Research in this area can

inform the development of interventions aimed at promoting positive mental health outcomes, fostering more supportive work environments, and ultimately benefiting both individual well-being and organizational productivity.

### 3. Aims and Objectives

This study aims to address a significant research gap regarding the impact of perceived organizational support on psychological well-being in Portuguese workers. It also aims to explore the mediating role of internalized stigma between perceived organizational support and psychological well-being in workers with a mental illness.

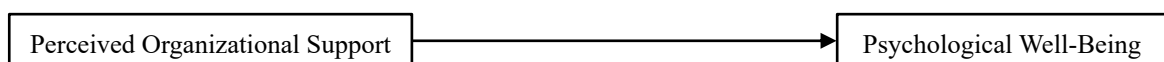
While previous research has demonstrated that perceived organizational support enhances psychological well-being by reducing stress, alleviating depression, and increasing job satisfaction (Kelley et al., 2014; Panaccio & Vandenberghe, 2009), few studies have explored whether perceived organizational support can also exert an influence on internalized mental health stigma. This stigma has been shown to reduce self-esteem, discourage help-seeking behavior, and worsen overall mental health outcomes (Catalano et al., 2021; Drapalski et al., 2013). Additionally, research on how perceived organizational support and internalized stigma together influence well-being in specific work environments, such as the Portuguese workforce, remains sparse.

As mentioned above, mental health problems are a major concern in Portugal, with high rates of psychiatric disorders affecting the working population. In this context, organizational factors such as perceived support from employers may be essential in improving employees' well-being.

Thus, the present study aims to fill this gap by investigating whether internalized stigma mediates the relationship between perceived organizational support and psychological well-being, particularly for employees with mental illness. To do that, this research includes two empirical studies.

The first part of Study 1 will examine the direct relationship between perceived organizational support and psychological well-being in the general Portuguese workforce. Based on this, the first hypothesis (H1) is formulated: Perceived organizational support is positively and significantly associated with psychological well-being.

**Figure 1.** Conceptual Model for Study 1



Mental health conditions in the workplace may pose unique challenges, particularly for employees who experience internalized stigma because of their diagnosis. Perceived organizational support may be a critical factor in promoting well-being and potentially mitigating the effects of stigma. Therefore, it is crucial to understand the mechanisms through which internalized stigma may exert an influence on how perceived organizational support is related to psychological well-being, particularly for employees coping with mental health conditions at work.

Study 2 will focus on employees with mental illness and will investigate whether internalized stigma mediates the relationship between perceived organizational support and psychological well-being. This study seeks to explore these dynamics through the following hypotheses:

H2: Perceived organizational support is positively and significantly associated with psychological well-being in workers diagnosed with a mental illness.

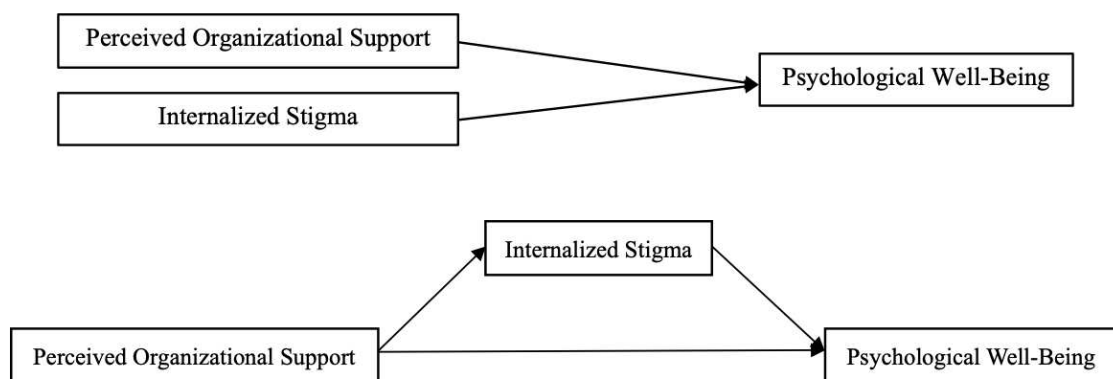
H3: Internalized stigma is negatively and significantly associated with psychological well-being in workers diagnosed with a mental illness.

H4: Perceived organizational support is negatively and significantly associated with internalized stigma in workers diagnosed with a mental illness.

H5: The relationship between perceived organizational support and psychological well-being is mediated by internalized stigma.

The purpose of this study is to understand how perceived organizational support can not only improve psychological well-being but also contribute to reducing the negative effects of internalized stigma, particularly for employees coping with mental health conditions at work.

**Figure 2.** Conceptual Model for Study Two



## 4. Method

### 4.1. Research Design

To investigate the influence of perceived organizational support on psychological well-being, as outlined in the literature review, this study employed a predictive analysis along with a mediation model to assess the role of internalized stigma. A cross-sectional design incorporating correlational and other quantitative analyses was used. Data was collected through an online survey, which included sociodemographic questions and three validated instruments to quantify all variables. The instruments were adapted and validated for the Portuguese population, and permissions from the authors of the Portuguese versions were obtained before their use.

