MENTAL HEALTH IS EVERYBODY'S BUSINESS:

MENTAL HEALTH STIGMA IN THE WORKPLACE

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Abstract

Title: Mental Health is everybody's business: Mental Health Stigma in the workplace

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Summary: Mental Health is a matter of utmost importance. Nonetheless, it is still intertwined with a culture of taboo and stigma. Many individuals with mental health conditions are subjected to unfair treatment as a result of stigmatized perceptions embedded in society. These stereotyped social constructs can impact their individuality coupled with undermining their capabilities, namely in the realm of employment. Thus, the present research aimed to deconstruct these cultural structures in order to understand if stigma was present in the workplace, how it was being perpetuated and whether this environment could serve as a platform to challenge it. Therefore, through the dissemination and analysis of a questionnaire, insights were gathered regarding the matter. Findings suggested that, although stigma is indeed present in the workplace, it was less manifested than anticipated. Furthermore, these stigmatized views were mainly supported by perceptions of unaccountability and incapability, thus culminating in a culture of pity and sympathy. Contrarily, physical conditions were perceived with higher accountability which prompted negative reactions such as anger. Results also underlined an interaction between the culture of the organization and the personal level of stigma. Thus, when workplaces foster stigma-free practices, participants demonstrated decreased stigma towards individuals with mental health conditions. Therefore, as the present environment revealed to be a powerful platform to challenge stigma, it is recommended to all organizations to engage in such initiatives with the aim of fostering a society exempted from stigma.

Keywords: Mental Health; Mental Health Stigma; Stigma; Conditions; Individuals with Mental Health Conditions; Mental Conditions; Physical Conditions; Trait Attribution; Workplace.

Sumário

Título: A importância da Saúde Mental: O Estigma no contexto laboral

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Sumário: Saúde Mental é uma temática de extrema relevância. Não obstante, esta está entrelaçada com uma cultura de tabo e estigma. Muitos indivíduos que padecem de psicopatologias estão sujeitos a um trato indevido como resultado de perceções estigmatizadas presentes na sociedade. Estas construções sociais impactam a sua individualidade assim como subestimam as suas capacidades, nomeadamente num contexto laboral. Consequentemente, este estudo pretendeu desconstruir estas estruturas sociais com o intuito de perceber se o estigma está presente num contexto laboral, como se perpetua e se este meio pode servir como uma plataforma para o desafiar. Por conseguinte, um questionário foi disseminado e analisado com o propósito de compreender a temática. Os resultados sugeriram que, embora o estigma esteja presente num contexto laboral, a sua manifestação é mais reduzida do que o que foi antecipado. Ademais, estas posições estigmatizadas são maioritariamente sustentadas por perceções de desresponsabilização e incapacidade, fomentando uma cultura de pena e compaixão. Contrariamente, condições físicas foram percecionadas com um maior nível de responsabilização, induzindo reações negativas como revolta. Adicionalmente, uma interação entre a cultura da organização e o nível pessoal de estigma foi também observado. Quando é fomentada uma cultura de anti-stigma num contexto laboral, as participantes manifestaram níveis de estigma mais reduzidos. Assim, uma vez que este meio revelou ser uma plataforma fulcral para desafiar o estigma, é recomendado às organizações que adotem estas medidas de modo a fomentar uma sociedade isenta de estigma.

Palavras-Chave: Saúde Mental; Estigma de Saúde Mental; Estigma; Condições; Indivíduos com psicopatologias; Condições Mentais; Condições Físicas; Atribuição de traços; Laboral

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Table of Contents

INTRODUCTION

Background and problem statement

Corrigan (2006) conceived a parallelism between mental health conditions and two-edged swords, highlighting that, as the latter, mental health conditions have the potential to strike individuals on two extremities. On the one hand, symptoms derived from the conditions can have a limiting and direct impact on individuals' lives depriving them of pursuing an independent lifestyle or attaining certain opportunities, namely in their social and work context. On the other hand, mental health conditions are often received with negative societal reactions due to stigma culminating in unfair treatment that, once again, interferes with an individual's achievements.

As touched upon, individuals with mental health conditions experience high levels of stigma whilst they move within a social space and conduct their interactions. Societal discrimination impacts all spheres of their existence, including their sense of self considering that public stigma is often embraced generating self-stigma. These stigmatizing conceptions are regularly mirrored when seeking employment and maintaining work placements. For instance, a study revealed that 47 percent of the wide public would be unwilling to work closely with an individual diagnosed with depression (Pescosolido et al., 2010). As portrayed, many individuals with mental health conditions are subjected to unfair treatment as their capabilities tend to be undermined and their work performance undervalued. Additionally, upon the disclosure of the condition at work, many become poorly perceived and are attributed less favorable personal or competence traits as a result of perceptions developed and fed within social constructs.

The present dissertation intends to understand how these stigmatized social constructs impact the workplace. Thus, if stigma concerning mental health conditions is present in this environment, how it is manifested opposed to physical conditions, whether efforts to eradicate it are being pursued by current workplaces and if fostering a favorable environment can impact the personal stigma. In detail, firstly, the present study aims to provide knowledge whether individuals with mental health conditions are perceived accurately or stigmatized, namely submitted to unjust trait attributions or distanced from. This is done in opposition to physical conditions whilst understanding if the difference is based on the perception of controllability of the conditions. Secondly, coupled with retrieving information regarding the previous matter, the study also seeks to understand if current workplaces are providing friendly environments for individuals with mental health conditions alongside fostering a culture of stigma-free initiatives

and behaviors, such as zero-tolerance policies towards mental health discrimination. After understanding whether such efforts are being pursued, this dissertation aimed to understand if there was a relation between the environment cultivated by the organization and the levels of personal stigma by the employees.

Aims and scope

In order to understand whether and how stigma concerning mental health conditions is perpetuated in the workplace, this study invited the researched population to share their perceptions on the matter, namely overall beliefs of mental conditions, work-related traits attributions and the legitimacy of mental health conditions when compared with physical disabilities. Upon understanding how stigma is sustained on an individual level, the dissertation aspires to apprehend whether current and inquired work environments are equipped to meet the needs of individuals with mental health conditions and lastly, relate the workplace culture with the level of personal stigma. Thus, the scope of the study is focused on the following research questions:

Research Question 1: How is mental health stigma manifested in the workplace?

Research Question 2: Is there a relation between workplace stigma culture and individual stigma?

This dissertation focuses primarily on mental health stigma within the workplace. Nonetheless, in order to understand how stigma is manifested in this environment, there was a need to consider its presence in society. Insights on how stigmatizing views are fostered and perpetuated within society are of pivotal importance to later comprehend how they are transferred to the realm of employment, modeling individual's behavior in their workplace. Thus, the social perspective is not the object of the study and was solely explored and inquired about in order to broaden the knowledge concerning the presence of mental health stigma in the workplace environment. Therefore, in order to answer the research subject, the following hypothesis were formulated:

Hypothesis 1: Mental health stigma is present in the workplace

Hypothesis 2: Individuals with mental health conditions are subjected more negative workplace trait attributions than those with physical conditions due to the perception of higher controllability

Hypothesis 3: Workplace culture concerning mental health conditions can influence personal stigma

Research methods

With the purpose of tackling the phenomenon previously addressed, a primary data approach was employed where a questionnaire was formulated and distributed. This questionnaire was destined to any individual who was currently working or had any former work experience. This population was aimed as they could provide insights about practices and interactions concerning mental health stigma in the workplace having been exposed to this environment, prior or currently. The sample consisted of 165 individuals with highly diverse demographics that will be explored further on.

Upon collection of answers, all statistical analyses were performed on SPSS. A descriptive approach was pursuit, treating the information quantitatively. In order to answer the formulated hypothesis, several tests were performed, namely two two-sample T-TEST, a two-way ANOVA with repeated measures, two one-sample T-TEST, a Linear Regression and a Correlation, alongside the observance of means. Following the analysis, the data collected from the questionnaire was contrasted with previous findings, secondary data, addressed on the literature review originated from scientific papers.

Relevance

Goffman (1963) defined stigma as an invisible mark that manifests as social disapproval and rejection, resulting in discrediment, isolation, wish for concealment and feelings of guilt, shame and inferiority. As a result of interaction, social constructs are built resulting in the creation of perceptions and attributions, many negative. Following its imprint in society, these stigmatizing conceptions are often transposed to the employment sphere where, as a result, many individuals struggle to find stable jobs or to maintain a current one, considering that many structures are faulty and managers unprepared.

Thus, it is of paramount importance to understand the roots of the stigma and how it is displayed in the workplace in order to address it. Through understanding what these stigmatizing structures are built on and how individuals with mental health conditions are perceived and treated in the workplace, one can start to grasp the underlying problem.
Consequently, the research conducted in this dissertation aims to better understand how stigma is displayed and understand whether workplaces can have a pivotal role in challenging personal stigma thus, ideally, leading to an eradication of mental health stigma.

Dissertation outline

The present study has been structured within five chapters. The present one, titled as introduction, concerns the problem statement and its underlying scope, research methods and relevance. The subsequent chapter presents the literature review on relevant matters such as mental health stigma and its impact in society and the workplace, alongside strategies on how to potentially eradicate it. The third chapter addresses the methodology and explores the data reliability for the statistical datasets employed in the study. Chapter four interests and discusses the main findings of the questionnaire. Lastly, the final chapter, underlines the most preeminent conclusions and discusses implications, limitations and recommendations for further research on mental health stigma in the workplace.

LITERATURE REVIEW

Mental Health Conditions

Theodore J. Kaczynski, one of the most notorious terrorists in the United States of America, argued that he would rather face the death penalty than entering an insanity defense where he would be labeled as mentally ill (Wahl, 1999). As Kaczynski, nowadays, many individuals feel reluctant to acknowledge and disclose mental health conditions.

Sean Fleming wrote, "the early years of the 21st century have witnessed a worldwide epidemic of poor mental health and related illnesses" (Fleming, 2019). Research on Mental Health has mapped that, in 2017, 792 million individuals worldwide (10.7 percent) lived with a mental health condition (Ritchie & Roser, 2020). Albeit these can lead to notable constraints undermining life quality, many individuals still feel reluctant to seek out care and engage in treatment. Prior work has shown that, in 2014, solely 37.3 percent of individuals diagnosed with a mental health condition had fully pursued and participated in interventions (Mental Health Foundation, 2018). Previous studies, which have disentangled the barriers to seeking treatment, suggest that this disparity is sustained by (1) a lack of insight regarding symptoms and how to address them and (2) the underlying stigma on mental health conditions that leads to prejudice and discrimination (Corrigan et al., 2014; Hanisch et al., 2016).

Stigma in Society

The present research aims to focus on the latter. Large-scale research by Patrick Corrigan has provided evidence that stigma is framed through four social-cognitive processes: cues, stereotypes, prejudice and discrimination (Corrigan, 2004). The cues are considered as manifest indicators of the conditions - for instance, psychiatric symptoms, social-skills deficits, physical appearance and labels (Corrigan, 2000; Penn & Martin, 1998). These will result in a stigmatizing response from others, inevitably leading to stereotyping, discriminatory behavior and the construction of labels. These labels can have harm effects as the study by Follmer and Jones (2017) highlighted. Once exposed, the condition of the individual will be considered by others as their sole identity thereby impacting how these individuals are treated (Follmer & Jones, 2017). To illustrate, Corrigan proposed a social cognitive framework exhibiting that a discriminative stimuli (signal) will trigger a cognitive mediator (stereotype) and generate a consequent discriminatory behaviour (Corrigan, 2006). Notwithstanding, it is worth noting that this matter

conveys ambiguity. Goffman alluded to the fact that not all mental illness cues will prompt stigma as some might be concealable. For instance, as such, other stigmatizing positions can be more easily concealed namely political affiliation or sexual orientation - whose awareness requires social construct (Schumacher et al., 2003). Furthermore, Brookey also suggested that some stimulus might lead to a false positive (Brookey, 2000). For instance, there is a tendency to intertwine homosexuality with effeminate conducts. This tendency is rooted on stereotyping as there is a social construct that most homosexual men portrait those features. Therefore, most men that depict that behavior, will be labeled as such by society.

Public Stigma

According to Corrigan, whereas stereotypes and prejudice represent the private experience of stigma, discrimination personificates it - instigating, therefore, public stigma (Corrigan, 2014). Previous studies revealed that this concept has a significant effect as it embeds even further stigmatized perceptions and first-hand influences the likelihood of individuals to seek out treatment (Link et al, 1997; Schomerus & Angermeyer, 2008) or attempts to integrate society (Link, 1982; Rosenfield, 1997). In order to illustrate the impact of public stigma, Pescosolido explored the factor social distance towards individuals with mental health conditions and found the levels of rejection to be substantial. For instance, 37 percent of the respondents would be unwilling to move next door to an individual with Schizophrenia and 60.6 percent would be against an individual with depression marrying into their family (Pescosolido, 2013).

Self-Stigma

The internalization of stigmatizing attitudes described above can elicit self-stigma (Hanisch et al., 2016). By accepting these conceptions endorsed culturally, many individuals with mental health conditions experience a decrease in their value and confidence, harming, therefore, their sense of self (Link, 1987; Link & Phelan, 2001). The Modified Labeling Theory shed light upon this notion indicating that labeling and public stigma impact individuals with mental health conditions, particularly their employment opportunities, networks, individuality and life quality (Link & Phelan, 1999). As internalization occurs, the more harmed the self will be. These conceptions were supported by a study regarding the family members' perceived impact of mental health stigma on their ill relatives (Wahl & Harman, 1989). 76.6 percent revealed they believe this stigma had affected their loved ones namely in self-esteem (76.4 percent), ability to make

and keep friendships (65.1 percent), recovery (47.8 percent) and willingness to admit to having mental illness (59.9 percent). In contrast, rather than engaging in character weakness, some individuals are energized by it. They experience anger towards the prejudice which boosts active participation in treatment and encourages improvements in society, namely mindset and services (Corrigan & Watson, 2006). However, the Modified Labeling Theory also approaches labeling as a "Package Deal" as it is able to induce both positive and negative outcomes. Upon undergoing treatment, individuals benefit from it and improve their condition. However, by being exposed, many are subjected to more stigma due to being officially labelled and considered mentally ill (Link & Phelan, 1999).

Attribution

Humans seek causal understanding of everyday events and behaviors by engaging in attribution. This understanding will help to identify and avoid behaviors thus facilitating the adaptation to environments and aid in overcoming challenges. Consequently, through participation in this vital automatic process of human motivation and emotion, individuals are capable of shaping emotional and behavioral responses as meanings were attributed to outcomes. (Weiner, 1982; Corrigan et al, 2000).

Meaning that, as a social compass, many engage in spontaneous trait inferences after observing a behavior. The former will elicit an unintentional attribution of trait and form an impression of an individual thus accrediting for the notion that traits refers not only to the behavior but also to the individual who is perpetuating it. Additionally, as attributions provide meaning, once this trait is inferred, it is also used to predict behavior and it is significantly harder to dismiss or correct thus potentially perpetuating wrongful and stigmatized attributions (Uleman at el., 1996; Todorov & Uleman, 2002).

