



The Disclosure of Mental Health Conditions (MHCs) in South African Organisations

**Nathalie Houtzamer**

**(HTZNAT001)**

A dissertation submitted in partial fulfilment of the requirements for the Degree of Master of  
Commerce in Organisational Psychology

**Faculty of Commerce**

**University of Cape Town 2020**

### **Compulsory Declaration**

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people, has been attributed, cited and referenced.

Signature:

Signed by candidate

Date: 28 February 2020

The copyright of this thesis vests in the author. No quotation from it or information derived from it is to be published without full acknowledgement of the source. The thesis is to be used for private study or non-commercial research purposes only.

Published by the University of Cape Town (UCT) in terms of the non-exclusive license granted to UCT by the author.

The copyright of this thesis vests in the author. No quotation from it or information derived from it is to be published without full acknowledgement of the source. The thesis is to be used for private study or non-commercial research purposes only.

Published by the University of Cape Town (UCT) in terms of the non-exclusive license granted to UCT by the author.

## **Acknowledgments**

I thank God for giving me the strength and health to complete this dissertation amidst the challenges of living with a diagnosed mental health condition (MHC).

I would like to thank my classmates, colleagues, UCT staff and especially Suki Goodman whose insights and guidance throughout this four-year research process made this dissertation possible.

I would also like to thank the South African Depression and Anxiety Group (SADAG) for allowing their online community to participate in this study. A huge thanks to the interviewees for sharing personal experiences of their MHCs; they were not only elucidating but extremely touching.

Finally, a special thanks to my friends, family, my church, and especially my psychiatrist, Dr Pieter Cilliers, for their unconditional support and encouragement throughout this challenging research journey.

## **Abstract**

In recent years, South African organisations have continued to underestimate the far-reaching negative impacts of mental health at work. This can largely be attributed to a lack of understanding and awareness owing to the under-researched nature of mental health conditions (MHCs) in the workplace, within the occupational health psychology (OHP) literature. It has thus become important to understand this phenomenon and raise the awareness needed to combat the negative consequences of MHCs in the workplace. Owing to this need and spurred on by the researcher's experience living with a MHC and her colleague taking his life while battling a MHC in 2016, the researcher sought to investigate the disclosure of MHCs within South African workplaces by affected employees. Specifically, she examined the relationship between when (disclosure timing) disclosure is likely to occur, the people (disclosure targets) to whom disclosure was made, perceived support offered to the people living with MHCs and the disclosers' perceived experiences owing to disclosing a MHC. The target population for the study were employees who have lived with a MHCs within South African workplaces. A sample of (N=109) was used. Data was analysed using the Software Package for Social Sciences (SPSS) and tests such as exploratory factor analysis, descriptive statistics, cross-tabulations and the Mann-Whitney U test were used. From the study it was revealed that disclosure of a MHC is more likely to occur after obtaining employment, as opposed to during the selection process. Apart from that it was also discovered that perceived support in respect of employee disclosure of a MHC is significantly lower within the organisation than that from external domains, such as family. In addition, it was found that perceived positive experiences owing to the disclosure of a MHC to an immediate line manager are not significantly different than to the Human Resource Department. Lastly, perceived negative experiences from the disclosure of MHCs to colleagues are not significantly different than disclosure to immediate

line Managers. The implications of these findings for future research and management are discussed. Lastly, throughout this research journey, the researcher continued questioning whether her colleague and the organisation where he had been employed would have benefited from an understanding of MHCs disclosure at work and whether this could have prevented his tragic suicide.

**Keywords:** mental health, mental health conditions, disclosure, roles of support of disclosure, the timing of disclosure, occurrence of disclosure, disclosure target, perceived positive experiences, perceived negative experiences, concealable stigmatised identities

## Table of Contents

	Page
<b>Acknowledgments .....</b>	<b>i</b>
<b>Abstract.....</b>	<b>ii</b>
<b>List of Tables .....</b>	<b>vii</b>
<b>Abbreviations .....</b>	<b>viii</b>
<b>1 Introduction.....</b>	<b>1</b>
1.1 The Disclosure of Mental Health Conditions (MHCs) in South African Organisations	1
1.2 Research Question .....	6
1.3 Structure of the Dissertation .....	6
<b>2 Literature Review .....</b>	<b>7</b>
2.1 Literature Search.....	7
2.2 Defining Mental Health (MH) .....	8
2.3 Defining Mental Health Conditions (MHCs) .....	8
2.4 Mental Health Conditions (MHCs) in the Workplace .....	10
2.5 Defining Disclosure in the Workplace.....	11
2.6 Theoretical Foundations of Disclosure .....	12
2.6.1 The Disclosure Process Model (DPM) .....	13
2.6.2 The Disclosure Decision-Making Model (DD-MM).....	14
2.6.3 The Disclosure Decision Model (DDM).....	15
2.6.4 The Social Penetration Theory (SPT) .....	16
2.6.5 The Risk Revelation Model (RRM).....	17
2.6.6 The Communication Privacy Management Theory (CPM).....	18
2.6.7 A Multilevel Model of Workplace Concealable Stigma Management.....	19
2.6.8 The Theory of Planned Behaviour (TPB) .....	20
2.7 Timing of Disclosure .....	22
2.8 Disclosure Target .....	23
2.9 The Role of Sources of Support.....	24
2.10 Perceived Positive Experiences in Respect of MHC Disclosure .....	25