### 4.2. Participants

#### 4.2.1. Study 1

The requirements for the participants to be part of the sample were that they had to be employed in an organizational context and be over 18 years old. Thus, a total of 278 portuguese workers participated in this study, with ages ranging from 18 to 66 years ( $M=37.05$ ,  $SD=13.18$ ). Among them, 78.8% ( $n=219$ ) identified as female, 20.9% ( $n=58$ ) as male, and 0.4% ( $n=1$ ) as transgender. Among all participants, 40.3% ( $n=112$ ) of participants reported having been diagnosed with a mental health condition (*e.g.*, depression, anxiety) by a healthcare professional at some point, while 59.7% ( $n=166$ ) had not. Of the participants who responded to having been diagnosed with a mental illness before, only 2.7% ( $n=3$ ) didn't agree to continue with the questionnaire. Additional details can be seen in Table 1. Moreover, participants worked in various fields, reflecting a wide range of professional backgrounds (see Appendix 1).

**Table 1.** Study 1 participants' characterization

Variable	<i>n</i> (%)	<i>M</i> ( <i>SD</i> )	<i>Min-Max</i>
<b>Gender</b>			
Feminine	219 (78.8%)		
Masculine	58 (20.9%)		
Transgender	1 (0.4%)		
<b>Age</b>	--	37.05 (13.18)	18-66
<b>Civil status</b>			
Single	134 (48.2%)		

Married/Civil partnership	121 (43.5%)		
Divorced/Separated	22 (7.9%)		
Widowed	1 (0.4%)		
<b>Educational level</b>			
9th grade	8 (2.9%)		
12th grade	76 (27.3%)		
Bachelor's Degree	130 (46.8%)		
Master's Degree or higher	64 (23.0%)		
<b>Type of working contract</b>			
Permanent Contract	147 (52.9%)		
Fixed-term Contract	73 (26.3%)		
Temporary Contract	20 (7.2%)		
Internship	24 (8.6%)		
Other	14 (5.0%)		
<b>Work Sector</b>			
Public	75 (27.0%)		
Private	173 (62.2%)		
Public-Private	11 (4.0%)		
Social Sector	19 (6.8%)		
<b>Company Size</b>			
Micro (up to 9 employees)	39 (14.0%)		
Small (between 10-49 employees)	53 (19.1%)		
Medium (between 50-250 employees)	65 (23.4%)		
Large (more than 250 employees)	121 (43.5%)		
<b>Antiquity in the company</b>	--	10.73 (11.59)	0-40
<b>Mental Illness Diagnostic</b>			
Yes	112 (40.3%)		
No	166 (59.7%)		

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#### 4.2.2. Study 2

Regarding the participants for this study, a total of 109 portuguese workers with a diagnosis of mental illness participated in this study, with ages ranging from 18 to 63 years ( $M=36.39$ ,  $SD=12.93$ ). Among them, 84.4% ( $n=92$ ) identified as female and 15.6% ( $n=17$ ) as male. More details can be seen in Table 2.

Like the participants from Study 1, their professional backgrounds were varied (see Appendix 2)

**Table 2.** Study 2 participants' characterization

<b>Variable</b>	<b><i>n</i> (%)</b>	<b><i>M</i> (<i>SD</i>)</b>	<b><i>Min-Max</i></b>
<b>Gender</b>			
Feminine	92 (84.4%)		
Masculine	17 (15.6%)		
<b>Age</b>	--	36.39 (12.93)	18-63
<b>Civil status</b>			
Single	55 (50.5%)		
Married/Civil partnership	48 (44.0%)		
Divorced/Separated	6 (5.5%)		
<b>Educational level</b>			
9th grade	4 (3.7%)		
12th grade	34 (31.2%)		
Bachelor's Degree	47 (43.1%)		
Master's Degree or higher	24 (22.0%)		
<b>Type of working contract</b>			
Permanent Contract	59 (54.1%)		
Fixed-term Contract	24 (22.0%)		
Temporary Contract	7 (6.4%)		
Internship	12 (11.0%)		
Other	7 (6.4%)		
<b>Work Sector</b>			
Public	32 (29.4%)		
Private	173 (56.9%)		
Public-Private	7 (6.4%)		
Social Sector	8 (7.3%)		
<b>Company Size</b>			
Micro (up to 9 employees)	14 (12.8%)		
Small (between 10-49 employees)	26 (23.9%)		
Medium (between 50-250 employees)	33 (30.3%)		
Large (more than 250 employees)	36 (30.0%)		
<b>Antiquity in the company</b>	--	10.15 (11.59)	0-38

### 4.3. Instruments

#### 4.3.1. *Perceived Organizational Support Scale*

The short version of the "Perceived Organizational Support Scale" by Eisenberger and colleagues (1986), adapted to portuguese by Santos and Gonçalves (2010), was used to measure the respondent's perception of organizational support. It consists of 8 items (*e.g.*, "The organization/institution really cares about my well-being"), divided into two factors:

cognitive component – composed of items 1, 4, 6, and 8 –, and affective component – composed of items 2, 3, 5, and 7. Responses are given on a 7-point Likert scale, ranging from 1 (“strongly disagree”) to 7 (“strongly agree”). The items 2, 3, 5, and 7 are inverted (Santos & Gonçalves, 2010).

A higher total score indicates a stronger perception of organizational support. This scale presented an internal consistency of  $\alpha = .93$ .

#### ***4.3.2. Psychological General Well-Being Index***

To measure psychological well-being, it was used the Portuguese version of the Psychological General Well-Being Index (PGWBI-S), the “Questionário Geral de Bem-Estar Psicológico” (QGBEP-R), adapted and translated by Pereira and others (2018).