These attributions can be detrimental to individuals coping with mental health conditions as negative traits will instigate stigma even further and impact them highly (Brohan et al., 2010). Therefore, the knowledge of which traits are attributed is of paramount importance as it mirrors societies' point of view and can therefore tackle misrepresentations and misunderstandings (O'Mahony, 1979). For instance, an environment highly subjected to incorrect attributions is the media, namely movies, where individuals with mental health conditions are stigmatized and poorly portrayed. Generally, they are represented as being homicidal, holding childish perceptions and often rebellious. Thus, by observing that behavior, many infer that all individuals with

mental health conditions are dangerous and to be feared (Hyler et al., 1991; Mayer & Barry, 1992).

Furthermore, situational elements are often neglected. The *discounting principle* codified by Kelley advises not to solely attribute an event to a causal agent when an additional causal agent is displayed, as some behaviors are dictated and required by certain situations. Nonetheless, many fail to do so. Thereupon humans internalize that individuals are programmed to behave in a similar pattern regardless of circumstances (Gilbert, 2002). This tendency to infer about a person's behavior disregarding the situation is referred to as correspondence bias. In order to avert it, one should always consider the individuals' surroundings and avoid the following mechanisms: lack of awareness, unrealistic expectations, inflated categorizations and incomplete corrections (Gilbert & Malone, 1995). Furthermore, as stated by Gilbert and Malone, many find it difficult to correct the trait inferences as they are constructed automatically, spontaneously and effortlessly.

Mental Health Conditions & Employment

As alluded, individuals with mental health conditions face many adversities when participating actively in society, namely, in employment. Coupled with impacting the lives of individuals, the economic consequences of mental health conditions are considerably tangible. A study conducted by the World's Health Organization evaluated that depression and anxiety cost, globally, US$ 1 trillion every year in lost productivity, both in absenteeism and presenteeism (World Health Organization, 2019). Individuals with these conditions reported, approximately, 27 lost workdays per year: 9 of them by taking time off work and the remaining 18 in lost productivity (Harvard Health Publishing, 2010). Under those circumstances, along with other beliefs, many employers feel reluctant to hire individuals with mental health conditions, which is reflected in the significantly low participation in the labor force (Mechanic et al., 2002). A prior study forecasted the employment rate for an individual with mental health conditions to be 77 percent, opposed to the 90 percent associated with those with no disorder (Baldwin & Marcus, 2007). Nonetheless, this figure can fluctuate depending on the condition as it was concluded that employment rates and the severity of the mental health condition were inversely proportional. As the severity of the illness increases, the employment rates decrease (Luciano & Meara, 2014).

Upon disclosure of their conditions, individuals become more vulnerable to stigma and discriminatory treatment in the workplace, as illustrated (Dewa, 2014). Thus, in pursuance of sheltering themselves, many adopt a concealment approach. A study revealed that 61.4 percent

would disclose a mental health condition mostly due to having a good relationship with their supervisors. On the contrary, the remaining 38.6 percent feared that sharing it would harm their career, work relationships and indicated negative experiences of others (Dewa, 2014). Therefore, prior disclosure can become a liability as some employers have voiced that their likelihood of hiring someone who disclosed their mental health condition was reduced, even when compared with individuals with physical disabilities (Brohan et al., 2012). Upon having a job, a study has evidentiated the existence of wage differentials as individuals with mental health conditions have 7.5 percent lower hourly salaries mainly due to income with work restrictions (Baldwin & Marcus, 2007). Additional research has reported that work relationships may be also affected as a study showed that 47 percent would not be willing to work closely with individuals with depression and 30 percent would not be willing to engage with them (Pescosolido et al., 2010). Additionally, scholars inquired workers with serious mental health conditions and discovered that 3.1 percent had been refused employment, 2.8 percent had been denied a promotion, 9.7 percent struggled in advancing in a job and 6.3 percent had been fired or told to resign (Baldin & Marcus, 2006).

Stigma on Mental Health Conditions in the Workplace

As depicted, many individuals with mental health conditions face discrimination in the workplace environment and are denied fair employment opportunities. These can be attributed to stigma as it lays the foundation for wrongful assumptions and notions to be fostered, resulting in predominantly negative perceptions such as lower expectations and undermining their capabilities in a work setting (Corrigan et al., 2004; Follmer & Jones, 2017a). A theoretical framework aimed to understand stigma in employment reviewed the main assumptions underlying its expressions in the workplace, which are placed within the following domains: Competence, Dangerousness, Legitimacy, Work and Mental Work as charity (Krupa et al., 2009).

Competence

It is widely believed that individuals with mental health conditions lack the competence to fulfill work requirements and demands (Krupa et al., 2009). In support of this notion, a study reported that managers felt uncomfortable employing and delegating work for these individuals as they perceived them as being less trustworthy, in need of more supervision, lacking initiative, difficulty following instructions, abiding rules and being inapt to be in a social context. The study also reported reluctance to trust them with financial matters and in handling confidential

information - thus, not meeting work demands (Biggs et al., 2010). Additional research on the matter replicated these findings, showing that individuals diagnosed with depression, bipolar disorder and anxiety were all perceived low in warmth (apart from anxiety) and competence due to their condition (Follmer & Jones, 2017b).

Dangerousness

Another assumption underlying stigma is the notion that individuals with mental health conditions are dangerous or unpredictable in the workplace. A sense of unpredictability is fostered and fed by the understanding that current stressful workplace environments fuel even further this aggressive behavior thus, embedding fear in colleagues and compromising work-related interactions (Krupa et al., 2009). Corrigan provided a framework that concerns dangerousness, explicitly, attributions, emotional responses and behavioral reactions to the impression that an individual with mental health conditions is dangerous (Corrigan, 2006). According to the study, when confronted with the perception that an individual is dangerous, people tend to respond with either anger or fear - based on the controllability element which will be delved into later. The sense of anger arises from the understanding that one's psychological behavioral disorders are controlled by the self, in opposition to physical conditions (Crandall & Moriarty, 1995). Thus, assuming that individuals can be held accountable for their actions, others develop feelings of resentment towards them which is reflected in punishment behaviors. Additionally, extensive research has supported the notion that many respond to dangerousness perceptions with fear which yields avoidant behaviors (Levey & Howells, 1995; Johnson-Dalzine et al., 1996).

Legitimacy

The domain of legitimacy is likewise referred to when discussing assumptions. A mistrust discredits diagnoses and its inherent recommendations from specialists. Equally, employers fear that workers will take advantage of their labelling and use it in order to gain access to special privileges and avoid responsibilities. At the root of this matter is the fact that these are invisible conditions in which symptoms cannot be manifested as easily as a physical disability would, in the majority of the situations (Krupa et al., 2009). When compared, symptoms that arise from a physical impairment are seldom subjected to discrimination as they are perceived to be less controllable than mental conditions (Crandall & Moriarty, 1995). In support of this notion, a framework was developed that explores the reactions towards the assumption that symptoms are controllable, or not, by exploring the ties between outcome events, attributions, affect, and behavioral responses (Corrigan, 2006). The model endorsed that people who were under the

belief that the individual was responsible for its condition and symptoms, showed anger and revealed a punishing behavior. Conversely, those who believed that the symptoms transcended the individual, responded with pity and a helping behavior.

Work

Contemporary work environments contain elements that can exacerbate stress levels and impact negatively workers' mental health. Thus, many assume that working is not healthy for individuals with mental health conditions as it is postulated that stress will trigger even further their conditions and behaviors. Being perceived as more vulnerable, employers with mental health conditions are considered to be more permeable to stress and less capable to cope with demanding environments (Krupa et al., 2009). Contrarily, several studies emphasized the importance of retaining work as it provides structure to daily life and it aids in the recovery process (Boot et al., 2015).

Work as an act of charity

The last assumption lays on the idea that providing employment for people with mental conditions is an act of charity. Many believe it is unnatural to employ these individuals based on the belief that they will represent a financial liability and the purpose of organizations is to make profit (Krupa et al., 2009).

Fostering a Stigma-free Culture in Society

Understanding how processes of stigma, its assumptions and attributions are perpetuated within social and work-related contexts is pivotal to gain insights on how to address them, elaborate anti-stigma interventions and foster stigma-free cultures (Stuart, 2004).

A study concerning the implications of coming out of the closet, considered the stigmatized communital experiences in sexual orientation and mental health to be rather similar. Findings emphasized that the gay community benefited from individual disclosure of sexual orientation as it instigated a movement and diminished its inherent stigma. It is advocated throughout the research that if people who identify themselves as mentally ill reproduced this behavior, identical outcomes could arise as the notion of having a mental health condition would be normalized. Hence, this study defends that stigma must be challenged through contact, considering that the general public is more likely to reduce its discriminatory mindset and behavior when engaging with individuals with mental health conditions (Corrigan & Matthews, 2003). Apace

with contact, Corrigan and Penn (1999) also considered protest and education to be crucial approaches to tackle discrimination and stigma. Through protesting on hostile representations on mental health conditions, stigma will be challenged in the media context, by stopping portraying inaccurate images, and by the public as they can stop believing these views. Additionally, it is argued that this approach lacks the advocacy of positive attitudes, which can be complemented by education as it provides individuals with the mechanisms to develop knowledgeable conceptions about mental health conditions (Corrigan et al., 2005; Corrigan, 2006). This notion was supported by previously made studies that reflected improvements in attitudes following the participation in education programs on mental health conditions. (Morrison et al.,1980; Thornton & Wahl, 1996).

Fostering a Stigma-free Culture in the Workplace

Significant anti-stigma initiatives have been promoted and policies imposed, on a global and national scale, in efforts to reduce the discrimination of mental health conditions in society. For instance, Mental Health First aid, an Australian initiative currently present in 27 countries, aims to diminish stigmatizing attitudes through the participation in informative workshops on mental health conditions (Szeto & Dobson, 2010). Legislation targeting employment equity has also been introduced with the purpose of protecting, promoting and underlining the obligations to employ individuals with mental health conditions (Stuart, 2006).

Even though there are a considerable number of campaigns promoting anti-stigma initiatives, similar interventions are less common within the work environment (Szeto & Dobson, 2010). Despite its frequency, mental illness in the workplace is still subjected to stigma, misunderstand and lack of support (Stratton et al., 2018). Additional research has also demonstrated a lack of confidence from organizational leaders in their competence in adequately supporting their employees with mental conditions as only 13% argued they felt "very confident" in doing so (Shann et al., 2014). In effect, abounding investigations have shed light on this matter identifying which strategies should be pursued to eradicate the stigma in this environment.

The previously mentioned approaches were corroborated by a study where workshops providing explanations of mental health conditions through personal narratives were conducted in the workplace. Participants showed promising improvements in knowledge on conditions and, slightly less but also significant, in stigmatizing attitudes thus suggesting that direct contact and education can have a bounded yet positive impact on employers' behavior towards individuals with mental health conditions (Knifton et al., 2009). In favor of this notion, similar studies have

highlighted the importance of stimulating a supportive organizational culture to boost the acceptance of individuals with conditions and aid in the process of returning to work. Thereby, it is recommended to create peer support networks and increase communication between individuals, employees and organizations (Follmer & Jones, 2017). By the same token, an exhaustive study has also argued that organizations can have a pivotal role in preventing the development, facilitating treatment and aid in the recovery of mental health conditions (Harvey et al., 2014). Thus, it delineated a practical framework on how to develop a mentally healthy workplace based on the interventions throughout the mental health journey on six main domains: (1) Designing and managing work to minimize harm by encouraging flexible hours and employee participation, (2) Promoting protective factors at an organizational level to maximize resilience through the development of policies and by ensuring manager's commitment to mental health, (3) Enhancing personal resilience with mentoring, (4) Promoting and facilitating early help-seeking through workplace counseling and support programs, (5) Supporting workers' recovery from mental illness by incorporating measures such as partial sickness absence or return-to-work programs, (6) Increasing awareness of mental illness and reducing stigma through education and trainings. This research widely endorses that adopting these six initiatives is of utmost importance considering that a responsible organization should prioritize supporting its employees and foster a stigma-free culture - which would naturally arise with the incorporation of these measures.

Hypotheses Formulation

Considering the overview provided regarding stigma of mental health conditions, mainly in the workplace context, it was possible to deduct three main hypotheses:

Hypothesis 1: Mental health stigma is present in the workplace

Prior research has proved workplace stigma concerning mental health conditions to be a constant, jeopardizing the lives of many. Nonetheless, regarding the current research, there is a need to understand whether stigma is present in the workplaces studied and to which extent. Only after, and if observable, it is possible to understand how it is perpetuated, fostered and addressed. Thus, this first hypothesis serves as a platform for the upcoming research.

Hypothesis 2: Individuals with mental health conditions are subjected more negative workplace trait attributions than those with physical conditions due to the perception of higher controllability

As it was referred earlier, mental health conditions are mainly associated with controllability. Thus, individuals who experience these conditions are often subjected to judgment as they are considered to be responsible for their disorder, and consequently, treatment. This hypothesis aims to explore whether mental health conditions are indeed subjected to a more negative trait attribution than physical conditions, which are often exempted from responsibility according to findings in the Literature Review, and if accountability is one of the factors that dictates a possible poor attribution to mental health conditions.

Hypothesis 3: Workplace culture concerning mental health conditions can influence personal stigma

As it was observed prior, workplaces that were subjected to anti-discriminatory initiatives experienced a decrease in workforce stigma towards colleagues with mental health conditions. Thus, this hypothesis concerns the impact the culture of the workplace may have on the stigma embedded in the individual. Thus, this research aims to understand whether there is a relation between both considering that, if so, it could be argued that workplaces are favorable environments to tackle stigma and eradicate it, as most individuals are subjected to these surroundings.

METHODOLOGY

The present chapter aims to unveil in detail the methodology used to answer the questions previously raised. Thus, throughout this section, matters concerning the construction of a questionnaire will be presented, namely, the materials, procedures and design. Additionally, upon collection of data, the participants and data reliability will be explored. Further information regarding these matters can be found in the appendices.

Materials & Procedures

In order to shed light on matter previously referred to, an online survey was distributed. The mentioned questionnaire was widespread through a link generated by Qualtrics Software and disseminated amongst several social media platforms, namely, Facebook, WhatsApp and LinkedIn.

Upon opening the survey, participants were confronted with a brief introduction where they were asked to collaborate in the study, taking into consideration that the information would solely be used for academic purposes and handled with confidentiality. When described what would be addressed throughout the questionnaire, there was an aim to diminish bias, thus, it was only stated that the following survey would concern perceptions and social interactions in the workplace, without mention of mental health stigma.

Following providing their consent, participants were asked to read a vignette. This proved to be an effective approach to decrease bias because as participants were not aware what they are being assessed on, the likelihood of gathering truthful answers was higher. Such method has been employed previously by renowned researchers, namely Corrigan, whose vignettes inspired the creation of a vignette that could fit this research. Thus, a vignette with a compelling narrative about an individual called James was created. James was described as a 29-year-old single male with a good educational background, currently employed as a consultant in a good company. Thereupon, workplace events and behaviors that could be explained either by physical or mental illnesses were introduced, with the intent to recognize which condition generated more stigma, and how both were perceived by the participants.