2.11	Perceived Negative Experiences in Respect of Disclosure of MHCs.....	27
2.12	MHCs, Disclosure and the Legislation in the South African Workplace .....	30
2.13	Relevant South African Legislation and its Understanding in Respect of MHCs...	32
2.14	Research Propositions .....	34
<b>3</b>	<b>Method .....</b>	<b>35</b>
3.1	Research Design.....	35
3.2	Research Sampling.....	35
3.3	Data Collection .....	36
3.4	Procedure .....	36
3.5	Participants.....	37
3.6	Measures .....	40
3.6.1	The Occurrence of an MHC Disclosure (OMCD).....	40
3.6.2	Support of a MHC Disclosure (SMCD).....	41
3.6.3	Perceived Positive Experiences Owing to Disclosure (PPED).....	41
3.6.4	Perceived Negative Experiences Owing to Disclosure (PNED).....	42
3.6.5	Demographic Characteristics .....	42
3.6.6	Statistical Analyses .....	42
<b>4</b>	<b>Results .....</b>	<b>43</b>
4.1	Preliminary Analysis.....	43
4.2	Factor Analysis .....	44
4.3	Reliability Analysis.....	48
4.4	Descriptive Statistics.....	48
4.5	Cross-tabulations.....	50
4.5.1	Cross- tabulation in Respect of Age, Tenure, When and to Whom Disclosed....	50
4.5.2	Cross-tabulation of Age, Tenure as a Result of Perceived Positive and Negative Experiences .....	55
4.5.3	The Mann-Whitney U Test .....	55
<b>5</b>	<b>Discussion.....</b>	<b>58</b>
5.1	Contributions of the Present Study .....	58
5.2	Disclosure of a MHC is More Likely to Occur Whilst Employed Rather than During the Selection Process.....	58

5.3	Work Colleagues, Immediate Line Managers and the Human Resources Department Offer Significantly Lower Support to People with MHCs Disclosure than People Outside of Work (Spouse/Partner, Parents, Siblings, Children, Friends).....	59
5.4	Perceived Positive Experiences Owing to the Disclosure of an MHC to an Immediate Line Manager are Significantly Different than Those Owing to Disclosure to the Human Resource Department.....	60
5.5	Perceived Negative Experiences (PNED) Owing to the Disclosure of an MHC to Colleagues are Significantly Different from Perceived Negative Experiences Owing to Disclosure to Immediate Line Managers .....	62
5.6	Limitations and Suggestions for Future Research .....	64
5.7	Implications of the Present Study .....	66
<b>6</b>	<b>Conclusion .....</b>	<b>69</b>
	<b>References.....</b>	<b>71</b>
	<b>Appendices.....</b>	<b>88</b>
	Appendix A.....	88
	Appendix B .....	91
	Appendix C.....	93

## List of Tables

Table 1: Summary Table of Studies on Perceived Positive and Negative Experiences Owing to Decision to Disclose in the Workplace.....	28
Table 2: Frequencies and Percentages of Participants' Demographics .....	38
Table 3: Summary of MHC Disclosure Descriptive Statistics for Demographics .....	40
Table 4: Factor Loadings for Exploratory Factor Analysis with Varimax Rotation of SMCD ...	45
Table 5: Factor Loadings for Exploratory Factor Analysis of Perceived Positive Experience Owing to Disclosure Scale (PPED) .....	46
Table 6: Factor Loadings for Exploratory Factor Analysis of Perceived Negative Experience Owing to Disclosure Scale (PNED) .....	47
Table 7: Descriptive Statistics of Scales under Investigation.....	49
Table 8: Descriptive Statistics Showing Frequencies for Occurrence (timing) of MHC Disclosure at Work .....	50
Table 9: Cross-tabulation When did a MHC Disclosure Occur at Work (Age).....	51
Table 10: Cross- tabulation When an MHC Disclosure Occurred at Work (Tenure) .....	52
Table 11: Cross-tabulation to Whom did Employees Disclose (Age).....	53
Table 12: Cross-tabulation to Whom Employees Disclosed (Tenure).....	54
Table 13: Mann-Whitney U Test Results: Perceived Positive Experiences Owing to MHC Disclosure .....	56
Table 14: Mann-Whitney U Test Results: Perceived Negative Experiences Owing to MHC Disclosure .....	56
Table 15: Summary of Findings .....	57

## Abbreviations

MHC	Mental health condition
MHCs	Mental health conditions
CSI	Concealable stigmatised identity
CSIs	Concealable stigmatised identities
EEA	Employment Equity Act
OMCD	Occurrence owing to MHC disclosure
SMCD	Support owing to MHC disclosure
SMCDAW	Support owing to MHC disclosure at work
SMCDOW	Support owing to MHC disclosure outside work
PPED	Perceived positive experience of MHC disclosure
PNED	Perceived negative experience of MHC disclosure
SADAG	South African Depression and Anxiety Group
WHO	World Health Organisation

# **1 Introduction**

## **1.1 The Disclosure of Mental Health Conditions (MHCs) in South African Organisations**

The World Health Organisation (WHO) has long recognised the extent and pervasiveness of mental health problems and thus declared them a top priority (Harnois & Gabriel, 2000; McDaid et al., 2005; Vickerstaff & Phillipson, 2011). The WHO has found that mental illnesses such as depression, bipolar mood disorder, anxiety and substance abuse are a leading cause of disability worldwide with a definitive impact on any working population. In fact, more importantly, the WHO posits that every 40 seconds somebody loses their life to suicide owing to mental illness. Therefore, the World Health Organisation (WHO, 2019a) Global Mental Health Action Plan 2013-2020 discusses the stigma associated with mental health and particularly suicide means that individuals who need help feel unable to reach out and ask for it, creating a barrier to appropriate care.

There is growing evidence of the adverse impacts of mental health in the workplace, where it has been found to affect employee performance, absenteeism, staff turnover, rates of illness and workplace accidents – all of which impact on both the individual and an organisation at large (Harnois & Gabriel, 2000; McDaid et al., 2005; Vickerstaff & Phillipson, 2011). While South African legislation has gone a long way in protecting employees against working conditions that could threaten their wellbeing, the focus has largely been on physical aspects of work, without adequate emphasis on emotional workplace health (Occupational Health and Safety Act 85, 1993). As a result, the burden of employee mental health has long been underestimated, as can be seen in the paucity of research in this regard within literature (Henderson, Brohan, et al, 2013).

MHCs largely fall into the category of concealable stigmatised identities (CSI) that are not readily apparent to others (Jones & King, 2014). Of concern are the low rates of mental health conditions disclosure in the workplace, owing to the stigma that is often attached to it (Bateman, 2015; Jones & King, 2014). As noted by Bateman (2015), people tend to shy away from disclosure because those living with mental health conditions (MHCs) such as depression and bipolar mood disorders are often perceived as erratic, less competent and more violent than the general population.