This instrument is a simple and short questionnaire composed of six items, answered on a 6-point Likert scale: items 1 and 2 have six alternatives of an answer regarding intensity levels. Item 1 varies between 0 (“extremamente”) to 5 (“nada”), while item 2 varies between 0 (“senti-me cheio de energia”) to 5 (“senti-me esgotado(a)”). Items 3, 4, 5, and 6 related to frequency levels, varying from 0 (“nunca”) to 5 (“sempre”). The scores for items 2, 3, and 6 are inverted. The higher the score, the higher the level of psychological well-being. The QGBEP-R demonstrated a Cronbach’s alpha of .89.

#### ***4.3.3. Internalized Stigma of Mental Illness***

The ISMI scale is an instrument used for measuring internalized stigma (Ritsher et al., 2003) and has been validated and adapted to Portuguese population by Oliveira and colleagues (2015). The portuguese version of this scale consists of 28 items, grouped into 5 different subscales: Alienation (7 items) refers to the subjective experience of not feeling fully a member of society; Stereotype Endorsement (5 items) refers to the degree of agreement with the stereotypes commonly attributed to people with mental illness; Discrimination Experience (5 items) refers to people’s perceptions of how they tend to be treated by others; Social Withdrawal (8 items) refers to the avoidance of talking about oneself and relating to others because of the weight of the experience of having a mental illness; Stigma Resistance (3 items) is the experience of resistance to or not being affected by the stigma of mental illness.

Each item is rated on a 4-point Likert scale, where 1 indicates “strongly disagree” and 4 indicates “strongly agree”. Items 6, 23, and 25, which are part of the Resistance to Stigma subscale, are reverse scored. The subscale scores are calculated by the mean of the responses to the corresponding items. The total score is the sum of all item scores divided by the total number of item responses. The interpretation of the results is based on the 4-Category Method (Lysaker et al., 2007). Scores between 1.00 and 2.00 reflect none to minimal internalized stigma; scores from 2.01 to 2.50 indicate low internalized stigma; scores from 2.51 to 3.00 reflect moderate internalized stigma; and scores between 3.01 and 4.00 indicate high internalized stigma. This score was also treated as a continuous variable in the analysis, allowing for greater flexibility in statistical modeling, such as regression and mediation analyses.

The Resistance to Stigma subscale was excluded due to its low internal consistency in previous research (Brohan et al., 2003; Ritsher et al., 2003). The exclusion of this subscale increases the reliability and quality of the results of the study and ensures that the results are more accurate and interpretable.

In this way, the total scale presented a Cronbach’s alpha of .83. Table 3 shows the values of internal consistency of the different dimensions of the scale.

**Table 3.** Internal consistency of the five dimensions of the ISMI scale

<b>Dimensions</b>	<b>Cronbach’s Alpha</b>	<b>Number of items</b>
Alienation	.87	7
Stereotype Endorsement	.77	5
Discrimination Experience	.82	5
Social Withdrawal	.86	8

#### **4.4. Procedures**

The data was collected through an online survey, constructed using the Qualtrics Survey software, and distributed between May 19th, 2024, and July 12th, 2024. The survey link was shared across various social media platforms (*e.g.*, Facebook, WhatsApp, Instagram, LinkedIn) and with close contacts. In addition, a non-probability sampling method (snowball) was used to encourage participants to share the survey link with others, further extending the reach of the study.

Before starting the questionnaire, all respondents were informed that their participation in the study was voluntary, and the confidentiality and anonymity of the participants and their respective responses were guaranteed, as well as the possibility of withdrawing at any time without any consequences. For participants who did not have any mental health conditions, the estimated duration for answering the questionnaire was 5 to 10 minutes, whereas, for those who answered that they had a mental health condition, a second part of the questionnaire was added, with an estimated duration of 5 to 7 minutes more.

Upon being informed of this and agreeing to proceed with the questions, the first two instruments were administered. One of the survey questions was whether respondents had ever been diagnosed by a professional with a mental illness. This was an essential question to determine whether respondents were eligible to continue with the survey. For those who had not been diagnosed, the sample for Study 1, the questionnaire concluded at that point. However, for those who had been diagnosed, the sample for Study 2, the questionnaire continued with additional questions and the administration of one more instrument. The survey concluded with a note of appreciation and a list of helpline contacts and information in case any respondent required it.

#### **4.5. Data Collection and Analysis**

To prepare the database for statistical analyses, preliminary analyses were conducted, to ensure that only those who met the criteria for participating in the survey and completed it in its entirety were included. Subsequently, some variables were categorized, including participants' ages, areas of work, and antiquity in the company. Four categories were created for the age (*e.g.*, less than 24 years old) and antiquity (*e.g.*, less than 1 year) variables, while five categories were identified for the area of work variable, according to the different broader areas of work (*e.g.*, technology and engineering).

Having collected the data, descriptive statistics (*i.e.*, means, standard deviations, interquartile ranges, skewness, and kurtosis) were calculated to summarize the main characteristics of the sample. All variables are assumed to follow a normal distribution, with values of skewness between -2 to +2 and kurtosis are placed between -7 to +7 used as cut-off criteria for a normal distribution (Hair et al., 2010). In addition, the Central Limit

Theorem supports this assumption by stating that for sufficiently large sample sizes, the distribution of the sample means will approximate normality.