Following the vignette, participants were asked to form an impression and describe James amongst antagonic traits on a 5-point scale from (1) Reliable to Unreliable, (2) Adaptable to Unadaptable, (3) Cooperative to Uncooperative, (4) Responsible to Irresponsible, (5) Dependent to Independent, (6) Motivated to Unmotivated, (7) Meticulous to Impulsive and (8) Lazy to

Industrious, with Dependency and Laziness being inversely coded. The purpose of this question was to understand which work-related traits participants considered James to manifest, prior to having been disclosed any additional information concerning having a mental or physical condition. The participants were then subjected to a randomizer survey and assigned one of two conditions: One stating that James had a knee problem and the other revealing that James had depression. Now, exposed to further information, participants were asked, once again, to describe James on the same antagonic traits scale in order to understand whether their perceptions were manipulated following having learned about one of his conditions, and if so, which of the two conditions manifested more stigma in a work environment. As a final remark, in order to understand which reactions James behaviour awakened in the participants, the short version of the attribution questionnaire (AQ9) (Corrigan, 2003) was presented, with the following dimensions: (1) Responsibility: James is to blame for his illness, (2) Pity: I would have sympathy for James, (3) Anger: James would make me angry, (4) Dangerousness: I would feel unsafe around James, (5) Fear: James would terrify me, (6) Avoidance: If I were an employer, I would interview James for a job, (7) Coercion: If I were in charge of James' treatment, I would require him to take his medication, (8) Segregation: I think it would be best for James' community if he were put away in a hospital and (9) Help: I would help James. Likewise, this scale was administered to both conditions with the objective of understanding whether participants had different reactions to James considering his mental or physical condition, thus inferring if mental health stigma is present in the workplace. Additionally, as the original AQ9 scale, these dimensions were evaluated with a 9-point Likert scale from "Not at all" to "Very much" at the endpoints. It is worth to mention that the analysis for this scale is done thought the sum of all variables. Thus, after summing, 9 would represent little stigma whereas 81 would translate into the highest amount of stigma.

Once completed the vignette section, participants were introduced to a new part which aimed to measure personal stigma in the workplace. The set of questions were adapted from a previous scale named the "Workplace Social Distance Scale", presented in a study performed by Hatsumi Yoshii and three additional researchers (Hatsumi Yoshii et al., 2015). Thus, to these original questions from this scale (1) It would bother me to work next to a coworker with a mental health condition, (2) It is best not to associate with a coworker with a mental health condition who has been in a mental hospital, (3) Bosses with mental health conditions should not be allowed to teach how to work at the workplace, (4) I would rather not hire a person with a mental health condition who had been in a hospital, the following dimensions were added (5) I would not employ someone if I knew they had a mental health condition, (6) I believe

organizations take a risk when employing people with mental health conditions and (7) I believe people should try to conceal their mental health conditions at work. Furthermore, these items were measured using a 9-point Likert scale with “Do not agree at all” to “Completely agree” at the endpoints.

Afterwards, the participants were challenged to share their workplace culture and experiences concerning the presence of individuals with mental health conditions at their workplace. This section was designed to understand whether current workplaces were fostering stigma-free environments, thus accommodating the needs of individuals with mental health conditions. In order to gather such insights, the following items were presented using a 9-point Likert scale with “Do not agree at all” to “Completely agree” at the endpoints: (1) Mental health is a debated topic in my organization, (2) My organization values employee’s mental health, (3) My organization has a policy to protect and support employees with mental health conditions, (4) My organization has zero-tolerance policy towards mental health discrimination, (5) My organization has employed someone with a mental health condition, (6) Colleagues of mine have or had a mental health condition, (7) Colleagues of mine have publicly disclosed a mental health condition.

Prior to the demographics section, participants were introduced to a scale where they shared their overall perceptions on mental health conditions. This scale was employed in a study conducted by Feldman and Crandall (2007), however in a different context. Considering that this scale was previously employed to question participants about specific disorders instead of overall perceptions, some items could feel slightly misplaced. Regardless, the 7-point scale with antagonic dimensions, aimed to grasp whether participants had a stigmatized view of mental health conditions with the following items: (1) Not at all dangerous to others to Very dangerous to others, (2) Symptoms are the person’s fault to Symptoms are not the person’s fault, (3) Avoidable to Unavoidable, (4) Not genetic/hereditary to genetic/hereditary, (5) Quite common to Very rare, (6) Not at all disruptive in social situations to Very disruptive in social situations, (7) Not treatable with medication to Treatable with medication, (8) Causes problems at work to Do not causes problems at work, (9) Not embarrassing to have to Embarrassing to have, (10) Symptoms are not sexual in nature to Symptoms are very sexual in nature, (11) Acute (short–lived) without treatment to Chronic (long–lasting) without treatment, (12) Person is in complete control of him/herself to Person is completely unable to control him/herself, (13) Not treatable with psychotherapy to Treatable with psychotherapy, (14) One sex gets it to Both sexes gets it and (15) Potentially concealable to Publicly visible.

Before submitting their responses, the participants were asked certain questions concerning their work and personal demographics. Gathering information concerning their work context was considered to be of utmost importance taking into account that the scope of the study is the workplace. Thus, insights regarding the sector, industry, position, permanence at the company and workforce, could be later addressed in order to understand whether these factors could have an impact on the underlying stigma on the person or the culture of the organization. The final section of the questionnaire aimed to collect data regarding the sample, namely, gender, age, nationality, education background and employment status. Demographic information was requested as it could, potentially, shed light on stigma patterns.

Design

The experiment followed mixed design with a between-subjects factors (Mental Condition Vs. Physical Condition) and a within-subjects factors (Prior Vs. Posterior learning about the conditions). Through the use of a randomized survey, participants were subjected to solely one of two conditions: mental condition or physical condition. Prior to the use of the feature, participants were shown a vignette about an individual named James and asked to evaluate him amongst the work-related traits exhibited. Afterwards, participants were assigned a condition and exposed to the information that James had a mental or physical condition. Following the additional information, participants were asked to evaluate, once again, the traits displayed previously in order to understand whether, and how, the different conditions could influence trait inference and attribution.

Participants

Upon collection of responses, a sample of 165 was gathered and analyzed. Thus, it was possible to quantify that 102 were female whereas 62 were male, and one individual preferred not to identify his gender. Participants of the study revealed their age to be between 20 and 69 years old, and further research demonstrated the dominant age gap to be within the following range: 22 and 24 years old (31.1 percent). Regardless of having been disseminated worldwide, the majority of respondents (85.5 percent) exhibited a Portuguese nationality. However, other countries such as Denmark, China and Mozambique were also represented, amongst others. In fact, the sample displayed individuals from every continent. Additionally, with regards to their educational background, most participants revealed to have a masters' degree (52.7 percent)

followed by a bachelor's degree (35.8 percent), however all educational gaps were represented. Lastly, concerning participants' occupation, it was observed that the most dominant category was full-time employees (62.4 percent) and students (19.4 percent), nevertheless, once again, all occupation status were displayed.

Further data regarding participants' work were also collected as the study focused mainly on the workplace environment. From the sample, 94 participants revealed to be working in the private sector whereas the remaining 71 in the public one. When considering industries, most respondents disclosed to be working in Academia/Science (14.5 percent), Accounting and Legal (25.5 percent), or Healthcare (9.7 percent), however, all industries were represented. To understand the degree of influence in their workplace, a question concerning their position was asked, to which most stated to "Someone supervises me, I supervise no one" (53.3 percent), followed by "Someone supervises me, I supervise one or more people" (41.2 percent) and "I supervise one or more people, no one supervises me" (5.5 percent). To conclude, most participants revealed to be working in their company for less than a year (37.6 percent) or over ten years (34.5 percent). Additionally, when questioned about the workforce, the majority stated that their company consisted of mostly 10 to 50 employees (26.1 percent) and over 1000 employees (24.8 percent).

Participants' overall perceptions of mental health conditions was also explored with a 7-point scale with antagonic dimensions. Throughout that analysis, most participants demonstrated to have a slightly stigmatized yet empathic view on these conditions. In detail, when asked about the dangerousness of mental health conditions, participants revealed an M=3.47 and a SD=1.300. Furthermore, when questioned about control, most leaned towards individuals not to be in complete control of themselves (M=4.77; SD=1.166). The same pattern manifested upon asking about disruptiveness as the majority gravitated towards "Very disruptive in social situations" (M=4.60; SD=1.253) and "Causes problems at work" (M=3.33; SD=1.33). These conditions were additionally considered to be mostly "Potentially concealable" (M=3.68; SD=1.302) and mainly treated with psychotherapy (M=5.35; SD=1.204) or medication (M=5.10; SD=1.417). Participants also described mental health conditions to be mainly common (M=2.84; SD=1.423), leaning towards hereditary (M=4.27; SD=1.437) and towards unavoidable (M=4.93; SD=1.536). Thus, the majority considered the "Symptoms are not the person's fault" (M=5.61; SD=1.853). When questioned about embarrassment, responses were located in the mid-value of the scale gravitating slightly towards the "Embarrassing to have" pole (M=3.97; SD=1.859).

Data Reliability

Prior to an analysis of the results, the Cronbach's alpha was measured in order to verify whether the extracted data manifested reliability and internal consistency. As referred, some scales employed in this research were adapted from prior studies to guarantee their reliability. Regardless, to ensure all measures were consistent in the questionnaire, further analysis was performed, and Cronbach's Alpha computed for all scales.

Most scales displayed an acceptable internal consistency as they revealed Cronbach's alphas higher than 0.7. The scale concerning the work-related traits showcased an overall consistency of 0.670 whilst looking at it as a composite measure. Although, while framing its items in terms of positive or negative valence, it can be understood that, for Reliability, Adaptability, Cooperation, Responsibility, Motivation and Meticulosity, lower values will be associated with positive valence whereas higher values will be translated more negatively, with the exception of Dependency and Laziness who are inversely coded. The following scale, adapted from Corrigan, named AQ9, displayed a high Cronbach's Alpha of 0.930 and 0.945 for the mental and physical condition, respectively. Concerning personal stigma in the workplace, an analysis revealed Cronbach's Alpha to be 0.814. When the analysis was conducted regarding the workplace culture scale, an internal consistency of 0.707 was exhibited. Lastly, the scale displaying the beliefs individuals have concerning mental health conditions revealed to have the lower Cronbach's Alpha value, of 0.534.

All SPSS outputs concerning each Cronbach's Alpha can be observed further in the appendix.

RESULTS

This chapter aims to unveil and discuss the main results. Through the execution of statistical analysis performed on SPSS, it was feasible to provide answers to the hypothesis established in chapter 1. Thus, the present section will aim to test each hypothesis while showcasing the correspondent analysis performed.

Hypothesis 1: Mental health stigma is present in the workplace

In the interest of understanding whether stigma concerning mental health conditions is present in the workplace, three main analyses were conducted.

For the first test performed, a scale that aimed to acknowledge personal stigma in the workplace was observed. The analysis of the present scale was performed through the observance of the means of each item.

Results indicated that participants manifested little stigma and prejudice towards individuals with mental health conditions in a work context. For this analysis, in order to understand whether stigma was present, the values were contrasted to the scale midpoint thus any value above 4 would convey stigma. It should be considered that when asked directly, respondents could gravitate towards providing a non-stigmatized answer, thus bias could be present. Nonetheless, findings suggest that when confronted with proximity in the questions "It would bother me to work next to a coworker with a mental health condition" and "It is best not to associate with a coworker with a mental health condition who has been in a mental hospital", participants revealed a mean of 3.88 (*SD*=2.403) and 3.34 (*SD*=2.291). Concerning the capability to lead, respondents' mean demonstrated to be 3.78 (*SD*=2.450), therefore, most disagree with the statement "Bosses with mental health conditions should not be allowed to teach how to work at the workplace". Regarding the recruitment process, hiring an individual that had been in a hospital (*M*=3.73; *SD*=2.130) raised slightly more concern than hiring an individual that solely demonstrated a mental health condition (*M*=3.53; *SD*=2.130). However, when asked if they believed organizations took a risk when employing people with mental health conditions, the mean value increased to 4.56 (*SD*=2.338), indicating that even though most respondents stated they would hire individuals that displayed these conditions, they similarly believe them to represent a possible liability. Lastly, when confronted with the notion whether individuals should try to conceal their mental health conditions at work, the mean value increased to 4.68 (*SD*=2.613).

Secondly, a two-sample T-TEST between the two conditions was performed. The present analysis was selected considering the sample: two independent groups of people that had been submitted to different information, either that James had depression or a knee problem. The analysis aimed to grasp how participants perceived individuals with each condition, thus inferring if one was more prone to stigmatization. Both were evaluated in the context of the vignette, being assessed through the AQ9 scale with the following independent variables: Responsibility, Pity, Anger, Dangerousness, Fear, Avoidance, Coercion, Segregation and Help.

Whilst analyzing the Sig. (2-tailed), considering the Levene's test for Equality of Variances, solely Pity (p=.000) and Anger (p=.003) revealed to be statistically significant for a p-value lower than 0.05. Furthermore, Segregation (p=.063) and Help (p=.051) could additionally be considered statistically significant for a p-value of 0.1. Regarding the remaining variables, the null hypothesis was assumed thus considering that the means for both groups were similar and not statistically significant.

Regarding Pity (t (163) = 5.544; p<0.05), results showed that participants showed a higher degree of pity towards an individual with a mental health condition (M=6.9886; SD=2.11451) rather than an individual with a physical condition (M=5.2337; SD=1.92556). Concerning Anger (t (163) = -2.978; p<0.05), respondents demonstrated they felt more anger towards an individual with a physical condition (M=4.4029; SD=2.07909) than an individual with a mental health condition (M=3.4659; SD=1.95906). With regards to Segregation (t (155.199) = -1.854; p<0.1), participants manifested more segregation towards the physical condition as the mean (M=2.9610; SD=2.10539) was higher than the mean for the mental condition (M=2.3864; SD=1.84099). With respect to Help (t (163) = 1.963; p<0.1), participants felt more inclined to help an individual with a mental condition (M=7.3977; SD=1.78461) instead of an individual that displayed a physical condition (M=6.8312; SD=1.92219).

In order to complement the analysis, an exploration of the Attribution Questionnaire was done. It was observable that the stigma regarding those who were exposed to the mental condition showed a wider range from 16 to 57 (M=30.863; SD=8.006; X=32,00), whereas those subjected to the physical condition were located within the following values: 22 and 55 (M=35.090; SD=7.143; X=39,00). Therefore, from these values it was possible to infer that the physical condition was subjected to more stigma within those AQ9 variables.