Moreover, the South African Depression and Anxiety Group (2016) has observed that South African discourses on the disclosure of MHCs paint a picture of fragmented employee support structures and policies. Blank et al. (2015) argue that building and maintaining an occupational identity is important for the mental wellness of people living with a MHC, as it is linked to the need to feel connected to others. Therefore, employment is especially important for someone with a MHC because work often defines the individual and provides them with an occupational identity, other than that of their illness (Seeman, 2009).

With a view to the above, it would be insightful and valuable to investigate the nature of MHCs within the workplace, the intricacies surrounding MHC disclosures, as well as perceived experiences of those diagnosed. This could go a long way in mitigating the adverse impacts of poor mental health in the work context and developing potential successful interventions. It is now widely accepted that the workplace is one of the key environments that affect mental well-being and mental health (Harnois & Gabriel, 2000). In her study on mental health in the workplace, Malachowski (2015) indicates that under the right conditions the workplace can be a contributing factor to mental well-being. Apart from this, the WHO (2004) suggest that developing policies for workplace mental health awareness and providing sources of support for employees' wellbeing contributes to a reduction in work-related risk factors and develops positive employee strengths.

In addition, as illustrated in the British Social Psychology (2017) report, poorly designed jobs, work that is not organised well, difficult work environments, poorly trained managers, and a lack of understanding of human behaviour in the workplace can give rise to or exacerbate mental ill-health. Furthermore, a lack of proper and adequate support and time off for employees with MHCs has a deleterious effect and impacts their ability to productively maintain their employment (British Social Psychology, 2017).

Other researchers have specifically highlighted the epidemiological and economic costs that mental health issues may have on the organisation (Dewa & McDaid, 2011). They specifically found associations between mental health issues and reduced productivity as a result of decreased labour force participation and performance at work (Dewa & McDaid, 2011). Although Dewa and McDaid's (2011) research were conducted in Canada. Figures from workplace health and wellness solutions company Occupational Care South Africa show that absenteeism costs the South African economy between R12 billion and R16 billion each year with much of it relating to workplace stress, burnout syndrome and employee health (Ebrahim, 2019).

In addition, as many as one in six South Africans suffer from anxiety, depression or substance-use problems (and this does not include more serious conditions such as bipolar disorder or schizophrenia), according to statistics released by the South African Depression and Anxiety Group (SADAG) (SADAG, 2016) Therefore, based on these statistics and the lived realities of employees with diagnosed MHCs, it is reasonable to argue that poor workplace interventions and MHC policies have a negative impact on both the organisation and people who have MHCs.

According to McDowell & Fossey (2015) managers are generally less accommodating of those experiencing mental health-related issues compared to those with physical health-related issues. Consequently, the risks of disclosing MHCs include the possibility of less

support from immediate line managers and co-workers, as well as barriers to career progression (Jones & King, 2014). This may influence the employee's decision to withhold disclosure of their MHC, thus affecting their mental health even more detrimentally.

In South Africa, employees with a diagnosed MHC are protected by provisions in labour law such as the Employment Equity Act (Act no. 55 of 1998). However, asserting the provisions from this legislation requires disclosure, at least to some extent, to the employer, and employees may choose not to disclose for fear of stigmatisation and other negative consequences (Schultz et al., 2011).

Disclosure involves the process of intentionally communicating information about one's non-visible stigmatised identity verbally to another person, and may include revealing thoughts, feelings and experiences (Brohan et al., 2012; Chaudoir & Fisher, 2010). A person deciding to disclose generally weighs up the risks and benefits of disclosure in the context in which they find themselves (Carpenter, 2017). Illustratively, disclosing a diagnosis to a friend or family member is likely to involve different considerations than when disclosing to an employer (Reavley & Jorm, 2014). Pahwa et al., (2017) suggest that considerations are affected by an individual's character, the nature and duration of the relationship with the disclosure target.

Disclosure tends to reflect perceived experiences which are both positive and negative. Researchers have encouraged employees to disclose their identities to reap positive psychological benefits and to experience positive reactions from those close to them (Ahmad et al., 2018; Chaudoir & Quinn, 2010). For someone with a MHC diagnosis, positive perceptions owing to the disclosure may include increased support, employer accommodations and reduced feelings of isolation (Garcia & Crocker, 2008).

The converse is, however, that evidence has also shown that the concealment of a CSI may help protect individuals from harassment or discrimination (Elliott & Doane, 2015). Jones et al. (2016) have in fact noted that concealment may sometimes predict positive physical health outcomes. On the balance though, it seems that negative perceptions of the outcomes of disclosure tend to outweigh perceived positive outcomes, including social rejection, stigma and discrimination (Thorncroft et al., 2009; Wahl, 1999). Whether or not a person has had such negative experiences, anxiety about anticipated discrimination and stigma, often lead to the decision to conceal (Lasalvia et al., 2013).

For someone with undiagnosed symptoms, labelling the problem as a MHC facilitates help-seeking, treatment compliance and relief from symptoms (Yap et al., 2011). It is safe to say that perceptions around a MHC disclosure, both positive and negative, can play a key role on the degree to which a MHC impacts a person's work-life.

Most people with a history of MHCs want to work, consider themselves able to work, and repeatedly express the need for job training, services and support (Brohan et al., 2012). Jones & King (2014) argue that to understand the disclosure of a CSI in the workplace, there must be an analysis of the many multifaceted and interrelated components involved in the disclosure. They further posit that outcomes of disclosure depend on certain factors, including when to disclose (disclosure timing), the reaction of the confidant (disclosure target), and the visibility of the stigma (perceived experiences) (Jones & King, 2014). The theoretical foundations concerning disclosure and information management will be assessed in the current study. The study specifically focuses on enriching the understanding of the disclosure of MHCs in the South African workplace and how work relations and experiences affect disclosure.