For Study 1, a simple linear regression analysis was conducted to determine whether perceived organizational support significantly predicted psychological well-being. In the second study, since it included the variable of internalized stigma of mental illness, only participants with a diagnosis were considered, as previously mentioned. A multiple regression analysis was conducted to test whether perceived organizational support and internalized stigma were predictors of psychological well-being. The statistical results were considered significant at a threshold of  $p < .05$ . The statistical analysis was conducted using the IBM SPSS Statistics software (version 28).

To test the indirect effect of perceived organizational support on psychological well-being through internalized stigma, a mediation analysis was conducted, using the SPSS PROCESS macro, Model 4 (Hayes, 2022, version 4.2), in which perceived organizational support was entered as the independent variable, internalized stigma as the mediator, and psychological well-being as the dependent variable. Following Preacher, Rucker and Hayes (2007) recommendations, the mediation effects were then analyzed using the bootstrapping estimation with 5000 observations.

## 5. Results

### 5.1. Study 1

#### 5.1.1. Descriptive Analysis

Firstly, an analysis of the descriptive data was conducted. Table 4 displays the mean, standard deviation, minimum, and maximum values and correlations for psychological well-being and perceived organizational support.

The descriptive statistics of psychological well-being showed that all participants have an average level of general psychological well-being ( $M=3.69$ ;  $SD = .98$ ). As for the perceived organizational support variable, the mean score was 4.21 ( $SD = 1.46$ ).

#### 5.1.2. Correlations

Psychological well-being was positively and significantly correlated with perceived organizational support ( $r = .58$ ,  $p < .001$ ), indicating that the participants who reported higher levels of organizational support were more likely to have a high psychological well-being.

**Table 4.** Descriptive statistics and Pearson correlations between Psychological Well-Being and Perceived Organizational Support

Variable	N	M(SD)	Min –Max	Skewness	Kurtosis	Correlations	
						1.	2.
1. Psychological Well-Being	278	3.69(.98)	1.17 – 6	-.14	-.52	-	--
2. Perceived Organizational Support	278	4.21(1.46)	1 – 7	-.03	-.80	.58**	-

\*\* $p < .001$

#### 5.1.3. Simple Regression Model Analysis

The results from simple regression analysis evidenced that perceived organizational support was a significant predictor of psychological well-being, explaining 33.7% of the variance in psychological well-being ( $R^2 = .34$ ). The regression model was statistically significant ( $F(1, 276) = 140.49$ ,  $p < .001$ ), indicating that for each unit increase in perceived organizational support, psychological well-being increases by .39 units ( $B = .39$ ,  $p < .001$ ). The residual analysis confirmed that there were no influential outliers and that the model fit was robust.

**Table 5.** Model Summary

R	R <sup>2</sup>	Adjusted R <sup>2</sup>	Std. Error of the Estimate	Durbin-Watson
.58	.34	.34	.80	1.90

**Table 6.** Linear Regression – ANOVA.

	Sum of Squares	df	Mean Square	F	p
Regression	89.81	1	89.81	140.49	< .001
Residual	176.43	276	.64		
Total	266.23	277			

**Table 7.** Effect of Perceived Organizational Support on Psychological Well-Being

	B	Std. Error	t	Sig.
(Constant)	2.05	.147	14.02	< .001
POS	.39	.03	11.85	< .001

## 5.2. Study 2

### 5.2.1. Descriptive Analysis

Another analysis of the descriptive data was conducted for this second study. Table 8 displays the mean, standard deviation, minimum, and maximum values and correlations for psychological well-being and perceived organizational support.

The descriptive statistics of psychological well-being showed that all participants had an average level of general psychological well-being ( $M = 3.42$ ;  $SD = .93$ ). As for the perceived organizational support variable, the mean score was 4.10 ( $SD = 1.43$ ). Finally, internalized stigma had a mean score of 1.70 ( $SD = .52$ ).

### 5.2.2. Correlations

Psychological well-being was positively and significantly correlated with perceived organizational support ( $r = .54^{**}$ ,  $p < .001$ ), indicating that the participants who reported higher levels of organizational support were more likely to have high psychological well-being. Internalized stigma was negatively and significantly correlated with psychological well-being ( $r = -.48^{**}$ ,  $p < .001$ ), whereas with perceived organizational support, there was no significant correlation ( $r = .05$ ,  $p = .56$ ).

**Table 8.** Descriptive statistics and Pearson correlations between Psychological Well-Being and Perceived Organizational Support

Variable	N	M(SD)	Min-Max	Skewness	Kurtosis	Correlations		
						1.	2.	3.
1. Psychological Well-Being	109	3.42(.93)	1.17 – 5.17	-.20	-.72	-		
2. Perceived Organizational Support	109	4.10(1.43)	1 – 7	-.05	-.51	.54**	-	
3. Internalized Stigma	109	1.70(.52)	1 – 3.24	.46	-.64	-.48**	-.05	-

\*\*p<.001

### 5.2.3. Multiple Regression Model Analysis

Results from the multiple regression model indicated that perceived organizational support and internalized stigma predicted psychological well-being. The model explained 49.1% of the variance in psychological well-being, indicating that nearly half of the differences in employees' well-being can be attributed to these two predictors.

The analysis showed that perceived organizational support had a significant positive impact on psychological well-being, with a regression coefficient of  $B = .33$  ( $p < .001$ ) and  $\beta = .513$ . At the same time, Internalized Stigma had a significant negative effect on psychological well-being, with a regression coefficient of  $B = -.80$  ( $p < .001$ ) and  $\beta = -.45$ , showing that while internalized stigma has a strong negative effect, it is slightly less impactful than the positive effect of perceived organizational support.