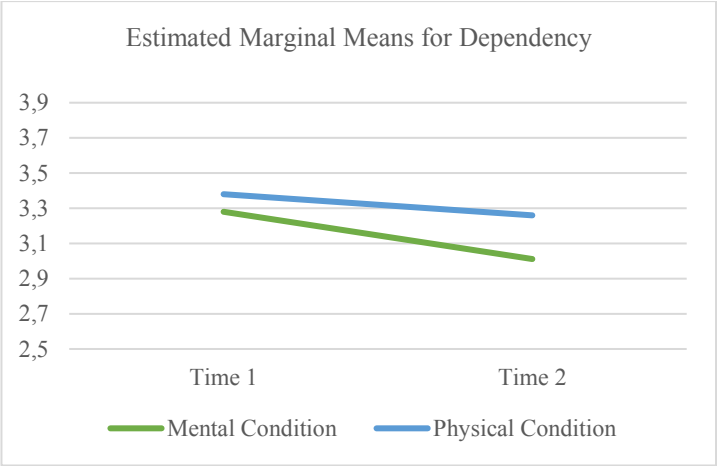
Hypothesis 2: Individuals with mental health conditions are subjected more negative work-place trait attributions than those with physical conditions due to the perception of higher controllability

In order to understand whether individuals with mental health conditions were subjected to mainly negative trait attributions, and whether the perception of controllability was the reason, four main analysis were performed.

Firstly, a two-way ANOVA with repeated measures was computed. The present analysis considered the within-subject factor to be time as participants were observed at two different points (Prior and Posterior receiving the information about the condition) and the between-subject factor to be the conditions (Physical Vs Mental). Although the analysis was computed for all variables solely Dependency, Responsibility and Motivation revealed to be statistically significant. To complement the analysis, a two-sample T-TEST solely concerning the Posterior moment for both conditions was performed and shall be mentioned.

Concerning Dependency (F (1, 163) = 8.510, $p < 0.05$), solely the main effect time of the within-subjects effects revealed to be statistically significant (p=0.004). By aggregating both conditions, it is noticeable that differences between the two times were present: Prior (M=3.33; SD=1.001) and Posterior (M=3.127; SD=0.97006). Thus, inferring that the individual was perceived as more dependent in the second time set, revealing that learning about the condition impacted participants' perceptions.

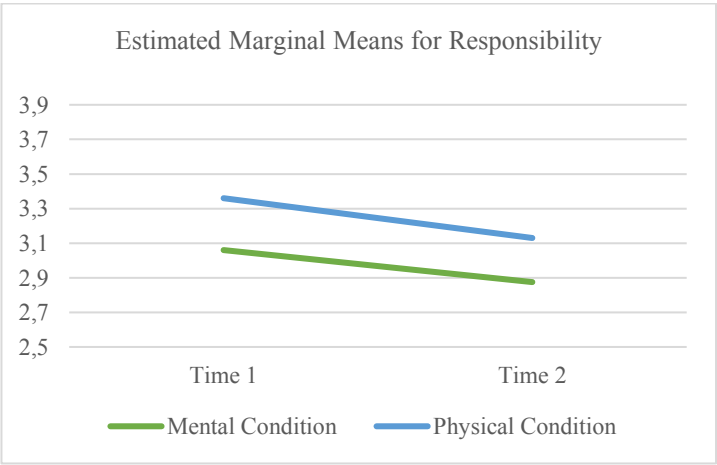
Further analysis conducted through an independent sample T-TEST, concerning solely the second time set for both conditions, revealed that participants perceived those with mental conditions (M=3.0114; SD=1.01167) to be much more dependent (t(163)=-1.649; p<0.1; p=.101) than those with physical conditions (M=3.2597; SD=0.89447) in the second moment after learning about the condition.



Graph 1 – Estimated Marginal Means for Dependency before and learning about the condition

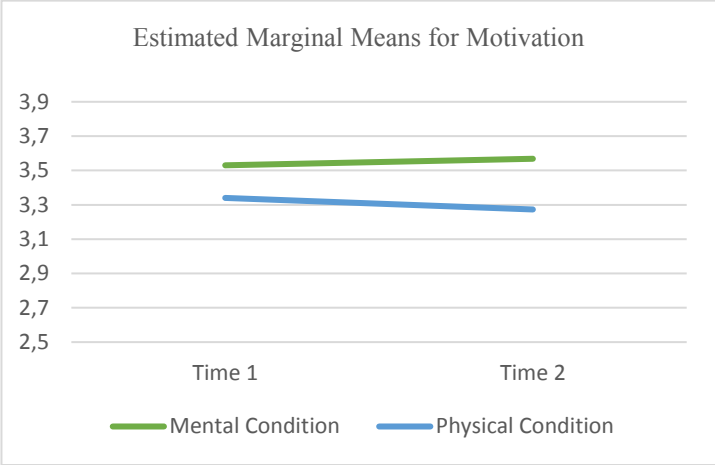
Regarding Responsibility, the Test of within-subjects effects concerning time (F (1, 163) = 8.833, $p < 0.05$) and Test of between-subjects effects (F (1, 163) = 4.039, $p < 0.05$) revealed to be statistically significant. It is observable that there were differences between the two-time sets (p=0.003) and the individual was perceived as more responsible the second time set (M_{Prior}=3.20; SD_{Prior}=1.005; $M_{Posterior}$=2.9939; $SD_{Posterior}$=0.95953). Furthermore, differences were observed between conditions (p=0.046) as participants perceived the individual as more responsible after learning about both conditions.

Further analysis conducted through an independent sample T-TEST showed that respondents considered the mental condition (M=2.8750, SD=0.94459) to be more responsible (t(163)=-1.712; p<0.1; p=.089) than the physical one (M=3.1299, SD=0.96451) in both time sets.



Graph 2 – Estimated Marginal Means for Responsibility before and after learning about the condition

With regards to Motivation, a significant p-value on between-subjects effects (F (1, 163) = 3.054, $p < 0.10$) was observed (p=,082). It could be understood that, after being exposed to the additional information, the individual with the physical condition (M_{Prior}=3.34; SD_{Prior}=.995; $M_{Posterior}$=3.2727; $SD_{Posterior}$=0.94083) was perceived to be more motivated whereas the individual with the mental condition was perceived as less motivated (M_{Prior}=3.53; SD_{Prior}=1.039; $M_{Posterior}$=3.5682; $SD_{Posterior}$=1.09119). Such results could be related with the lack of motivation being one of the perceived side-effects of depression, thus being a manipulation check.
Further analysis conducted through an independent sample T-TEST, corroborated such findings and demonstrated that participants perceived individuals with mental health conditions (M=3.5682; SD=1.09119) to be less motivated (t(162.969)=1.868; p<0.1; p=.064) than individuals with physical conditions (M=3.2727; SD=0.94083).



Graph 3 – Estimated Marginal Means for Motivation before and after learning about the condition

Although the effects from the ANOVA were not significant, the independent sample T-TEST, shed light upon the variable Laziness (t(163)=1.688; p<0.1; p=0.093) demonstrating that participants considered the individual with the physical condition (M=2.9481; SD=0.79300) to be more lazy than the one with the mental condition (M=3.1705; SD=0.88696), after learning the additional information.

Furthermore, one-sample paired T-TEST were computed for both conditions with the same variables. The purpose of the analysis was to understand the differences between the traits attributions, prior and posterior, for each condition.

Concerning the mental condition, while observing the p-value, it was gathered that solely the variables Dependency (p=0.018) and Responsibility (p=0.077) demonstrated to be statistically significant for a p-value of 0.05 and 0.1, respectively. Participants considered James to be less independent (t (87) = 2.417; p<0.05) after learning about his condition as the mean decreased from 3.28 (*SD*=1.072) to 3.01 (*SD*=1.023). Concerning Responsibility (t (87) = 1.789; p<0.05 the inverse occurred. Following the information participants considered James to be more responsible (*M*=2.88; *SD*=0.945) after learning that he had depression than prior (*M*=3.06; *SD*=1.043).

A second paired T-TEST was conducted regarding the physical condition. When analyzing the p-values, solely the variable Responsibility (p=0.015) revealed to be statistically significant for a p-value of 0.05 and the variable Dependency (p=0.060) for a p-value of 0.1. About Dependency (t (76) = 1.909; p<0.1), participants considered James more independent before (*M*=3.38; *SD*=0.918) learning about his condition (*M*=3.26; *SD*= 0.894). The contrary was observed regarding Responsibility as participants considered James to be more responsible (t (76) = 2.485; p<0.05) following learning about this condition as the mean decreased from 3.36 (*SD*=1.050) to 3.13 (*SD*=0.965).

Although for the remaining variables the null hypothesis was assumed thus considering the means for both conditions to be similar and not statistically significant, it could be relevant to touch upon them briefly in order to understand how individuals were perceived solely in the second moment.

It was understood that the mental condition was attributed to more negative traits than the physical condition, thus conveying more stigmatization. Participants portrayed individuals with mental health conditions to be more unreliable (*M*=3.2529; *SD*=0.97906) than those with a physical condition (*M*=3.1418; *SD*=1.003). A similar scenario was observed with the majority of the variables where individuals with mental conditions were identified as more unadaptable (*M*=3.1477; *SD*=0.92897), unmotivated (*M*=3.5682; *SD*=1.09119), dependent (*M*=3.0114; *SD*=1.02267) and impulsive (*M*=3.4318; *SD*=0,98021) than individuals with physical conditions: Adaptability (*M*=3.1039; *SD*=0.86731), Motivation (*M*=3.2727; *SD*=0.94083), Dependency (*M*=3.2597; *SD*=0.89447) and Meticulosity (*M*=3.4026; *SD*=0.90699). Contrarily, those who manifested physical conditions were portrayed by participants as more lazy (*M*=2.9481; *SD*=0.79300), uncooperative (*M*=3.1039; *SD*=0.88235) and irresponsible (*M*=3.1299;

SD=0.96451) than those with mental health conditions: Laziness (*M*=3.1705; *SD*=2.9481), Co-operation (*M*=3.0114; *SD*=0.95285) and Responsibility (*M*=2.8750; *SD*=0.94459).

Hypothesis 3: Workplace culture concerning mental health conditions can influence personal stigma

Concerning the third hypothesis, firstly, means were observed in order to understand how current workplaces were engaging with stigma-free practices. With respect to the openness of the organization, the mean revealed to be 4.41 (*SD*=2.739). Responses from "My organization values employee's mental health" demonstrated to be fairly distributed with a mean of 4.88 (*SD*=2.782). Regarding the existence of a policy to protect and support employees with mental health conditions, the mean was 4.27 (*SD*=2.712). The results for a zero-tolerance policy towards mental health discrimination reflected similar values as before (*M*=4.39; *SD*=2.631). When asked about the hiring process, findings demonstrated a mean of 5.35 (*SD*=2.643) concerning having employed individuals with a mental health condition. Furthermore, when questioned whether "Colleagues of mine have or had a mental health condition" (*M*=5.58; *SD*=2.737), it was observed that 26.1 percent of people gravitated towards the "Completely agree" value. However, in contrast, when asked if "Colleagues of mine have publicly disclosed a mental health condition", the mean decreases to 4.25 (*SD*=2.742) and the "Completely agree" value decreased to 12 percent. Such finding suggests that many individuals manifest(ed) mental health conditions, however, chose not to disclose nor share them.

In order to deepen the understanding regarding the relation between workplace culture and personal stigma, additional analysis was conducted.

A linear regression was performed to understand whether culture of the organization could predict individual stigma perpetuated by individuals. For that, the mean of the personal stigma scale was used as a dependent variable whereas the items of the culture of the organization scale embodied the independent variables. When accounting for the p-value, it is observable that the model is statistically significant (F (7,157) =2.251, p=.033). Additionally, through the R square, it can be inferred that 9.1 percent of the variance in personal stigma can be explained by the culture of the organization. Before engaging in the analysis, it is worth noting that all elements of the scale were tested, nonetheless, not all revealed to be significant predictors. When addressing the predictors individually, solely "My organization has employed someone with a

mental health condition" (p=.005) and "Colleagues of mine have publicly disclosed a mental health condition" (p=.034) revealed to be statistically significant. Meaning that there is a significant relationship between these two predictors and the internal level of stigma. Therefore, findings suggest that the disclosure of the condition and the hiring of individuals with mental health conditions revealed to be important factors in decreasing the amount of personal stigma.

Additionally, for the same purpose, a correlation between the items from the scale of work culture and the scale of personal stigma was executed. Although all items of the scales were accounted for, solely some correlations could be observed. The item "My organization has employed someone with a mental health condition" proved to be an important indicator as it inversely correlated with the following items: "It would bother me to sit next to someone with a mental health condition" (r(163)= -0.214, p= .006), "It is best not to associate with a coworker with a mental health condition who had been in an mental health hospital" (r(163)= -0.237, p= .002) and "I would rather not hire a person with a mental health condition who had been in a hospital" (r(163)= -0.266, p= .001). Thus, when organizations hire more individuals with mental health conditions, participants revealed to be more willing to sit next to, associate or hire an individual who has been in a hospital. Furthermore, the item "I believe people should try to conceal their mental health condition at work", correlated negatively with "Mental health is a debated topic in my organization" (r(163)= -0.180, p=.020), "My organization has a policy to protect and support employees with mental health conditions" (r(163)=-0.175, p=.025) and "My organization has employed someone with a mental health condition" (r(163)=-0.184, p= .018). Thus, implying that people are less likely to believe individuals should conceal their conditions at work when mental health is a debated topic, when there is a policy in action and when the organization has employed individuals with mental health conditions.

CONCLUSIONS AND LIMITATIONS

The present chapter aims to highlight the main conclusions of the dissertation, alongside exposing its implications and limitations. Furthermore, future research and recommendations will be presented.

Main conclusions

The present research aimed to create a sequence logic whilst creating the hypothesis and presenting the results. Thus, the same approach will be exhibited here as the main conclusions will be presented, and divided, within hypothesis.

Hypothesis 1: Mental health stigma is present in the workplace

Participants showed lower levels of stigma towards individuals' mental health conditions than it had been anticipated. The little prejudice manifested was reflected in mostly non-stigmatized answers, for instance, in the willingness to engage and hire individuals with mental health conditions and the trust in their capacity to lead. As mentioned, concerning the engagement, most people revealed to have high levels of willingness to proximity and association. These results were more optimistic than a study previously conducted (Pescosolido et al., 2010) where 47 percent would not be willing to work closely with individuals with depression, opposed to the 3.6 percent manifested here. Nonetheless, one cannot consider that stigma was not present in these results. For instance, most participants mirrored that they would be highly receptive to hiring an individual that displayed such conditions. However, many still remained reluctant which could be also reflected in the question whether hiring individuals represented a risk, to which many considered so. These findings corroborated previous research that stated that the likelihood of hiring was reduced, and many individuals had been refused employment (Brohan et al., 2012; Baldin & Marcus, 2006). Furthermore, even though more participants demonstrated progressive views, many still consider that individuals should seek a concealment approach thus hiding their condition at work - which has been the decision for 38.6 percent of individuals due to fear (Dewa, 2014). Nonetheless, it is worth noting that the values for this particular question were well distributed revealing that the number of participants that endorsed a concealment (12.1 percent) or exposure (15.2 percent) approach were rather similar.

Upon contact with individuals with mental health conditions, participants revealed a non-anticipated reaction. Thus, stigma was present but not perpetuated through the expression of mainly negative perceptions. Participants considered mental health symptoms to transcend the individual, alongside with their incapacity to control themselves, thus, perceiving the conditions as unavoidable. From these views a sense of unaccountability was expressed which prompted mainly reactions of pity and help. Contrarily, the physical condition was linked with controllability thus culminating in a higher degree of anger and segregation. Such findings can be supported by a framework provided by Corrigan (2006) which suggests that when individuals are under the impression that symptoms are not controlled by the individual, they tend to develop emotions of pity which prompts a helping behavior. Diversely, higher accountability can lead to a reduced willingness to help and resentment (Crandall & Moriarty, 1995).