## **1.2 Research Question**

*What is the relationship between disclosure of diagnosed MHCs, when (disclosure timing) and to whom (disclosure target), perceived support and perceived experiences amongst disclosing employees in the South African workplace?*

## **1.3 Structure of the Dissertation**

This chapter provided the context and rationale for the study. Following this, the literature review provides a detailed evaluation of research conducted on the topic. This includes literature on the definitions of mental health, mental health conditions (MHCs) and disclosure in the workplace. Theoretical frameworks of disclosure, disclosure targets, roles of sources of support, perceived experiences and the legislation concerning disclosure of a MHC, are also discussed. The literature review will conclude with the research propositions put forward for the study. Following this, the method and results sections will outline the various analyses used to answer the research question and examine the propositions. A discussion section concludes with a synthesis of research findings in line with extant literature. Study limitations, key contributions, and recommendations for future research are also presented.

## **2 Literature Review**

This section presents an overview of and background to the relevant research literature and theoretical framework for understanding mental health condition (MHC) disclosure at work. The disclosure of a diagnosed MHC in the South African (SA) workplace is a relatively underdeveloped topic as no study of its kind has been conducted in South Africa. Living with a diagnosed MHC forms part of the broader concept known as a “concealable stigmatised identity” (CSI). A host of research around disclosure of MHCs or CSIs was used as the groundwork for understanding the disclosure of a MHC in the South African workplace.

Firstly, the review focuses on the conceptualisation of mental health and MHC disclosure in the workplace. Theoretical foundations of disclosure, disclosure timing, disclosure targets, sources of support, perceived experiences and the legislation and disclosure at work are discussed. Lastly, the propositions for the study are highlighted at the end of this section.

### **2.1 Literature Search**

The literature search was conducted using several electronic research databases. These databases included Google Scholar, PsycINFO, Emerald, JSTOR, Science Direct, psycARTICLES, PRIMO and Academic Source Premier. The literature search was undertaken by means of Boolean keyword searches using a combination of multiple key terms. These terms included "mental health", “mental health conditions”, “disclosure”, "non-disclosure", "personal information management", "concealable stigmatised identities (CSI's)", "stigma", "revealing private information", "concealing", "non-disclosure", "disclosure models", "disclosure theories", "mental health legislation", "WHO", "mental health in the workplace", "employee wellness", "concealing stigmas", "health decisions in the workplace" "support of mental health", “experiences of disclosure”, "perceptions of disclosure", "disabilities in the

workplace", "private information management", "stigmatised information management" and "behaviour intentions". The main literature search was conducted over a period of 18 months, from July 2017 to December 2019. After that, searching was an ongoing and regular exercise which continued until January 2020 to ensure that all relevant articles were included.

## **2.2 Defining Mental Health (MH)**

The construct of mental health is a well-researched area and the definition is essential in this study of understanding disclosure of MHCs at work. The World Health Organisation (WHO) defines mental health as a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively, and is able to contribute to their community (WHO, 2004, p.10). Furthermore, mental health is a state of successful performance of mental functions, resulting in productive activities, fulfilling relationships with other people, and an ability to adapt to change and to cope with adversity (Goldman and Grob, 2006). Keyes (2006; 2014) identifies three components of mental health: emotional well-being, psychological well-being and social well-being. On the other hand, Goldman and Grob (2006) through their study on mental health hold that mental ill-health is a term that refers collectively to all diagnosable mental disorders. Mental disorders are health conditions characterised by alterations in thinking, mood, or behaviour (or some combination thereof) associated with distress and/or impaired functioning. The mental health definition of Goldman and Grob (2006) has been employed in this study, given its association with mental health conditions (MHCs). This is definition is highlighted in the section below.

## **2.3 Defining Mental Health Conditions (MHCs)**

A mental health issue becomes a mental health condition (MHC) when ongoing signs and symptoms cause frequent stress and affect the individual's ability to function (Goldman

and Grob, 2006). The authors inform that if treated professionally, these signs and symptoms may lead to the diagnosis of a wide range of mental health conditions, all of which are generally characterised by a combination of abnormal thoughts, perceptions, emotions, behaviour and relationships with others.

In a report by the General Medical Council (2015) on supporting medical students with MHCs, it is noted that MHCs include depression, generalised anxiety disorder, panic disorder, social anxiety disorder, obsessive-compulsive disorder, post-traumatic stress disorder, addiction, bipolar mood disorder and schizophrenia. Examples of signs and symptoms include feeling sad or down, confused thinking, reduced ability to concentrate, excessive fears or worries or extreme feelings of guilt, extreme mood changes (highs and lows), withdrawal from friends and any activities (including work), significant tiredness and low energy or problems with sleeping (General Medical Council, 2015). MHCs affect not only the individual's ability to manage their thoughts, emotions, behaviours and interactions with others, but also affects social, cultural, economic, political and environmental factors such as national policies, social protection, living standards, working conditions, and community social supports (WHO, 2019b).

The challenges related to MHCs continue to grow including the significant effect they have on health and the major social, human rights and economic impacts they have across the world (WHO, 2019b). People with MHCs require social support and care, including help in accessing educational programmes that fit their needs, and employment and housing to enable them to live and be active in their local communities (WHO, 2019b).

Recent research from the South African Depression and Anxiety Group (SADAG) (2016) indicates that one in three employees suffer from a MHC in South Africa. Therefore, it is important that Governments and organisations alike understand the crucial role they play in promoting mental health, including the mental health of workers and ensuring that symptoms

of MHCs are recognised early and treated effectively. In conclusion, the WHO posits that well-formulated policies and programmes, and specifically the effective implementation thereof, will facilitate MHC awareness amongst all stakeholders, and support those with MHCs in the workplace (WHO, 2004).

## **2.4 Mental Health Conditions (MHCs) in the Workplace**

MHCs and psychosocial related disabilities are considerably ill-defined, complex and controversial when applied in the context of the workplace (Bender & Kennedy, 2004). Studies also indicate that MHCs have staggering social and economic costs that place an especially heavy burden on the workplace (Martin et al., 2009). In addition, MHC problems have several major socioeconomic consequences and costs on organisations such as absenteeism, labour turnover and loss of productivity (WHO, 2018).