The overall model was statistically significant,  $F(2,276) = 51.08$  ( $p < .001$ ), confirming that the combination of perceived organizational support and internalized stigma is a meaningful predictor of psychological well-being.

Additionally, there were no concerns about multicollinearity, as evidenced by the VIF values close to one, indicating that perceived organizational support and internalized stigma are independent predictors

**Table 9.** Model Summary

R	R <sup>2</sup>	Adjusted R <sup>2</sup>	Std. Error of the Estimate	Durbin-Watson
.70	.49	.48	.67	1.80

**Table 10.** Multiple Regression – ANOVA

	Sum of Squares	<i>df</i>	Mean Square	<i>F</i>	<i>Sig.</i>
Regression	45.85	2	22.93	51.08	<.001 <sup>a</sup>
Residual	47.57	106	.45		
Total	93.42	108			

a. Predictors: (constant), Internalized Stigma, Perceived Organizational Support

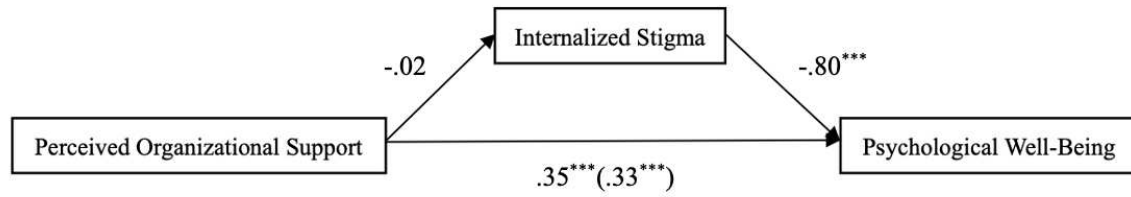
**Table 11.** Coefficients

	Unstandardized Coefficients		Standardized Coefficients			Correlations		
	<i>B</i>	Std. Error	Beta	<i>t</i>	<i>p</i>	Zero-order	Partial	Part
(constant)	3.41	.29	-	11.6	<.001	-	-	-
Perceived Organizational Support	.334	.05	.51	7.39	<.001	.54	.58	.51
Internalized Stigma	-.80	.12	-.45	-6.49	<.001	-.48	-.53	-.45

#### 5.2.4. Mediation Model Analysis

As illustrated in Figure 3 **Erro! A origem da referência não foi encontrada.**, results from the mediation model indicated that there is a significant and positive direct effect between perceived organizational support and psychological well-being ( $\beta = .35, p < .001, 95\% CI [.24, .45]$ ), which remains significant even with the introduction of the mediator ( $\beta = .33, p < 0.001, 95\% CI [.24, .42]$ ). Additionally, internalized stigma is negatively related to psychological well-being ( $\beta = -.80, p < .001, 95\% CI [-1.04, -.55]$ ), suggesting that higher levels of stigma are associated with lower psychological well-being. However, the results indicate that perceived organizational support did not significantly predict internalized stigma ( $\beta = -.02, p = .573, 95\% CI [-.09, .05]$ ). Consequently, the indirect effect of perceived organizational support on psychological well-being through internalized stigma was not statistically significant (Indirect effect =  $-.02, SE = .03, 95\% CI [-.04, .08]$ ). Thus, the relationship between perceived organizational support and psychological well-being is not mediated by internalized stigma.

**Figure 3.** Results of the mediation model



**Table 12.** Model Coefficients for Internalized Stigma and Psychological Well-Being

Outcome Variable	Predictor	<i>B</i>	<i>SE</i>	<i>t</i>	<i>p</i>	LLCI	ULCI
	Constant	1.78	.15	11.59	.000	1.48	2.09
Internalized Stigma	Perceived Organizational Support	-.02	.04	-.56	.573	-.09	.05
	Constant	3.41	.29	11.60	.000	2.82	3.99
Psychological Well-Being	Perceived Organizational Support	.33	.05	7.39	.000	0.24	.42
	Internalized Stigma	-.80	.12	-6.49	.000	-1.04	-.55

Note: LLCI = lower limit confidence interval; ULCI = upper limit confidence interval.

\*\*\**p* < .0001

**Table 13.** Model Summaries for Internalized Stigma and Psychological Well-Being

Model Summary	<i>R</i>	<i>R</i> <sup>2</sup>	<i>MSE</i>	<i>F</i>	<i>df1</i>	<i>df2</i>	<i>p</i>
Internalized Stigma	.05	.00	.28	.32	1	107	.573
Psychological Well-being	.70	.49	.45	51.08	2	106	.000

\*\*\**p* < .0001

**Table 14.** Total, Direct, and Indirect Effects of Perceived Organizational Support on Psychological Well-Being

Effect Type	Effect	<i>SE</i>	<i>t</i>	<i>p</i>	<i>LLCI</i>	<i>ULCI</i>
Total Effect (POS → PWB)	.35	.05	6.59	.000	.24	.45
Direct Effect (POS → PWB)	.33	.05	7.39	.000	.24	.42
Indirect Effect (POS → Internalized Stigma → PWB)	.02	.03	-	-	-.04	.07

*Note:* Bootstrap sample size = 5000; LLCI = lower limit confidence interval; ULCI = upper limit confidence interval. POS = Perceived Organizational Support, PWB = Psychological Well-Being. \*\*\**p* < .0001

## 6. Discussion

The workplace has become a critical area of study across various disciplines, including psychology, anthropology, and sociology, due to its significant influence on both employee well-being and organizational effectiveness (Kowalski & Loretto, 2017). With increasing awareness of mental health issues, especially in high-stress environments, organizations are adopting interventions aimed at improving mental health and job satisfaction (Noblet & LaMontagne, 2006; Cartwright & Cooper, 2013). Understanding how workplace factors, such as perceived organizational support, impact psychological well-being is essential for cultivating a supportive work environment and enhancing productivity. Research has consistently shown that focusing on employee well-being improves both quality of life and organizational health (Guest, 2017; Kowalski & Loretto, 2017).