Therefore, the first hypothesis revealed to be supported as stigma towards individuals with mental health conditions is present in the workplace. Nonetheless, it is less visible than expected and is rooted mostly on emotions of pity due to participants considering the conditions to be unavoidable. The opposite was observed with physical conditions, which were perceived to convey more accountability and thus, generating more anger. Additionally, it could be interesting to note that even though the majority of participants portrayed themselves as open-minded and progressive towards individuals with mental health conditions, many demonstrated negative perceptions concerning mental conditions as a whole. Through the analysis of the overall perceptions on mental conditions, it was observed that most participants gravitated towards the negative beliefs that mental health conditions are dangerous to others, cause problems at work, are disruptive in social situations and embarrassing to have.

Hypothesis 2: Individuals with mental health conditions are subjected more negative workplace trait attributions than those with physical conditions due to the perception of higher controllability

Participants did manifest slightly more stigmatized views upon individuals with mental health conditions. Nonetheless, once again, the tendency to intertwine physical conditions with a sense of accountability was higher than with mental conditions. Therefore, the former was not exempted from negative trait attributions either.

As a result of stereotyping, it is widely believed that individuals with mental health conditions are in need of more supervision and lack the competence to perform certain work-related tasks

(Biggs et al., 2010). Additionally, they are perceived as more fragile and vulnerable thus incapable to cope with certain environments (Krupa et al., 2009), which could be translated into lack of motivation. Such stigmatizing views were indeed held in the findings as participants perceived individuals with mental health conditions to be more unmotivated and dependent. Further observance also shed light on the matter revealing that individuals with mental health conditions were also considered to be more unadaptable and impulsive. However, a culture of unaccountability was also present as participants perceived the individual as more responsible following the additional information that he had a condition.

Furthermore, as referred to prior, physical conditions conveyed more perceived controllability thus prompting negative reactions from participants, as they consider the outcomes the individuals' responsibility. Therefore, these conditions were reflected more negatively by participants as they considered the individual with a physical condition to be more irresponsible and lazier. It could be argued that participants perceived the individual with a physical condition to be more reckless thereby being more liable for their actions and consequences, opposed to the mental condition. Contrarily, previous research by Crandall & Moriarty (1995) suggested that physical conditions would be associated with a lower level of accountability. Nonetheless, it could be argued that it is contingent to the nature of the disease and other conditions could not prompt such reactions from the participants nor be associated with accountability, which shall be discussed in the limitations.

Therefore, the second hypothesis revealed to be partly supported as individuals with mental health conditions are indeed subjected to more negative and stigmatized attributions. However, these are not the result of a culture of accountability. Instead, a culture of pity, unavoidableness and incapability was witnessed considering that mental health conditions prompted feelings of compassion and sympathy rather than feelings of anger and resentment. Nonetheless, these reactions can still be perceived as stigma as many do not reflect accurate presentations thereby highlighting the presence of stereotypes. Thus, unfair perceptions of mental health conditions are still being fostered in society and being translated into the workplace context. Such behavior, as poor trait attribution, can be very disruptive as it perpetuates stigma even further.

Hypothesis 3: Workplace culture concerning mental health conditions can influence personal stigma

While assessing whether workplaces were fostering stigma-free environments, it could be observed that there was no predominantly polarized response. As displayed, approximately half are adapting and providing support to individuals with mental health conditions which reflects a progressive approach. Nonetheless, some are still not engaging in such practices thus suggesting that there is still room for improvement. Additionally, despite the forward-looking views, results demonstrated that individuals are still reluctant to publicly disclose their mental health conditions at work which could be interpreted as counterproductive in the movement towards a stigma-free environment.

Furthermore, the workplace was considered to have a pivotal role in the manifestations of personal stigma. Therefore, in order to challenge it, the present environment should be mindful of the impact that the culture they foster can have of their employees and, consequently, society. Findings revealed that, when subjected to interaction with individuals with mental health conditions in the workplace, participants tended to diminish the level of personal stigma. To illustrate, when organizations hire more individuals with mental health conditions, participants revealed to be more willing to sit next to, associate or hire an individual who had been in a hospital. Additionally, participants were less likely to believe individuals should conceal their conditions at work when mental health is a debated topic, when there is a policy in action and when the organization employed individuals with mental health conditions. These findings corroborated previous researches showcased in the Literature Review that defended contact to be an element that could challenge stigma, thus suggesting that people would be more likely to reduce its discriminatory behavior through exposure to individuals with mental health conditions (Corrigan & Matthews, 2003; Knifton et al., 2009).

Therefore, results showed the third hypothesis to be confirmed as there was a relation between the culture of the organization and the individual level of stigma. Despite the fact that solely half of the current workplaces are showing progressive views, it was observed that when the culture is more engaging and supportive, individuals tend to manifest lower levels of stigma. Thus, it is possible to infer that the workplace revealed to be an extremely important platform to challenge stigma. Considering that most people are subjected to workplace environments, if all would foster stigma-free approaches and encourage its eradication, personal levels of stigma would certainly decrease. Therefore, it can be concluded that workplaces should engage with such practices of hiring and exposing employees to individuals with mental health conditions.

Managerial Implications

We are the product of a society who proudly aims to shatter the paradigms, who perceives themselves as tolerant, who considers voicing their needs a birthright. However, equality is not a virtue shared by all and many minorities are still subjected to stigma. This so-called privilege is still unattainable for many and the present dissertation aimed to illustrate how this is a reality for individuals who suffer from mental health conditions. As a result of faulty structures and stigmatized perceptions embedded in society, many are deprived from opportunities within the realm of their individuality and employment. Thus, firstly, the present research aimed to raise awareness for this matter and, hopefully, sensitize the reader for the challenges faced by those who suffer from mental health conditions in order to instill a sense of change and support whilst normalizing these conditions.

Furthermore, solely after understanding the foundations that hold stigma, is one able to deconstruct them. Therefore, after observing how these stigmatized structures are fostered in the workplace, insights on how to tackle it and stimulate positive perceptions were suggested, namely through contact. Thus, the present research revealed this context to be an effective platform to challenge stigma as most individuals are exposed to the workplace environment daily. Hence, hopefully, considering prior insights, workplaces can now understand the importance and instilled responsibility of fostering stigma-free environments and the positive impact that those can have to diminish, and ideally, eradicate stigma in society.

Limitations

The present investigation conveys certain limitations that can have a disruptive role in the prosperity of the results. Nonetheless, when recognized, these can be efficient for the success of future research.

The first limitation exhibited concerns the sample. A highly diverse sample was presented, accounting for the people from different countries, educational backgrounds, work fields and ages. An extensive sample is considered to be an asset, however, in this study the diversity was not portrayed equally, which could be perceived as a liability. Thus, not targeting a particular group of people will reflect in a broader overview, which can be interesting, however, more inconclusive in terms of answers.

A second limitation lies within the amount of answers from each condition. When computing the survey, a randomizer was used where an equal number of participants would be submitted

to each condition. Nonetheless, this was not observed as the physical condition displayed 77 participants whereas the mental condition exhibited 88 respondents. Therefore, as a result of disparity where conditions were not equally distributed, the results could be altered slightly and not completely representatively.

The third limitation considers the gathering of data. Within the questionnaire, some questions were more straightforward and asked directly how participants felt regarding certain topics. As participants recognize that having stigma is perceived as something negative, they could be more prone to delivering politically correct responses instead of responses on how they truly feel. Thus, it should be considered that, when asked directly, respondents could gravitate towards providing a non-stigmatized answer which would generate the presence of bias and a non-reflective sample on the actual perceptions of the respondents.

Additionally, throughout the study it was observable that participants associated a sense of control with the physical condition, perceiving that the knee injury was one's responsibility thus generating anger. Nonetheless, one cannot generalize all physical conditions as not all convey accountability. For instance, if the research had been done with an autoimmune disease instead of a knee problem, certainly the results would have been much different as participants, most likely, would not have evoked a sense of responsibility and, consequently, anger.

Future research

Several avenues of research could be followed when addressing this theme given its contemporary character.

A possible exploration concerns the reactions towards mental or physical conditions. Prior studies suggested mental conditions to be subjected to more stigmatized answers from society. Nonetheless, it was observed in this dissertation that negative stigma was not particularly displayed as it prompted feelings of help rather than segregation. Contrarily, physical conditions prompted more negative inferences from the participants. Thus, it would be interesting to look further and understand how both conditions are perpetuated considering that the initial conception that stigma on mental health conditions would be more negatively perceived than physical conditions did not reveal to be completely accurate. As mentioned previously, it could be interesting to contrast diseases that are generally not portrayed as one's responsibility, such as autoimmune ones, with a mental health condition.

Furthermore, another particular topic was considered to be worthy of explanation considering its strong values and possibilities of exploration. The matter concerns the relationship between

familiarity and stigma. Research suggests that augmenting the level of engagement and familiarity with individuals with mental health conditions in the workplace will result in a decrease of stigma on the same environment. Such findings could be explored and applicable on the mentioned environment or even broaden it to society. Therefore, by understanding deeply how contact challenges stigma, one could be closer to eradicate it fully in all contexts.

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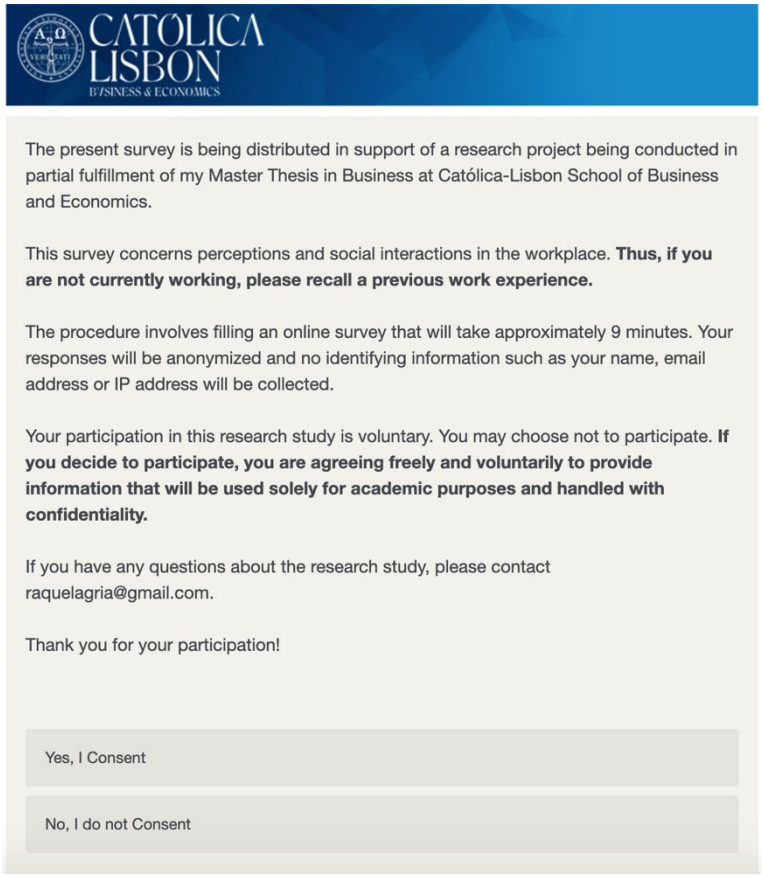
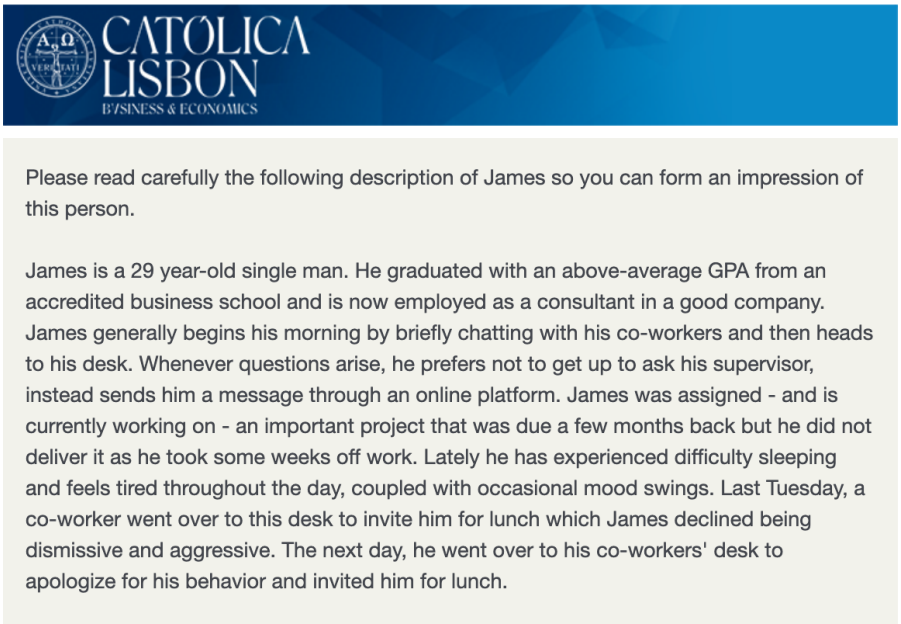
Appendices