Apart from higher unemployment rates, MHCs create decreasing productivity and in turn greater absence rates and overall costs for organisations (Lerner & Henke, 2008). Furthermore, other studies with similar findings by Memish et al., (2017) support this finding. However, Honey (2004) noted a variety of benefits associated with employment for individuals diagnosed with MHCs, including increased confidence and self-esteem; feelings of self-worth and normalcy; enhanced social status; financial security; independence; opportunities for social interaction; community participation; and personal and professional growth. The researcher suggests this may indicate that MHC challenges in the workplace appear to be a global issue and should be treated as a priority in the workplace.

On this premise, Irvine (2011) suggests that an enhanced focus on public policy discourse and concepts of mental well-being and positive mental health, as matters of universal relevance, may lead to earlier recognition of and better support for common mental health problems at work. If policy and public health messages focus more on mental 'well-being' and

less on mental 'illness', people may be better equipped to talk to others at work when they experience difficulties with mental health, and therefore receive better support (Irvine, 2011). The deliberate disclosure of a diagnosed MHC in the employment context is a personal, complex, and potentially a difficult decision, and mental health professionals are frequently asked for advice on whether and how to go about it (Henderson, Brohan, et al., 2013). Therefore, in the following section, an understanding of the definition of disclosure in the workplace is discussed in detail.

## **2.5 Defining Disclosure in the Workplace**

According to Checton (2010), although Jourard in 1971 was the first author to use the term "self-disclosure," and much scholarly research has since explored this phenomenon, over the last 20 years, disclosure research has shifted the focus from "self-disclosure" to a broader conceptualisation that views "disclosure" as the process of revealing (or concealing) private information (e.g., Greene et al., 2006; Kelly, 2002; Petronio, 2004) in social and work contexts. The present study focuses specifically on the disclosure of diagnosed MHCs in the workplace, and the term "disclosure" adapted for this study refers to a situation of deliberately informing someone at work about one's visible or concealable identity or sharing information about oneself that is considered private, for example, one's MHC or sexual orientation (Chaudoir & Fischer, 2010).

The literature suggests that disclosure is best conceptualised as a process rather than an event and that disclosure is not an all-or-nothing phenomenon but occurs, rather, on a continuum (Ragins, 2008). Thus, disclosure may be understood as a series of selective and partial revelations occurring in a range of contexts or circumstances (Brunner, 2007). Furthermore, disclosure is linked to several important outcomes for both individuals holding the information and their relationships.

Firstly, people who disclose may have greater access to social support and resources (Davidson et al., 2006; Substance Abuse and Mental Health Services Administration (SAMHSA), 2008). In addition, individuals who disclose may find better ways of coping with stressful life events (Corrigan & Rao, 2012; Williams et al., 1998). Disclosure allows individuals with invisible stigmas to identify and affiliate with others, thus offering a source of support that provides resources, strategies, and mentoring, as well as a means of dealing with role-related stress (Meyer, 2003). Lastly, disclosure is also a form of voice (Creed, 2003) for the employee that can increase awareness, influence organisational culture (Bowen & Blackmon, 2003), and create social and organisational change (Creed & Scully, 2000; Meyerson & Scully, 1995).

The literature on the disclosure process is broad in both its scope and diversity (Greene et al, 2006; Omarzu, 2000). Henceforth, deciding when (timing), how, and to whom (disclosure target) to disclose a MHC remains one of the most difficult decisions an employee can face on a day- to-day basis (Marrs & Staton, 2016). Motives for disclosure can be diverse, ranging from seeking catharsis or relief (Derlega et al., 2008; Hastings, 2000), building intimacy (Altman & Taylor, 1973) to receiving support from others (Derlega et al., 2008). On this backdrop, the theoretical foundations with respect to disclosure literature were evaluated with the aim of understanding the disclosure of a MHC diagnosis in the workplace.

## **2.6 Theoretical Foundations of Disclosure**

Several theoretical frameworks have been published in the fields of applied and organisational psychology to explain personal information management, disclosure, concealable stigmatised identities, privacy, secrets and topic avoidance and behavioral intentions - each of which provides a process approach model of disclosure decisions (for example, Capell et al., 2016; Chaudoir & Fisher, 2010; Clair, et al., 2005; Jones & King, 2014;

Omarzu, 2000; Pachankis, 2007; Ragins, 2008; Taylor & Altman, 1987; Petronio, 1991, 2002; Afifi & Steuber, 2009 and Azjen, 1991). Below, the theoretical foundation frameworks are discussed in detail.

### **2.6.1 The Disclosure Process Model (DPM)**

According to Chaudoir and Fischer (2010), the DPM firstly suggests that disclosure must be conceptualised as a process that essentially involves decision-making and outcome processes. Therefore, the DPM dichotomizes motivations for disclosure and non-disclosure into approach and avoidance goals. With approach goals, an individual may disclose to acquire positive reactions such as stronger relationships and support. Conversely, with avoidance goals, an individual anticipates negative outcomes from disclosing in a relationship, such as judgment, discrimination, or violence, and subsequently chooses to conceal or not to disclose his or her status in those relationships (Chaudoir & Fischer, 2010).

The DPM provides a theoretical framework to understand when and why disclosure is beneficial for individuals who live with a CSI such a MHC (Chaudoir et al., 2011). In the context of the disclosure, those living with MHCs with approach goals must focus on obtaining positive experiences to strengthen an important relationship and those with avoidance goals might focus on avoiding negative outcomes such as life conflict or social rejection (Chaudoir et al., 2011).

There is substantial research including the study by Rüschi et al. (2014) identifying that more trusting and supporting relationships are associated with higher rates of disclosure. Within the field of mental health, willingness to disclose personal experiences to help others has been shown to be dependent upon feelings of safety in relationships adding to perceptions of support (Marino, Child, & Krasinski, 2016). Beals et al. (2009) suggest that most participants

in their study engaged in selective disclosure in which they were open about their experiences with partners, family, and friends but limited disclosure with acquaintances and colleagues.