Having this in mind, the present study had a main objective for each study. For Study 1, the aim was to examine whether perceived organizational support had a positive and significant effect on the psychological well-being of Portuguese workers in general. As for Study 2, the objective was to investigate whether this same effect occurred for workers with mental illness, while also assessing if internalized stigma of mental illness had a mediating role in this relationship.

As hypothesized, the results of Study 1 indicated that perceived organizational support positively and significantly impacted psychological well-being (confirming H1). This suggests that employees who perceive their organization as supportive and concerned, tend to experience better psychological outcomes, reinforcing the existing evidence on this topic.

This finding aligns with previous studies, such as Rhoades and Eisenberger (2002), who found that higher levels of perceived organizational support were associated with better psychological health. Additionally, perceived organizational support has been shown to buffer against stress and burnout, providing socioemotional support and increasing resilience in high-demand roles (Kurtessis et al., 2017). This is in line with resource-based models like the Job Demands-Resources model (Demerouti et al., 2001), which highlights the role of organizational support in mitigating job stress. Xu and Yang (2021) also found that perceived organizational support moderates the relationship between job stress and burnout, especially in stressful environments, by fostering a sense of belonging and

reducing emotional exhaustion. In this way, employees who perceive that their organization values their contributions and well-being develop greater resilience to workplace challenges like workload pressure or role ambiguity, leading to improved psychological well-being.

As expected, findings from Study 2 revealed that perceived organizational support had a positive and significant impact on the psychological well-being of employees diagnosed with a mental illness (confirming H2). This suggests that employees who perceive their organization as supportive experience better psychological health, regardless of mental health status.

Another potential explanation for the positive effect of perceived organizational support on psychological well-being is its influence on employee turnover. Research has shown that perceived organizational support reduces turnover intentions and behaviors and contributes to job stability, which is another key factor in improving psychological well-being (Allen et al., 2003; Rhoades & Eisenberger, 2002). Job instability has been linked to poor mental health, as prolonged insecurity leads to higher levels of depression (Rocha et al., 2006). By promoting job satisfaction and security, perceived organizational support may indirectly improve well-being through increased emotional stability.

As predicted, this study it was also found that internalized stigma negatively affected psychological well-being, supporting H3. This suggests that employees with mental illness who internalize negative beliefs about their condition experience worse psychological health. Our results are consistent with existing research indicating that internalized stigma exerts a negative influence in different domains, such as lower life satisfaction, higher levels of depression and anxiety (Pinto et al., 2023), diminished self-esteem, and worse quality of life (Oliveira et al., 2016). Internalized stigma can also create barriers to seeking support, which can increase feelings of isolation and worsen mental health outcomes (Link & Phelan, 2001).

Furthermore, internalized stigma can act as a barrier to accessing social support and mental health services, further reducing psychological well-being. For example, Hanisch and colleagues (2016) suggested that the stigma associated with mental illness discourages employees from accessing workplace health services. As a result, many employees delay seeking help until their symptoms have a significant impact on their daily lives, rather than seeking help earlier on when it could be more effective.

With the growing awareness of mental health issues among both the general and the working population, the workplace has emerged as a critical setting for mental health promotion, prevention, and intervention. However, these efforts can be compromised if stigma persists and a supportive environment is not created (Hanisch et al., 2016).

Organizations should address internalized stigma through interventions such as psychoeducation and support groups, as studies show that these types of programs can improve mental health by increasing self-esteem and resilience (Yanos et al., 2015).

Contrary to expectations, the study did not find evidence that perceived organizational support significantly reduces internalized stigma among employees with mental illness, contradicting H4. Although unexpected, this suggests that while perceived organizational support enhances the overall well-being of the majority of employees, it may not be sufficient to address the deeper, internalized beliefs associated with mental illness, at least for those who suffer from a mental health condition. This highlights the need for targeted anti-stigma interventions beyond general organizational support, as structural and social stigma is often reinforced by larger social attitudes that organizational support alone cannot overcome (Szeto & Dobson, 2010; Corrigan, 2006).

In addition, it is plausible that even in supportive environments, employees may be reluctant to disclose mental health issues out of fear of negative consequences (Jones, 2011). The persistence of informal stigma among coworkers and supervisors may also interfere with formal support efforts (Kreiner et al., 2022).

In a recent study, Schuller and colleagues (2024) suggest that stigma held by managers or colleagues may create barriers to reducing self-stigma, even when organizations provide formal support.

While this study reinforces the positive impact of perceived organizational well-being on psychological well-being, it also highlights the limitations of relying solely on organizational support to reduce internalized stigma. Future research should investigate specific interventions designed to reduce stigma and examine their effects on psychological well-being at work.