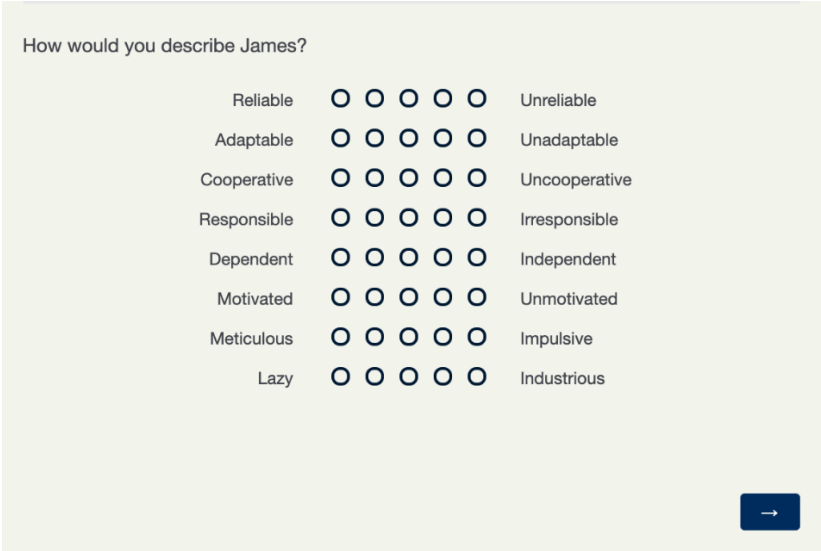
Appendix I: Survey

Block 1: Introduction

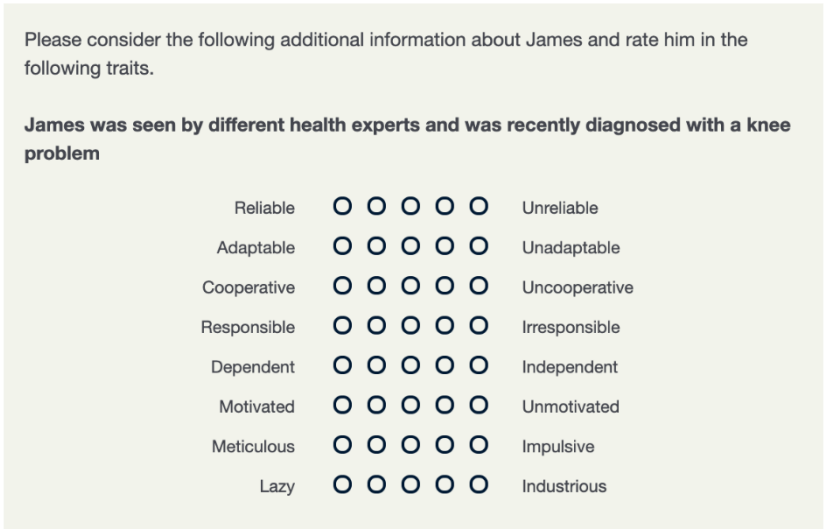


Block 2: Vignette and work-related traits





Block 3 and 4: Work-related traits and AQ9 for both conditions



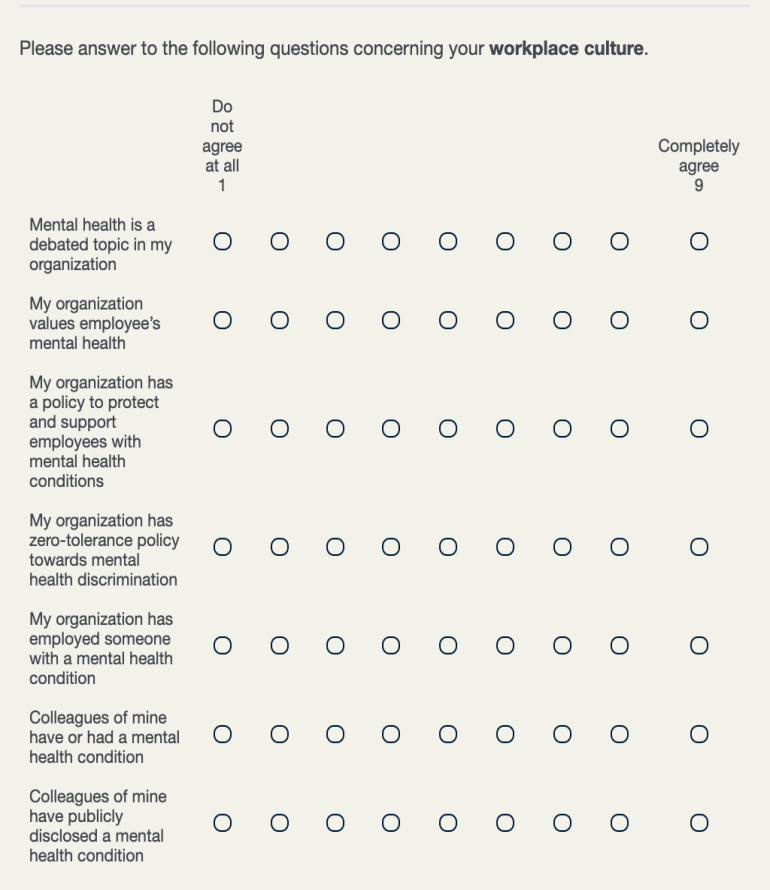
Considering the vignette and the additional information, please answer the following questions about James.

	Not at all								Very much
James is to blame for his illness	O	O	O	O	O	O	O	O	O
I would have sympathy for James	O	O	O	O	O	O	O	O	O
James would make me angry	O	O	O	O	O	O	O	O	O
I would feel unsafe around James	O	O	O	O	O	O	O	O	O
James would terrify me	O	O	O	O	O	O	O	O	O
If I were an employer, I would interview James for a job	O	O	O	O	O	O	O	O	O
If I were in charge of James' treatment, I would require him to take his medication	O	O	O	O	O	O	O	O	O
I think it would be best for James' community if he were put away in a hospital	O	O	O	O	O	O	O	O	O
I would help James	O	O	O	O	O	O	O	O	O

Block 5: Perceptions of workplace stigma and workplace culture

Please answer to the following questions concerning your **perceptions of mental health conditions in the workplace**.

	Do not agree at all 1								Completely agree 9
It would bother me to work next to a coworker with psychosis	O	O	O	O	O	O	O	O	O
It is best not to associate with a coworker with a mental health condition who has been in a mental hospital	O	O	O	O	O	O	O	O	O
Bosses with mental health conditions should not be allowed to teach how to work at the workplace	O	O	O	O	O	O	O	O	O
I would rather not hire a person with a mental health condition who had been in a hospital	O	O	O	O	O	O	O	O	O
I would not employ someone if I knew they had a mental health condition	O	O	O	O	O	O	O	O	O
I believe organizations take a risk when employing people with mental health conditions	O	O	O	O	O	O	O	O	O
I believe people should try to conceal their mental health conditions at work	O	O	O	O	O	O	O	O	O



Please answer to the following questions concerning your **workplace culture**.

	Do not agree at all 1								Completely agree 9
Mental health is a debated topic in my organization	○	○	○	○	○	○	○	○	○
My organization values employee's mental health	○	○	○	○	○	○	○	○	○
My organization has a policy to protect and support employees with mental health conditions	○	○	○	○	○	○	○	○	○
My organization has zero-tolerance policy towards mental health discrimination	○	○	○	○	○	○	○	○	○
My organization has employed someone with a mental health condition	○	○	○	○	○	○	○	○	○
Colleagues of mine have or had a mental health condition	○	○	○	○	○	○	○	○	○
Colleagues of mine have publicly disclosed a mental health condition	○	○	○	○	○	○	○	○	○

Block 6: Overall perceptions of mental health conditions

Please answer to the following questions concerning your overall **perceptions of mental health conditions**.

Not at all dangerous to others	○ ○ ○ ○ ○ ○ ○	Very dangerous to others
Symptoms are the person's fault	○ ○ ○ ○ ○ ○ ○	Symptoms are not the person's fault
Avoidable	○ ○ ○ ○ ○ ○ ○	Unavoidable
Not genetic/hereditary	○ ○ ○ ○ ○ ○ ○	Genetic/hereditary
Quite common	○ ○ ○ ○ ○ ○ ○	Very rare
Not at all disruptive in social situations	○ ○ ○ ○ ○ ○ ○	Very disruptive in social situations
Not treatable with medication	○ ○ ○ ○ ○ ○ ○	Treatable with medication
Causes problems at work	○ ○ ○ ○ ○ ○ ○	Does not cause problems at work
Not embarrassing to have	○ ○ ○ ○ ○ ○ ○	Embarrassing to have
Symptoms are not sexual in nature	○ ○ ○ ○ ○ ○ ○	Symptoms are very sexual
Acute (short–lived) without treatment	○ ○ ○ ○ ○ ○ ○	Chronic (long–lasting) without treatment
Person is in complete control of him/herself	○ ○ ○ ○ ○ ○ ○	Person is completely unable to control him/herself
Not treatable with psychotherapy	○ ○ ○ ○ ○ ○ ○	Treatable with psychotherapy
One sex gets it	○ ○ ○ ○ ○ ○ ○	Both sexes get it
Potentially concealable	○ ○ ○ ○ ○ ○ ○	Publicly visible

Block 7: Workplace demographics

In which sector do you work in?

- Private
- Public

Which of the following industries most closely matches the one in which you are employed in?

- None
- Academia/Science
- Accounting & Legal
- Agriculture
- Automotive
- Construction
- Energy
- Financial Services
- Food and Beverage
- Health Care
- Housing and Real Estate
- Manufacturing
- Non-Profit
- Pharmaceuticals & Biotechnology
- Printing & Publishing
- Retail
- Telecommunications & Media
- Transportation & Logistics
- Other

Which of the following statements best describes your position?

- Someone supervises me, I supervise no one
- Someone supervises me, I supervise one or more people
- I supervise one or more people, no one supervises me

How many people work in your company?

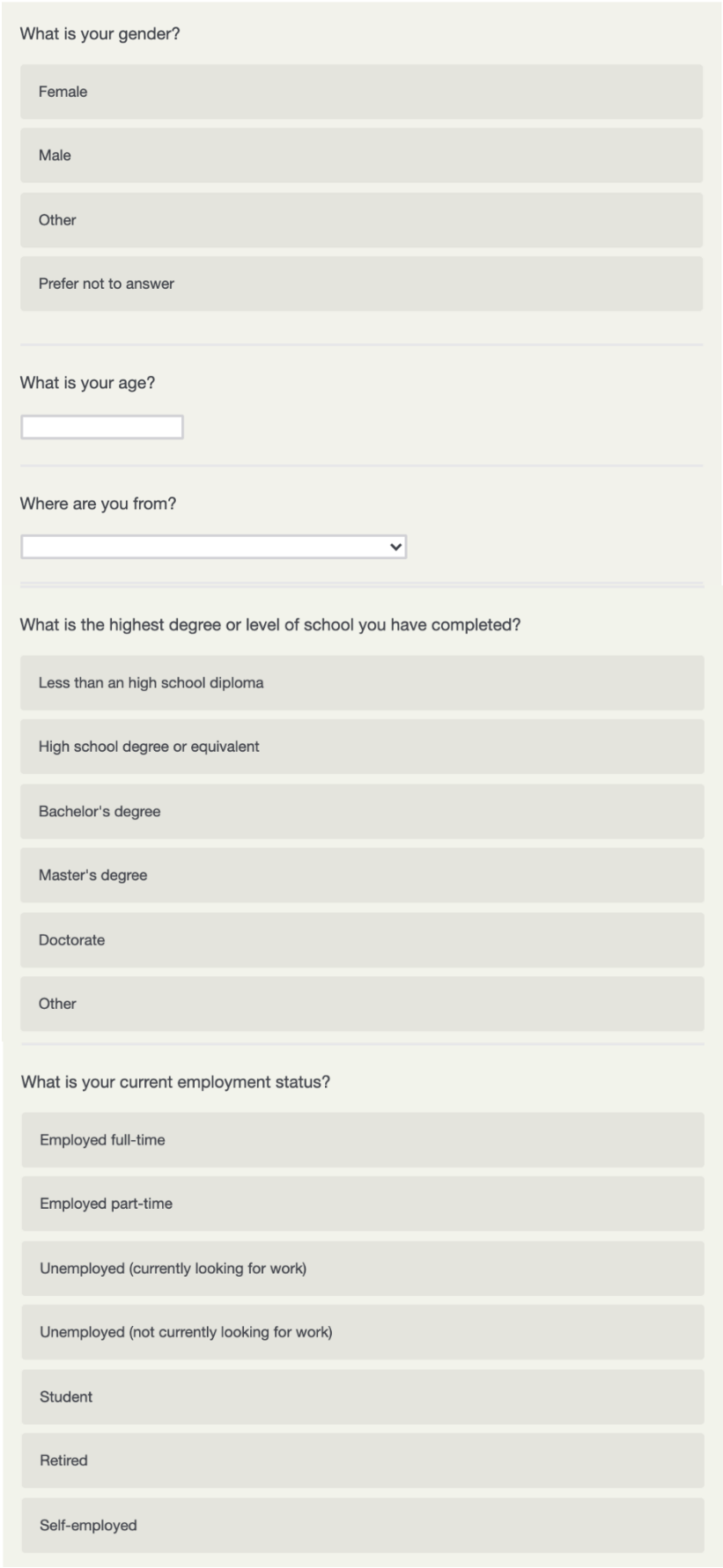
- Less than 10 people
- 11-50 people
- 51-250 people
- 250-1000 people
- Over 1000 people

How long have you worked in the company?

- Less than 1 year
- 1-3 years
- 3-6 years
- 6-10 years
- Over 10 years

→

Block 8: Demographics



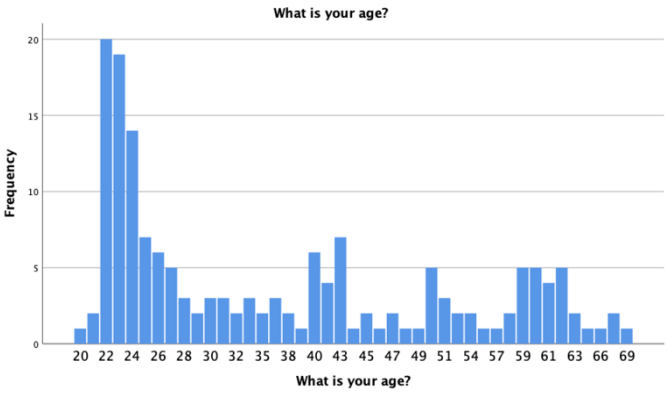
Appendix II: Sample description

Gender of participants

What is your gender?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Female	102	61,8	61,8	61,8
	Male	62	37,6	37,6	99,4
	Prefer not to answer	1	,6	,6	100,0
	Total	165	100,0	100,0	

Age of participants



Country of participants

List of Countries

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Argentina	1	,6	,6	,6
	Armenia	1	,6	,6	1,2
	Australia	1	,6	,6	1,8
	Canada	1	,6	,6	2,4
	China	1	,6	,6	3,0
	Czech Republic	1	,6	,6	3,6
	Denmark	3	1,8	1,8	5,5
	Egypt	1	,6	,6	6,1
	France	1	,6	,6	6,7
	Germany	1	,6	,6	7,3
	Hong Kong (S.A.R.)	1	,6	,6	7,9
	Italy	4	2,4	2,4	10,3
	Mozambique	2	1,2	1,2	11,5
	Philippines	1	,6	,6	12,1
	Portugal	141	85,5	85,5	97,6
	Romania	1	,6	,6	98,2
	Switzerland	1	,6	,6	98,8
	United Kingdom of Great Britain and Northern Ireland	1	,6	,6	99,4
	United States of America	1	,6	,6	100,0
	Total	165	100,0	100,0	

Education of participants

What is the highest degree or level of school you have completed?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	High school degree or equivalent	12	7,3	7,3	7,3
	Bachelor's degree	59	35,8	35,8	43,0
	Master's degree	87	52,7	52,7	95,8
	Doctorate	4	2,4	2,4	98,2
	Other	3	1,8	1,8	100,0
	Total	165	100,0	100,0	

Employment status of participants

What is your current employment status?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Employed full-time	103	62,4	62,4	62,4
	Employed part-time	7	4,2	4,2	66,7
	Unemployed (currently looking for work)	6	3,6	3,6	70,3
	Unemployed (not currently looking for work)	5	3,0	3,0	73,3
	Student	32	19,4	19,4	92,7
	Retired	4	2,4	2,4	95,2
	Self-employed	8	4,8	4,8	100,0
	Total	165	100,0	100,0	

Work-Sector of participants

In which sector do you work in?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Private	94	57,0	57,0	57,0
	Public	71	43,0	43,0	100,0
	Total	165	100,0	100,0	