Such a disclosure pattern can act to optimize social support and limit stigmatizing responses for individuals faced with MHC disclosure decisions. No research is available in applying the DPM in the disclosure of a MHC at work. Important to this study is that the DPM provides critical insights for disclosing a CSI (for example, MHC) in general, specifically antecedents of approach goals and avoidance goals. Results from a literature review and application of the Disclosure process model by Chaudoir et al. (2011), indicate that individuals are more likely to disclose after considering strong goals for disclosure or when they are disclosing to those whom they have close relationships. In contrast, participants were less likely to disclose when they had strong goals-against disclosure. Important to note, is that people who are faced with the decision of whether to disclose the MHC constantly weigh up the costs and benefits (MacDonald-Wilson et al, 2010), hence the antecedents of the DPM play an important role in the disclosure decision of a CSI.

### **2.6.2 The Disclosure Decision-Making Model (DD-MM)**

The disclosure decision-making model (DD-MM) is a recent model developed to explain why individuals decide to disclose a health issue in interpersonal settings (Greene, 2009). The DD-MM grew out of an interest in the cognitive decision-making process surrounding disclosure (for example, Greene et al., 2006). The DD-MM proposes two aspects of the disclosure recipient (disclosure target) assessments that influence disclosure decisions, relational quality, and anticipated response (Choi et al., 2016). In the DD-MM the disclosure target is used to consider the quality of the relationship between discloser, their target and the anticipated response to the disclosure (Greene, 2009). Greene (2009) suggests the model

focuses on the complexity of information management decisions rather than putting the most emphasis on outcomes.

The DD-MM is a complex model with several propositions applied to understand what information affects the decision to disclose. In respect to the current study, Pahwa et al. (2017) assessed the DD-MM model in MHC disclosure specifically in relation to disclosure targets. Given the disclosure target idea is examined in the current study, important to note is that the authors inform that family members and friends were central to the disclosure process. In another study by Choi et al. (2016), it was identified that people presumed positive responses (for example, the provision of support) from disclosure targets that were close to them (e.g. friend and family), which was also reported in previous DD-MM research (e.g., Greene et al., 2012). The research using antecedents of DD-MM focuses on disclosure from the individual point of view. Therefore, it is suggested that future studies conceptualise disclosure across contexts because its assessment could be different depending on its degree of seriousness, the content, and or the situation. However, the DD-MM provides important insights about the quality of relationships for the current study, which is likely to be related to increased disclosure.

### **2.6.3 The Disclosure Decision Model (DDM)**

The disclosure decision model (DDM) developed by Omarzu (2000) specifies a cognitive process resulting in decisions that affect the content, depth, breadth, and duration of self-disclosure (Omarzu, 2000). One of the five possible disclosure goals, namely social approval, intimacy, relief of stress, social control, and identity clarification must appear within reach for the DDM to be activated. The disclosure must be chosen as a strategy for achieving goals, and a disclosure target must be selected (Omarzu, 2000). The DDM proposes that under conditions of both high subjective utility and high subjective risk, potential disclosers will

experience more distress and anxiety than under other conditions. This combination of high subjective utility and risk creates an approach-avoidance conflict in which individuals are drawn to achieving a goal but fear the likelihood of rejection (Omarzu, 2000).

The DDM has yet to be empirically tested in order to produce evidence of the model's predictions, its efficacy and to determine how well the model integrates with existing theories of disclosure communication and settings (Carpenter, 2017). Like the DDM most other models also emphasise some form of risk assessment, which is pivotal in helping the potential discloser to evaluate what kind of social support they may get from the disclosure target, and whether the disclosure target's reaction to the disclosure is likely to be positive (Flett, 2012).

#### **2.6.4 The Social Penetration Theory (SPT)**

The social penetration theory developed by Altman and Taylor (1973) was the first theory focused on relationship development and how individuals use communication as a mechanism to become familiar with one another. The authors developed SPT to explain how disclosure changes throughout a developing relationship, mostly close relationships (that is partner and friends). SPT follows the assumption which states that the "greater the ratio of rewards to costs, the more rapid the penetration process" (Taylor & Altman, 1987, p. 264). Most of these SPT studies focused on college students and how relationships with no history developed or how romantic relationships and friendships developed.

The theory clearly outlined the process of disclosing information in initial interactions, but there is little information about how these interactions occur in established relationships or other kinds of relationships such as between co-workers (Carpenter, 2017). SPT is thus somewhat limited in scope and considers information primarily at the individual level rather than being shared by dyads or groups. Research on SPT has led to the development of other theories, but tests of the theory itself are no longer conducted. Disclosure has been identified

as a central focus of the SPT theory, and the SPT proposes there must be an exchange of information for an interpersonal relationship to develop. To this end and in respect of the current study, the SPT was considered in understanding MHC disclosure in the South African workplace.

### **2.6.5 The Risk Revelation Model (RRM)**

The risk revelation model (RRM) is grounded in assessing risks, it looks at how individuals weigh up the risks of sharing a secret against the benefits thereof. It assesses several risks, including the risk to self, to the relationship, and to the other (Derlega et al., 2004). The risk is also inherently tied to the valence of the secret. Consequently, more negative secrets are likely to pose a significant risk, which is the reason why some people might say they would never reveal a secret under any condition (unless they were forced to do so) (e.g. were directly confronted about the secret) (Afifi & Steuber's, 2009).

Afifi and Steuber (2009) in their study suggests that among other things, people assess the risks involved with the disclosure of secrets and that this risk assessment is what predicts people's readiness or willingness to reveal them. People are more willing to reveal their secrets under certain conditions: (1) for catharsis, (2) if the disclosure target needs to know/have the right to know the information, and (3) if other people (including the target) are encouraging the person to reveal or disclose. Additionally, the authors inform that if disclosers decide the benefits of disclosing outweigh the risks, then communication efficacy and willingness to reveal or disclose is likely to occur. Willingness to reveal includes considerations such as closeness with the disclosure target. Little is known about the risk-reward interaction process and how it varies in different contexts. For example, for individuals who are newly diagnosed HIV-positive (CSI), sharing this information could be very risky (Derlega et al., 2000).