At the same time, mental health literacy initiatives could contribute significantly to reducing internalized stigma. A recent study by Roche and others (2024) defines mental health literacy as the knowledge and beliefs about mental disorders that support their recognition, management, and prevention. Thus, improving mental health literacy should

not be seen as an end in itself, but rather as an important component of a broader, more comprehensive process aimed at promoting overall positive mental health.

There were some other limitations to this study. The first one to be noted is that the sample was predominantly composed of women, which may limit the generalizability of the findings to male or other gendered workers. This is especially important because men often face additional challenges related to mental health stigma. Societal norms around masculinity can discourage men from seeking help or being open about their mental health struggles. In male-dominated industries, workers are less likely to seek professional help for emotional distress, have lower levels of mental health literacy, and are more likely to experience mental health-related stigma (Rocher et al., 2024). Differences in how men and women perceive organizational support and experience internalized stigma may also have influenced the results of this study. Future research should aim for more gender-balanced samples and examine the specific challenges men face in addressing mental health and stigma in the workplace, as well as how traditional male roles may shape their perceptions of support and well-being.

Additionally, this study focused only on Portuguese workers, which may limit the applicability of the results to other cultural and organizational contexts. Factors specific to Portugal, such as social norms and work environments, could have influenced the outcomes. Thus, future studies should include more diverse samples.

Another limitation relates to the measures used for perceived organizational support and psychological well-being. The scales used to measure these constructs had few items, which may not have fully captured the multidimensional nature of these constructs. Both perceived organizational support and psychological well-being are broad concepts that may require more detailed instruments to adequately reflect their complexity. Further, the use of a convenience sample limits the generalizability of the findings, as the results cannot be generalized with confidence to the general population. Also, causal relationships cannot be established based on this study. Future research should use more comprehensive scales and aim for more representative sampling methods to improve the robustness of the results.

Finally, this study did not account for differences in mental health diagnoses, which may result in varying levels of internalized stigma and perceptions of organizational support. Different mental health conditions could lead to distinct experiences of stigma and affect how organizational support is perceived. Future research should explore how

specific mental health conditions interact with both perceived organizational support and internalized stigma.

Given the high prevalence of mental health issues in both the general and working population, workplaces must increasingly recognize the need for addressing mental health concerns and implementing psychological interventions. While the internalized stigma of mental illness can act as a barrier to employment (Corrigan et al., 2012), individuals who internalize societal stereotypes may avoid seeking promotions or engaging fully in the workplace due to fears of rejection or failure. These internalized beliefs can prevent people from reaching their full potential, even in supportive work environments, which, in turn, may not diminish the internalization of stigma.

From a practical point of view, organizations should focus on creating supportive environments while implementing targeted mental health interventions. Addressing stigma through awareness campaigns, psychoeducation, and mental health training can foster a more inclusive workplace. A combination of general organizational support and specific anti-stigma initiatives is essential to meet employees' diverse needs and cultivate a culture of openness and acceptance. Thus, addressing mental health stigma is fundamental for maximizing the effectiveness of workplace mental health initiatives, as it can influence the perceived organizational support by those with mental health problems, which, in turn, can mitigate the harmful effects of internalized stigma and improve work performance and related outcomes.

## 7. Conclusion

The purpose of this study was to understand the impact of perceived organizational support on the psychological well-being of employees, focusing on the role of internalized stigma in this relationship for employees diagnosed with a mental illness. The main question of this research was whether a supportive organizational environment could positively influence employees' psychological well-being, and if this support could mitigate the negative effects of internalized stigma for those with a mental illness. Because of the growing attention on mental health and well-being at work, this study offers further evidence and insights on how organizations can better provide support for the psychological well-being of their employees.

Overall, these findings highlight the need for organizations to go beyond fostering a generally supportive environment and implement specific interventions that directly target stigma. By addressing the attitudes and beliefs that contribute to internalized stigma, interventions such as anti-stigma campaigns, psychoeducation, and mental health training programs can complement the benefits of perceived organizational support. Creating an inclusive workplace where mental health challenges are openly discussed and supported requires a multifaceted approach that addresses both the individual and the broader organizational culture.

From a broader perspective, this study makes an important contribution to the understanding of the role of organizational support in the promotion of the mental health of employees. Future studies should examine the effects of perceived organizational support in different cultural and organizational settings to assess the generalization of these findings. In addition, research should examine other potential mediators between perceived organizational support and psychological well-being, such as self-efficacy or mental health literacy, to develop a more comprehensive understanding of the mechanisms linking organizational support and psychological well-being.

In conclusion, this dissertation reinforces the positive impact of perceived organizational support on employee well-being while providing an understanding of its limitations regarding internalized stigma. The lack of mediation indicates that organizational support alone may not be sufficient to reduce internalized stigma. Therefore, organizations aiming to promote a mentally healthy workforce must prioritize

both general support and specific anti-stigma interventions to create a more inclusive and supportive environment for all employees.