Work-Industry of participants

Which of the following industries most closely matches the one in which you are employed in?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	None	3	1,8	1,8	1,8
	Academia/Science	24	14,5	14,5	16,4
	Accounting & Legal	42	25,5	25,5	41,8
	Agriculture	2	1,2	1,2	43,0
	Automotive	1	,6	,6	43,6
	Construction	4	2,4	2,4	46,1
	Energy	3	1,8	1,8	47,9
	Financial Services	6	3,6	3,6	51,5
	Food and Beverage	5	3,0	3,0	54,5
	Health Care	16	9,7	9,7	64,2
	Housing and Real Estate	1	,6	,6	64,8
	Manufacturing	4	2,4	2,4	67,3
	Non-Profit	4	2,4	2,4	69,7
	Pharmaceuticals & Biotechnology	2	1,2	1,2	70,9
	Printing & Publishing	1	,6	,6	71,5
	Retail	9	5,5	5,5	77,0
	Telecommunications & Media	8	4,8	4,8	81,8
	Transportation & Logistics	2	1,2	1,2	83,0
	Other	28	17,0	17,0	100,0
	Total	165	100,0	100,0	

Work-Position of participants

Which of the following statements best describes your position?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Someone supervises me, I supervise no one	88	53,3	53,3	53,3
	Someone supervises me, I supervise one or more people	68	41,2	41,2	94,5
	I supervise one or more people, no one supervises me	9	5,5	5,5	100,0
	Total	165	100,0	100,0	

Workforce in participants' company

How many people work in your company?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Less than 10 people	28	17,0	17,0	17,0
	11-50 people	43	26,1	26,1	43,0
	51-250 people	34	20,6	20,6	63,6
	250-1000 people	19	11,5	11,5	75,2
	Over 1000 people	41	24,8	24,8	100,0
	Total	165	100,0	100,0	

Years working at company

How long have you worked in the company?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Less than 1 year	62	37,6	37,6	37,6
	1-3 years	25	15,2	15,2	52,7
	3-6 years	14	8,5	8,5	61,2
	6-10 years	7	4,2	4,2	65,5
	Over 10 years	57	34,5	34,5	100,0
	Total	165	100,0	100,0	

Appendix III: Reliability Tests

Cronbach's Test for AQ9 (Mental Condition)

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
,930	,941	9

Cronbach's Test for AQ9 (Physical Condition)

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
,945	,952	9

Cronbach's Test for Personal Stigma Scale

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
,814	,821	7

Cronbach's Test for Workplace Culture Scale

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
,707	,703	5

Cronbach's Test for Overall Perceptions of Mental Health Conditions

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
,534	,531	15

Appendix IV: Statistical Tests for Hypothesis 1

Mean Analysis for Perceptions of Workplace Stigma

Statistics

		It would bother me to work next to a coworker with psychosis	It is best not to associate with a coworker with a mental health condition who has been in a mental hospital	Bosses with mental health conditions should not be allowed to teach how to work at the workplace	I would rather not hire a person with a mental health condition who had been in a hospital	I would not employ someone if I knew they had a mental health condition	I believe organizations take a risk when employing people with mental health conditions	I believe people should try to conceal their mental health conditions at work
N	Valid	165	165	165	165	165	165	165
	Missing	0	0	0	0	0	0	0
Mean		3,88	3,34	3,78	3,73	3,53	4,56	4,68
Std. Deviation		2,403	2,291	2,450	2,130	2,307	2,338	2,613
Minimum		1	1	1	1	1	1	1
Maximum		9	9	9	9	9	9	9

Independent T-TEST with AQ9

Group Statistics

	New_DEPRESSION	N	Mean	Std. Deviation	Std. Error Mean
SUM_Resposability_both	Depression	88	2,7159	2,29917	,24509
	Knee problems	77	2,7532	2,00103	,22804
SUM_Pity_both	Depression	88	6,9886	2,11451	,22541
	Knee problems	77	5,2338	1,92556	,21944
SUM_Anger_both	Depression	88	3,4659	1,95906	,20884
	Knee problems	77	4,4026	2,07909	,23693
SUM_Danger_both	Depression	88	2,8977	2,06804	,22045
	Knee problems	77	3,1688	2,07366	,23632
SUM_Fear_both	Depression	88	1,9545	1,46145	,15579
	Knee problems	76	2,2105	1,47256	,16891
SUM_Avoidance_both	Depression	88	5,1023	2,34908	,25041
	Knee problems	77	4,8312	1,94261	,22138
SUM_Coercion_both	Depression	88	6,7273	2,26785	,24175
	Knee problems	77	6,8312	2,11761	,24132
SUM_Segregation_both	Depression	88	2,3864	1,84099	,19625
	Knee problems	77	2,9610	2,10539	,23993
SUM_Help_both	Depression	88	7,3977	1,78461	,19024
	Knee problems	77	6,8312	1,92219	,21905

		Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
SUM_Resposability_both	Equal variances assumed	,250	,618	-,111	163	,912	-,03734	,33788	-,70453	,62986
	Equal variances not assumed			-,112	162,997	,911	-,03734	,33477	-,69838	,62371
SUM_Pity_both	Equal variances assumed	,267	,606	5,544	163	,000	1,75487	,31656	1,12979	2,37995
	Equal variances not assumed			5,578	162,730	,000	1,75487	,31458	1,13368	2,37606
SUM_Anger_both	Equal variances assumed	,226	,635	-2,978	163	,003	-,93669	,31458	-1,55786	-,31552
	Equal variances not assumed			-2,966	157,118	,003	-,93669	,31583	-1,56051	-,31286
SUM_Danger_both	Equal variances assumed	,047	,829	-,839	163	,403	-,27110	,32312	-,90915	,36694
	Equal variances not assumed			-,839	159,990	,403	-,27110	,32318	-,90935	,36714
SUM_Fear_both	Equal variances assumed	,625	,430	-1,115	162	,267	-,25598	,22966	-,70950	,19753
	Equal variances not assumed			-1,114	158,190	,267	-,25598	,22979	-,70983	,19787
SUM_Avoidance_both	Equal variances assumed	3,923	,049	,801	163	,424	,27110	,33847	-,39726	,93946
	Equal variances not assumed			,811	162,504	,418	,27110	,33424	-,38891	,93112
SUM_Coercion_both	Equal variances assumed	,828	,364	-,303	163	,762	-,10390	,34316	-,78151	,57372
	Equal variances not assumed			-,304	162,296	,761	-,10390	,34159	-,77843	,57063
SUM_Segregation_both	Equal variances assumed	4,012	,047	-1,871	163	,063	-,57468	,30721	-1,18130	,03195
	Equal variances not assumed			-1,854	152,199	,066	-,57468	,30997	-1,18707	,03772
SUM_Help_both	Equal variances assumed	,416	,520	1,963	163	,051	,56656	,28869	-,00350	1,13662
	Equal variances not assumed			1,953	156,237	,053	,56656	,29013	-,00653	1,13964

Analysis (sum) of AQ9 for the Physical and Mental Condition

Statistics

A9_total_physical

N	Valid	77
	Missing	88
Mean		35,0909
Median		35,0000
Mode		39,00
Std. Deviation		7,14361
Variance		51,031
Minimum		22,00
Maximum		55,00

Statistics

A9_total_mental

N	Valid	88
	Missing	77
Mean		30,8636
Median		32,0000
Mode		32,00[a]
Std. Deviation		8,00601
Variance		64,096
Minimum		16,00
Maximum		57,00

Appendix V: Statistical Tests for Hypothesis 2

Two-way ANOVA with repeated measures for Reliability

	New_DEPRESSION	Mean	Std. Deviation	N
Reliable:Unreliable	Depression	3,32	1,094	87
	Knee problems	3,29	,886	77
	Total	3,30	,999	164
POS_JAMES_RELIABILITY	Depression	3,2529	,97906	87
	Knee problems	3,1818	,94210	77
	Total	3,2195	,95961	164

Tests of Within-Subjects Contrasts

Measure: MEASURE_1

Source	time	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
time	Linear	,610	1	,610	1,785	,183	,011
time * New_Depression	Linear	,025	1	,025	,073	,788	,000
Error(time)	Linear	55,378	162	,342			

Tests of Between-Subjects Effects

Measure: MEASURE_1

Transformed Variable: Average

Source	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Intercept	3474,088	1	3474,088	2188,048	,000	,931
New_Depression	,235	1	,235	,148	,701	,001
Error	257,217	162	1,588			

Two-way ANOVA with repeated measures for Adaptability

Descriptive Statistics

	New_DEPRESSION	Mean	Std. Deviation	N
Adaptable:Unadaptable	Depression	3,14	1,019	88
	Knee problems	3,23	,857	77
	Total	3,18	,945	165
POS_JAMES_ADAPTABILITY	Depression	3,1477	,92897	88
	Knee problems	3,1039	,86731	77
	Total	3,1273	,89826	165

Tests of Within-Subjects Contrasts

Measure: MEASURE_1

Source	time	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
time	Linear	,288	1	,288	,907	,342	,006
time * New_Depression	Linear	,410	1	,410	1,288	,258	,008
Error(time)	Linear	51,845	163	,318			

Tests of Between-Subjects Effects

Measure: MEASURE_1

Transformed Variable: Average

Source	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Intercept	3271,138	1	3271,138	2353,448	,000	,935
New_Depression	,059	1	,059	,042	,837	,000
Error	226,559	163	1,390			

Two-way ANOVA with repeated measures for Cooperation

Descriptive Statistics

	New_DEPRESSION	Mean	Std. Deviation	N
Cooperative: Uncooperative	Depression	3,06	1,010	88
	Knee problems	3,10	,912	77
	Total	3,08	,963	165
POS_JAMES_COOPERATION	Depression	3,0114	,95285	88
	Knee problems	3,1039	,88235	77
	Total	3,0545	,91900	165

Tests of Within-Subjects Contrasts

Measure: MEASURE_1

Source	time	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
time	Linear	,042	1	,042	,100	,752	,001
time * New_Depression	Linear	,042	1	,042	,100	,752	,001
Error(time)	Linear	68,909	163	,423			

Tests of Between-Subjects Effects

Measure: MEASURE_1

Transformed Variable: Average

Source	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Intercept	3094,364	1	3094,364	2280,894	,000	,933
New_Depression	,400	1	,400	,295	,588	,002
Error	221,133	163	1,357			

Two-way ANOVA with repeated measures for Responsibility

Descriptive Statistics

	New_DEPRESSION	Mean	Std. Deviation	N
Responsible: Irresponsible	Depression	3,06	1,043	88
	Knee problems	3,36	1,050	77
	Total	3,20	1,055	165
POS_JAMES_RESPONSIBILITY	Depression	2,8750	,94459	88
	Knee problems	3,1299	,96451	77
	Total	2,9939	,95953	165

Tests of Within-Subjects Contrasts

Measure: MEASURE_1

Source	time	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
time	Linear	3,546	1	3,546	8,833	,003	,051
time * New_Depression	Linear	,055	1	,055	,138	,711	,001
Error(time)	Linear	65,442	163	,401			

Tests of Between-Subjects Effects

Measure: MEASURE_1
Transformed Variable: Average

Source	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Intercept	3170,115	1	3170,115	1976,631	,000	,924
New_Depression	6,478	1	6,478	4,039	,046	,024
Error	261,419	163	1,604			

Two-way ANOVA with repeated measures for Dependency

Descriptive Statistics

	New_DEPRESSION	Mean	Std. Deviation	N
Dependent:Independent	Depression	3,28	1,072	88
	Knee problems	3,38	,918	77
	Total	3,33	1,001	165
POS_JAMES_DEPENDENCY	Depression	3,0114	1,02267	88
	Knee problems	3,2597	,89447	77
	Total	3,1273	,97006	165

Tests of Within-Subjects Contrasts

Measure: MEASURE_1

Source	time	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
time	Linear	3,117	1	3,117	8,510	,004	,050
time * New_Depression	Linear	,499	1	,499	1,362	,245	,008
Error(time)	Linear	59,701	163	,366			

Tests of Between-Subjects Effects

Measure: MEASURE_1
Transformed Variable: Average

Source	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Intercept	3433,829	1	3433,829	2185,801	,000	,931
New_Depression	2,386	1	2,386	1,519	,220	,009
Error	256,068	163	1,571			

Two-way ANOVA with repeated measures for Motivation

Descriptive Statistics

	New_DEPRESSION	Mean	Std. Deviation	N
Motivated:Unmotivated	Depression	3,53	1,039	88
	Knee problems	3,34	,995	77
	Total	3,44	1,020	165
POS_JAMES_MOTIVATIO	Depression	3,5682	1,09119	88
	Knee problems	3,2727	,94083	77
	Total	3,4303	1,03136	165

Tests of Within-Subjects Contrasts

Measure: MEASURE_1

Source	time	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
time	Linear	,020	1	,020	,043	,837	,000
time * New_Depression	Linear	,201	1	,201	,439	,509	,003
Error(time)	Linear	74,787	163	,459			

Tests of Between-Subjects Effects

Measure: MEASURE_1

Transformed Variable: Average

Source	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Intercept	3861,029	1	3861,029	2373,145	,000	,936
New_Depression	4,968	1	4,968	3,054	,082	,018
Error	265,196	163	1,627			

Two-way ANOVA with repeated measures for Meticulosity

Descriptive Statistics

	New_DEPRESSION	Mean	Std. Deviation	N
Meticulous:Impulsive	Depression	3,47	1,005	88
	Knee problems	3,45	1,046	77
	Total	3,46	1,021	165
POS_JAMES_METICULOSITY	Depression	3,4318	,98021	88
	Knee problems	3,4026	,90699	77
	Total	3,4182	,94400	165

Tests of Within-Subjects Contrasts

Measure: MEASURE_1

Source	time	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
time	Linear	,152	1	,152	,473	,492	,003
time * New_Depression	Linear	,007	1	,007	,020	,887	,000
Error(time)	Linear	52,345	163	,321			

Tests of Between-Subjects Effects

Measure: MEASURE_1

Transformed Variable: Average

Source	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Intercept	3884,834	1	3884,834	2391,759	,000	,936
New_Depression	,034	1	,034	,021	,885	,000
Error	264,754	163	1,624			

Two-way ANOVA with repeated measures for Laziness

Descriptive Statistics

	New_DEPRESSION	Mean	Std. Deviation	N
Lazy:Industrious	Depression	3,06	1,021	88
	Knee problems	2,91	,798	77
	Total	2,99	,924	165
POS_JAMES_LAZINESS	Depression	3,1705	,88696	88
	Knee problems	2,9481	,79300	77
	Total	3,0667	,84920	165

Tests of Within-Subjects Contrasts

Measure: MEASURE_1

Source	time	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
time	Linear	,478	1	,478	1,240	,267	,008
time * New_Depression	Linear	,115	1	,115	,297	,587	,002
Error(time)	Linear	62,873	163	,386			

Tests of Between-Subjects Effects

Measure: MEASURE_1

Transformed Variable: Average

Source	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Intercept	2998,546	1	2998,546	2539,800	,000	,940
New_Depression	2,813	1	2,813	2,383	,125	,014
Error	192,442	163	1,181			

Independent T-TEST with Work-Related Traits (After)