On the other hand, for a couple revealing their pregnancy, sharing this information could include different kinds of risks. There is not enough empirical testing of the RRM to draw any significant conclusions (Derlega et al., 2004) and the RRM requires further testing as only two empirical tests exist (Carpenter, 2017). However, the RRM model is consistent with other disclosure theories specifically in that if people think the respondent will react negatively to the disclosure, they are much less likely to reveal it (Afifi, et al., 2005). Negative perceptions as a result of disclosure support the notion of avoidance and hostility toward disclosure. Henceforth both negative and positive perceived perceptions of the reactions of the disclosure target are important for understanding diagnosed MHC's disclosure in the workplace.

#### **2.6.6 The Communication Privacy Management Theory (CPM)**

The communication privacy management theory (CPM) developed by Petronio (1991, 2002), originally as the communication boundary management theory (CBM) (1991), considers how individuals manage private information. CPM makes three assumptions: firstly, privacy boundaries are created when sharing and disclosing private information (i.e., individuals "own" their information), then boundaries are "regulated to minimize risks" (p. 314), and finally individuals use decision rules to decide what information to reveal to others (Petronio, 1991).

The CPM has been tested primarily using qualitative methodologies such as interviews and focus groups (for example, Afifi, 2003; Caughlin & Golish, 2002; Petronio et al., 1996; Steuber & Solomon, 2011). The researcher found that this theory has predominately been assessed in terms of personal relationships rather than work relationships. However, in applying the CPM in understanding disclosure of CSI's, Greene and Faulkner's (2002) study on disclosing HIV status found that responses to their disclosure included negative emotional

reactions, the expectation to be treated differently, the expectation to receive support from disclosure targets and the expectation to be treated no differently.

Importantly, the first empirical study of its kind by Smith and Brunner (2017) through a qualitative method in using CPM to understand disclosure in the workplace suggests core criteria used by people when deciding to disclose private information at work. The themes emerging from the study include boundary maintenance based on organisational culture, relational considerations, risk/benefit disclosure consideration and desire for feedback. These outcomes are consistent with other disclosure theories specifically the relational considerations, risk/benefit disclosure considerations and desire for feedback. The outcome of boundary maintenance based on organisational culture is specifically related to the workplace, henceforth a noteworthy consideration in respect of the CPM theory for the current study.

### **2.6.7 A Multilevel Model of Workplace Concealable Stigma Management**

Jones and King (2014) provided an expanded model of disclosure processes at both the between-person level and the within-person level, meaning that identity management varies as a function of situational characteristics (i.e., within-person) but that people will also manage their CSI's in a certain way on average (i.e., between-person). Further, disclosure was identified to predict positive individual and organisations outcomes depending on certain factors such as the timing of disclosure, the target's reaction, and the visibility of the stigma.

According to meta-analysis results (Jones, 2011), disclosure outcomes varied, with some positive results on disclosure (for example, more emotional support from supervisors) and some negative results (for example, in one study approximately 40% of participants reported worse treatment post-disclosure and increased conflict or discomfort with co-workers). Furthermore, in a recent study on pregnancy disclosure Jones (2017) findings suggest that pregnant employees' expectations about pregnancy discrimination play a role in shaping

disclosure behaviours at work. In addition, certain behavioural strategies for disclosure were linked with average reports of experienced discrimination and momentary reports of psychological distress.

This model is consistent with prior models of disclosure (for example, Chaudoir & Fisher, 2010; Clair et al., 2005 and Ragins, 2008). Specifically, at the within-person level, the model recognises the contextual factors that influence individual disclosure decisions, such as the anticipated consequence of that disclosure. Moreover, Jones and King's (2014) model highlights the dynamic nature of disclosure decisions and suggests that these decisions will not only vary across individuals but also across contexts in the case of a single individual (Carpenter, 2017).

The above-mentioned models are complex both in breadth and depth, therefore a more parsimonious behavioural theory is reviewed which may yield similar or better results concerning the disclosure of MHCs in the workplace. On this premise, in addition to the abovementioned theoretical framework foundations reviewed, the researcher assessed the theory of planned behavior (TPB) by Ajzen (1991) to understand disclosure of a MHC in the workplace since a meta-analysis of the TPB model by Armitage and Conner (2010) supported the overall effectiveness of the theory in behavioural intentions. In addition, the TPB provides a detailed framework to build a questionnaire, namely constructing a TPB questionnaire document (Ajzen, 2002), which is not available for the other disclosure frameworks reviewed.

### **2.6.8 The Theory of Planned Behaviour (TPB)**

The Theory of Planned Behaviour (TPB; Ajzen, 1985), an extension of the Theory of Reasoned Action (TRA; Fishbein & Ajzen, 1975), has been the dominant theoretical approach to guide research on health-related behaviour for the past three decades. The theory is well recognised amongst researchers and is also familiar to many students, practitioners, and policy-

makers. Hence the researcher identified the TPB literature for this study. The TPB posits that individuals are more likely to engage in a certain behaviour if they have a favourable attitude towards it (behavioural beliefs) if they believe that people whose views, they value think that they should carry out the behaviour (normative beliefs) and if they feel that they have the necessary to engage resources and opportunities (control beliefs) in the behaviour (Ajzen, 1991).

The TPB has been reviewed to understand a variety of factors regarding disclosure of health behaviour's; the researcher was particularly interested in studies in respect of CSI health-related studies regarding disclosure. Empirical studies assessed included for example disclosure of HIV/AIDS, sexual orientation and dementia (Jemmott, et al., 2014; Mak et al., 2010, Foy et al., 2007). These articles provide successful outcomes of the use of the TPB on CSI disclosure behaviour. To this end, this study suggests elements from the TPB to better understand the disclosure of a MHC in the South African workplace.

Important to note is that even the most effective theories, models and training cannot ensure that disclosure will be beneficial, interventions that help disclosers set approach focused goals and equip them with effective communication and coping skills which may help give them greater control over mutually beneficial desired outcomes of the disclosure (Chaudoir & Fischer, 2010).