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## 9. Appendix

### Appendix 1. Study 1 participants' categorization, by working areas

Area	<i>n</i>	%
Technology and Engineering	20	7.2
Administration and Finance	68	24.5
Health and Well-being	69	24.8
Education and Research	48	17.3
Marketing and Communications	13	4.7
Others	60	21.6
Total	278	100

### Appendix 2. Study 2 participants' categorization, by working areas

Area	<i>n</i>	%
Technology and Engineering	3	2.8
Administration and Finance	37	33.9
Health and Well-being	23	21.1
Education and Research	16	14.7
Marketing and Communications	5	4.6
Others	25	22.9
Total	109	100

### Appendix 3. “Perceived Organizational Support Scale”

	<b>Discordo totalmente</b>	<b>Discordo bastante</b>	<b>Discordo um pouco</b>	<b>Não discordo nem concordo</b>	<b>Concordo moderadamente</b>	<b>Concordo bastante</b>	<b>Concordo totalmente</b>
1. A organização/instituição valoriza o meu contributo para o bem-estar institucional.							
2. A organização/instituição não aprecia devidamente o meu esforço profissional.							
3. A organização/instituição ignora os meus protestos.							
4. A organização/instituição preocupa-se realmente com o meu bem-estar.							
5. Mesmo que desempenhasse o meu trabalho o melhor possível, a organização/instituição não iria aperceber-se.							
6. A organização/instituição preocupa-se com a minha satisfação profissional.							
7. A organização/instituição demonstra muito pouca preocupação por mim.							
8. A organização/instituição preza a minha realização profissional.							

#### **Appendix 4. “Questionário Geral de Bem-Estar Psicológico”**

##### **1. Durante o último mês, sentiu-se incomodado(a) / aborrecido(a) / nervoso(a)?**

- Extremamente (ao ponto de não poder trabalhar ou tomar conta das minhas coisas)
- Muito
- Moderadamente
- Algo (o suficiente para me incomodar/aborrecer)
- Ligeiramente
- Nada

##### **2. Durante o último mês, quanta energia ou vitalidade sentiu?**

- Senti-me cheio de energia e muito animado(a)
- Senti que o meu nível de energia variou bastante (com energia a maior parte das vezes)
- Senti que o meu o meu nível de energia variou um pouco
- Geralmente senti-me com pouca energia e pouco animado(a)
- Muito pouco animado(a) e com pouca energia, na maior parte das vezes
- Senti-me esgotado(a). Sem qualquer energia ou ânimo.

##### **3. Durante o último mês, sentiu-se abatido?**

- Nunca
- Poucas vezes
- Algumas vezes
- Uma boa parte do tempo
- Muitas vezes
- Sempre

##### **4. Durante o último mês, sentiu-se emocionalmente estável?**

- Nunca
- Poucas vezes
- Algumas vezes
- Uma boa parte do tempo
- Muitas vezes

- Sempre

**5. Durante o último mês, sentiu-se alegre?**

- Nunca
- Poucas vezes
- Algumas vezes
- Uma boa parte do tempo
- Muitas vezes
- Sempre

**6. Durante o último mês, sentiu-se cansado(a), exausto(a) ou desgastado(a)?**

- Nunca
- Poucas vezes
- Algumas vezes
- Uma boa parte do tempo
- Muitas vezes
- Sempre

## Appendix 5. ISMI scale

	<b>Discordo Totalmente</b>	<b>Discordo</b>	<b>Concordo</b>	<b>Concordo Totalmente</b>
1. Sinto-me deslocado/a no mundo porque tenho uma doença mental.				
2. As pessoas discriminam-me porque tenho uma doença mental.				
3. Procuro não me aproximar de pessoas que não têm uma doença mental de modo a evitar a rejeição.				
4. Sinto-me embaraçado/a ou envergonhado/a por ter uma doença mental.				
5. As pessoas com doença mental não devem casar.				
6. As pessoas com doenças mentais dão um contributo importante à sociedade.				
7. Sinto-me inferior àquelas pessoas que não têm uma doença mental.				
8. Não socializo tanto como anteriormente, por causa da minha doença mental, que pode fazer com que eu pareça ou reaja de forma “estranha”.				
9. As pessoas com uma doença mental não conseguem viver uma vida boa e gratificante.				
10. Não falo muito de mim mesmo/a porque não quero sobrecarregar as outras pessoas com a minha doença mental.				

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11. As ideias negativas ou estereótipos sobre as doenças mentais fazem com que me isole do mundo dito “normal”.

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12. Estar com pessoas que não têm uma doença mental faz com que me sinta deslocado/a ou inadequado/a.

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13. Não me sinto à vontade ao ser visto/a em público com uma pessoa que tem manifestamente uma doença mental.

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14. As pessoas muitas vezes tratam-me com um ar condescendente ou tratam-me como uma criança só porque tenho uma doença mental.

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15. Estou desiludido/a comigo por ter uma doença mental.

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16. Ter uma doença mental estragou a minha vida.

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17. As pessoas conseguem ver que tenho uma doença mental pela aparência que tenho.

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18. Devido à minha doença mental preciso que os outros tomem a maioria das decisões por mim.

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19. Evito situações sociais para proteger a minha família e amigos de embaraços.

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20. As pessoas que não têm uma doença mental não iriam conseguir compreender-me.

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21. As pessoas ignoram-me ou não me levam tão a sério só porque tenho uma doença mental.

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22. Não consigo contribuir em nada para a sociedade porque tenho uma doença mental.

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23. Viver com uma doença mental tem feito de mim um/a lutador/a sobrevivente.

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24. Ninguém iria querer aproximar-se de mim porque tenho uma doença mental.

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25. De um modo geral consigo viver a minha vida da maneira que eu quero.

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26. Não me sinto realizado/a ou satisfeito/a e bem com a vida, por causa da minha doença mental.

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27. As pessoas pensam que não consigo alcançar muita coisa na vida porque tenho uma doença mental.

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28. As ideias negativas ou estereótipos sobre as pessoas com doença mental aplicam-se a mim.

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