Group Statistics

	New_DEPRESSION	N	Mean	Std. Deviation	Std. Error Mean
Sum_Reliability	Depression	87	3,2529	,97906	,10497
	Knee problems	77	3,1818	,94210	,10736
Sum_Adaptability	Depression	88	3,1477	,92897	,09903
	Knee problems	77	3,1039	,86731	,09884
Sum_Cooperation	Depression	88	3,0114	,95285	,10157
	Knee problems	77	3,1039	,88235	,10055
Sum_Responsibility	Depression	88	2,8750	,94459	,10069
	Knee problems	77	3,1299	,96451	,10992
Sum_Motivation	Depression	88	3,5682	1,09119	,11632
	Knee problems	77	3,2727	,94083	,10722
Sum_Meticulosity	Depression	88	3,4318	,98021	,10449
	Knee problems	77	3,4026	,90699	,10336
Sum_Laziness	Depression	88	3,1705	,88696	,09455
	Knee problems	77	2,9481	,79300	,09037
Sum_Dependency	Depression	88	3,0114	1,02267	,10902
	Knee problems	77	3,2597	,89447	,10193

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
Sum_Reliability	Equal variances assumed	,781	,378	,472	162	,637	,07106	,15050	-,22615	,36826
	Equal variances not assumed			,473	160,853	,637	,07106	,15015	-,22546	,36757
Sum_Adaptability	Equal variances assumed	,488	,486	,312	163	,756	,04383	,14056	-,23372	,32138
	Equal variances not assumed			,313	162,299	,754	,04383	,13991	-,23245	,32012
Sum_Cooperation	Equal variances assumed	,166	,684	-,644	163	,520	-,09253	,14366	-,37622	,19115
	Equal variances not assumed			-,647	162,463	,518	-,09253	,14293	-,37477	,18970
Sum_Responsibility	Equal variances assumed	,231	,632	-1,712	163	,089	-,25487	,14886	-,54881	,03907
	Equal variances not assumed			-1,710	159,163	,089	-,25487	,14907	-,54927	,03953
Sum_Motivation	Equal variances assumed	4,092	,045	1,849	163	,066	,29545	,15977	-,02002	,61093
	Equal variances not assumed			1,868	162,969	,064	,29545	,15820	-,01693	,60784
Sum_Meticulosity	Equal variances assumed	,382	,537	,198	163	,843	,02922	,14774	-,26251	,32095
	Equal variances not assumed			,199	162,477	,843	,02922	,14698	-,26101	,31945
Sum_Laziness	Equal variances assumed	,691	,407	1,688	163	,093	,22240	,13177	-,03780	,48261
	Equal variances not assumed			1,700	162,919	,091	,22240	,13079	-,03586	,48067
Sum_Dependency	Equal variances assumed	,283	,595	-1,649	163	,101	-,24838	,15059	-,54573	,04898
	Equal variances not assumed			-1,664	163,000	,098	-,24838	,14925	-,54309	,04633

One-Sample Paired T-TEST (Mental Condition)

Paired Samples Statistics

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Reliable:Unreliable	3,32	88	1,089	,116
	Depression_Reliable: Unreliable	3,25	88	,974	,104
Pair 2	Adaptable:Unadaptable	3,14	88	1,019	,109
	Depression_Adaptable: Unadaptable	3,15	88	,929	,099
Pair 3	Cooperative: Uncooperative	3,06	88	1,010	,108
	Depression_Cooperative :Uncooperative	3,01	88	,953	,102
Pair 4	Responsible: Irresponsible	3,06	88	1,043	,111
	Depression_Responsible :Irresponsible	2,88	88	,945	,101
Pair 5	Dependent:Independent	3,28	88	1,072	,114
	Depression_Dependent: Independent	3,01	88	1,023	,109
Pair 6	Motivated:Unmotivated	3,53	88	1,039	,111
	Depression_Motivated: Unmotivated	3,57	88	1,091	,116
Pair 7	Meticulous:Impulsive	3,47	88	1,005	,107
	Depression_Meticulous: Impulsive	3,43	88	,980	,104
Pair 8	Lazy:Industrious	3,06	88	1,021	,109
	Depression_Lazy: Industrious	3,17	88	,887	,095

Paired Samples Correlations

		N	Correlation	Sig.
Pair 1	Reliable:Unreliable & Depression_Reliable: Unreliable	88	,661	,000
Pair 2	Adaptable:Unadaptable & Depression_Adaptable: Unadaptable	88	,622	,000
Pair 3	Cooperative: Uncooperative & Depression_Cooperative :Uncooperative	88	,417	,000
Pair 4	Responsible: Irresponsible & Depression_Responsible :Irresponsible	88	,544	,000
Pair 5	Dependent:Independent & Depression_Dependent: Independent	88	,490	,000
Pair 6	Motivated:Unmotivated & Depression_Motivated: Unmotivated	88	,510	,000
Pair 7	Meticulous:Impulsive & Depression_Meticulous: Impulsive	88	,622	,000
Pair 8	Lazy:Industrious & Depression_Lazy: Industrious	88	,560	,000

Paired Samples Test

		Paired Differences					t	df	Sig. (2-tailed)
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference Lower	Upper			
Pair 1	Reliable:Unreliable - Depression_Reliable: Unreliable	,068	,855	,091	-,113	,249	,748	87	,456
Pair 2	Adaptable:Unadaptable - Depression_Adaptable: Unadaptable	-,011	,851	,091	-,192	,169	-,125	87	,901
Pair 3	Cooperative: Uncooperative - Depression_Cooperative :Uncooperative	,045	1,060	,113	-,179	,270	,402	87	,689
Pair 4	Responsible: Irresponsible - Depression_Responsible :Irresponsible	,182	,953	,102	-,020	,384	1,789	87	,077
Pair 5	Dependent:Independent - Depression_Dependent: Independent	,273	1,058	,113	,048	,497	2,417	87	,018
Pair 6	Motivated:Unmotivated - Depression_Motivated: Unmotivated	-,034	1,055	,113	-,258	,190	-,303	87	,763
Pair 7	Meticulous:Impulsive - Depression_Meticulous: Impulsive	,034	,864	,092	-,149	,217	,370	87	,712
Pair 8	Lazy:Industrious - Depression_Lazy: Industrious	-,114	,903	,096	-,305	,078	-1,181	87	,241

One-Sample Paired T-TEST (Physical Condition)

Paired Samples Statistics

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Reliable:Unreliable	3,28	78	,881	,100
	knee problem_Reliable: Unreliable	3,14	78	1,003	,114
Pair 2	Adaptable:Unadaptable	3,23	77	,857	,098
	knee problem_Adaptable: Unadaptable	3,10	77	,867	,099
Pair 3	Cooperative: Uncooperative	3,10	77	,912	,104
	knee problem_Cooperative: Uncooperative	3,10	77	,882	,101
Pair 4	Responsible: Irresponsible	3,36	77	1,050	,120
	knee problem_Responsible: Irresponsible	3,13	77	,965	,110
Pair 5	Dependent:Independent	3,38	77	,918	,105
	knee problem_Dependent: Independent	3,26	77	,894	,102
Pair 6	Motivated:Unmotivated	3,34	77	,995	,113
	knee problem_Motivated: Unmotivated	3,27	77	,941	,107
Pair 7	Meticulous:Impulsive	3,45	77	1,046	,119
	knee problem_Meticulous: Impulsive	3,40	77	,907	,103
Pair 8	Lazy:Industrious	2,91	77	,798	,091
	knee problem_Lazy: Industrious	2,95	77	,793	,090

Paired Samples Correlations

		N	Correlation	Sig.
Pair 1	Reliable:Unreliable & knee problem_Reliable: Unreliable	78	,601	,000
Pair 2	Adaptable:Unadaptable & knee problem_Adaptable: Unadaptable	77	,640	,000
Pair 3	Cooperative: Uncooperative & knee problem_Cooperative: Uncooperative	77	,673	,000
Pair 4	Responsible: Irresponsible & knee problem_Responsible: Irresponsible	77	,667	,000
Pair 5	Dependent:Independent & knee problem_Dependent: Independent	77	,825	,000
Pair 6	Motivated:Unmotivated & knee problem_Motivated: Unmotivated	77	,631	,000
Pair 7	Meticulous:Impulsive & knee problem_Meticulous: Impulsive	77	,734	,000
Pair 8	Lazy:Industrious & knee problem_Lazy: Industrious	77	,429	,000

Paired Samples Test

		Paired Differences					t	df	Sig. (2-tailed)
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference Lower	Upper			
Pair 1	Reliable:Unreliable - knee problem_Reliable: Unreliable	,141	,849	,096	-,050	,332	1,468	77	,146
Pair 2	Adaptable:Unadaptable - knee problem_Adaptable: Unadaptable	,130	,732	,083	-,036	,296	1,557	76	,124
Pair 3	Cooperative: Uncooperative - knee problem_Cooperative: Uncooperative	,000	,725	,083	-,165	,165	,000	76	1,000
Pair 4	Responsible: Irresponsible - knee problem_Responsible: Irresponsible	,234	,826	,094	,046	,421	2,485	76	,015
Pair 5	Dependent:Independent - knee problem_Dependent: Independent	,117	,537	,061	-,005	,239	1,909	76	,060
Pair 6	Motivated:Unmotivated - knee problem_Motivated: Unmotivated	,065	,833	,095	-,124	,254	,684	76	,496
Pair 7	Meticulous:Impulsive - knee problem_Meticulous: Impulsive	,052	,724	,082	-,112	,216	,630	76	,531
Pair 8	Lazy:Industrious - knee problem_Lazy: Industrious	-,039	,850	,097	-,232	,154	-,402	76	,689

Appendix VI: Statistical Tests for Hypothesis 3

Mean Analysis of the Workplace Culture Scale

Statistics

		Mental health is a debated topic in my organization	My organization values employee's mental health	My organization has a policy to protect and support employees with mental health conditions	My organization has zero-tolerance policy towards mental health discriminatio n	My organization has employed someone with a mental health condition	Colleagues of mine have or had a mental health condition	Colleagues of mine have publicly disclosed a mental health condition
N	Valid	165	165	165	165	165	165	165
	Missing	0	0	0	0	0	0	0
Mean		4,41	4,88	4,27	4,39	5,35	5,85	4,25
Std. Deviation		2,736	2,782	2,712	2,631	2,643	2,737	2,742
Minimum		1	1	1	1	1	1	1
Maximum		9	9	9	9	9	9	9

Linear Regression with the Personal Stigma Variable and Workplace Culture Scale

Model Summary[b]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	,302[a]	,091	,051	1,58378

a. Predictors: (Constant), Colleagues of mine have publicly disclosed a mental health condition, My organization values employee's mental health, My organization has employed someone with a mental health condition, My organization has zero-tolerance policy towards mental health discrimination, Mental health is a debated topic in my organization, Colleagues of mine have or had a mental health condition, My organization has a policy to protect and support employees with mental health conditions

b. Dependent Variable: Stigma_average_perceptions

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	39,519	7	5,646	2,251	,033[b]
	Residual	393,813	157	2,508		
	Total	433,332	164			

a. Dependent Variable: Stigma_average_perceptions

b. Predictors: (Constant), Colleagues of mine have publicly disclosed a mental health condition, My organization values employee's mental health, My organization has employed someone with a mental health condition, My organization has zero-tolerance policy towards mental health discrimination, Mental health is a debated topic in my organization, Colleagues of mine have or had a mental health condition, My organization has a policy to protect and support employees with mental health conditions

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients			95,0% Confidence Interval for B		Correlations		
		B	Std. Error	Beta	t	Sig.	Lower Bound	Upper Bound	Zero-order	Partial	Part
1	(Constant)	4,827	,421		11,460	,000	3,995	5,659			
	Mental health is a debated topic in my organization	-,062	,054	-,104	-1,154	,250	-,167	,044	-,108	-,092	-,088
	My organization values employee's mental health	,084	,066	,144	1,279	,203	-,046	,214	-,022	,102	,097
	My organization has a policy to protect and support employees with mental health conditions	-,035	,066	-,059	-,534	,594	-,165	,095	-,078	-,043	-,041
	My organization has zero-tolerance policy towards mental health discrimination	-,067	,051	-,108	-1,313	,191	-,167	,034	-,092	-,104	-,100
	My organization has employed someone with a mental health condition	-,146	,052	-,238	-2,831	,005	-,248	-,044	-,222	-,220	-,215
	Colleagues of mine have or had a mental health condition	-,053	,054	-,089	-,971	,333	-,160	,054	-,054	-,077	-,074
	Colleagues of mine have publicly disclosed a mental health condition	,117	,055	,197	2,140	,034	,009	,225	,055	,168	,163

a. Dependent Variable: Stigma_average_perceptions

Correlation between the Workplace Culture Scale and the Personal Stigma Scale

Correlations

		Mental health is a debated topic in my organization	My organization values employee's mental health	My organization has a policy to protect and support employees with mental health	My organization has zero-tolerance policy towards mental health discrimination	My organization has employed someone with a mental health condition	Colleagues of mine have or had a mental health condition	Colleagues of mine have publicly disclosed a mental health condition
It would bother me to work next to a coworker with psychosis	Pearson Correlation	-0,104	-0,015	-0,078	-0,076	-,214**	-0,061	0,032
	Sig. (2-tailed)	0,183	0,850	0,322	0,334	0,006	0,437	0,681
	N	165	165	165	165	165	165	165
It is best not to associate with a coworker with a mental health condition who has been in a mental hospital	Pearson Correlation	-0,082	0,056	0,001	-0,068	-,237**	-0,102	0,046
	Sig. (2-tailed)	0,293	0,473	0,989	0,387	0,002	0,193	0,555
	N	165	165	165	165	165	165	165
Bosses with mental health conditions should not be allowed to teach how to work at the workplace	Pearson Correlation	-0,039	-0,069	-0,084	-0,111	-0,134	-0,110	-0,061
	Sig. (2-tailed)	0,618	0,376	0,286	0,156	0,087	0,158	0,434
	N	165	165	165	165	165	165	165
I would rather not hire a person with a mental health condition who had been in a hospital	Pearson Correlation	-0,041	-0,032	-0,018	-0,024	-,266**	-0,141	-0,054
	Sig. (2-tailed)	0,602	0,681	0,816	0,764	0,001	0,072	0,490
	N	165	165	165	165	165	165	165
I would not employ someone if I knew they had a mental health condition	Pearson Correlation	-0,034	-0,059	-0,040	-0,086	-0,126	-0,085	0,016
	Sig. (2-tailed)	0,664	0,449	0,609	0,274	0,108	0,276	0,836
	N	165	165	165	165	165	165	165
I believe organizations take a risk when employing people with mental health conditions	Pearson Correlation	-0,024	0,106	0,037	-0,032	0,085	0,106	,293**
	Sig. (2-tailed)	0,763	0,175	0,639	0,680	0,277	0,174	0,000
	N	165	165	165	165	165	165	165
I believe people should try to conceal their mental health conditions at work	Pearson Correlation	-,180*	-0,082	-,175*	-0,045	-,184*	0,107	-0,004
	Sig. (2-tailed)	0,020	0,297	0,025	0,563	0,018	0,172	0,961
	N	165	165	165	165	165	165	165

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).