The summarised theoretical frameworks outlined above provide a good foundation for the current study in understanding the disclosure of a MHC at work. The current study aims to gain further understanding of this phenomenon in the South African work context by in what follows. To expand an understanding of core concepts drawn from the literature and theoretical frameworks, namely timing of disclosure, disclosure targets, roles of sources support and perceived experiences owing to disclosure is discussed.

## 2.7 Timing of Disclosure

Disclosure is irreversible; therefore, the decision to disclose, how to disclose and its timing, remains at the discretion of the employee. Research indicates that if one needs to disclose, the timing of disclosure can be critical (Sassin, 2011). In the absence of empirical research on the timing of disclosure of a CSI, it is difficult to fully understand what influences the timing and motives for disclosure (Follmer, Sabat & Siuta, 2019).

Thus, Brohan et al., (2012) in their systematic review of beliefs and behaviours influencing factors associated with disclosure of a MHC in the workplace, identified the concept of disclosure dimensions. These dimensions include selective disclosure “represents using or wishing to use selective disclosure strategies when deciding to disclose” (p.8) partial disclosure “represents occasions where individuals disclosed highly selective information about their illness e.g., disclosing ‘I have an illness’ or ‘I have a mental illness” (p.8). Inadvertent disclosure “represents accidental disclosure, brought about either by visible symptoms or carelessness such as blurting out something regarding illness” (p.8) and strategically timed disclosure " describes waiting until a point at which the person feels secure in their position, or with their colleagues before disclosure was highlighted" (p.8). Pearson et al. (2003) support the notion of disclosure as a strategically placed timing. In addition, Goldberg et al. (2005) suggest that later timing of disclosure can be helpful because co-workers in the workplace have had the opportunity and time to get to know each other first.

Disclosure decisions are further amplified or suppressed depending on the presence of certain contextual factors, including the interpersonal relationship between the discloser and the disclosure target. Banks et al. (2006) found that disclosure often occurred during the development stages while in the job. Ellison et al., (2003), found that the minority of participants made their disability known when applying for the job (e.g. during the recruitment and selection process). Importantly, Wahl (1999) indicated a significant number of participants

(32%) reported that disclosure during the recruitment process prevented them from receiving job offers. Sassin (2011) informed that disclosure should be done after rapport is established between parties at the earliest and after the job is offered. In addition, a few studies indicate that disclosure tends to occur before or early in the job. Together, these studies provide preliminary evidence that disclosure timing may influence important workplace outcomes for those with stigmatized identities, though more research is needed (Follmer et al, 2019).

## **2.8 Disclosure Target**

It is clear from the research that disclosure is chosen as a strategy for reaching a goal, and a disclosure target also known as the confidant is also intentionally selected (Omarzu, 2000). Disclosure may only yield psychological benefits to the extent that people feel supported and accepted by their disclosure target (for example, Beals et al., 2009). Further, individuals having close, trusting relationships with their disclosure target report disclosing was less challenging than in other situations (Derlega et al., 2000; Knobloch & Carpenter-Theune (2004); Pistole, 1993). Reavley and Jorm (2014) posits that disclosing a diagnosis to a friend or family member is likely to involve different considerations than disclosing to an employer. In addition, Afifi and Steuber (2009) argue that feelings of closeness to the disclosure target might reduce perceptions of risk (Bos et al., 2009; Pahwa et al., 2017).

Studies reveal that people living with a CSI were relatively open to disclose to people close to them and least open about disclosure towards acquaintances and colleagues (Bos et al, 2009). In a longitudinal examination of disclosure of a CSI (abortion) those who disclosed but felt that the disclosure target was not supportive and did not show benefits of disclosure in the form of less psychological distress (Major et al., 1990).

Further experimental manipulations have also revealed similar findings, indicating that participants do not experience the benefit of disclosure when their disclosure target reactions

are hostile (Lepore, Ragan, & Jones, 2000; Rodriguez & Kelly, 2006). Finally, Greene et al. (2006) posits there is no doubt that the mental health benefits of disclosure depend in part on the reaction of the disclosure target. Therefore, concerning the disclosure target, it is important to understand the conditions under which disclosure is beneficial and under which it is detrimental. Therefore, the researcher sought to assess the roles of sources of support factors in the disclosure process.

## **2.9 The Role of Sources of Support**

The value of emotional and pragmatic support, as well as disclosure in respect of MHCs, has been recognized over the years. Studies have demonstrated that both disclosure and social support are beneficial in improving perceived self-efficacy and helping improve the quality of life (De Choudhury & De, 2014). Disclosure is important for achieving certain goals such as developing close relationships and gaining emotional support (Greene et al., 2006).

Ragins (2008) emphasises that the decision to disclose should be made in a supportive work and non-work environment. Researchers emphasise the importance of supportive relationships in general and the importance of supportive targets in disclosure (Beals et al., 2009; Chaudoir & Fisher, 2010; Gignac & Cao, 2009; Ragins, 2008). Existing research suggests that the reaction of the disclosure target is one of the most important factors in predicting whether disclosure will be beneficial or not (Major et al., 1990; Lepore et al., 2000; Rodriguez & Kelly, 2006).

Henceforth, for employees faced with disclosure, the extent to which an organisation is perceived to be supportive plays an extremely important role in disclosure decisions. For instance, employees often consider the organisational culture and policies and anticipated reactions of co-workers before making a disclosure decision (Follmer et al., 2019).

A study by Munir et al. (2005) highlights the importance of creating a supportive work environment for those suffering from a MHC (for example, depression). Specifically, the support of line managers on disclosure was found to be a significant independent predictor of disclosure in the workplace (Munir et al., 2005). In addition, the author's implore support on disclosure may help such employees not only to manage their MHC effectively at work but also to minimise the extent to which it may affect their work itself, including work relationships.

Brohan et al., (2012) in their systematic review of beliefs, behaviours and influencing factors associated with disclosure of a MHC in the workplace provide a subtheme for disclosure of a MHC, namely, to obtain emotional support. This represents beliefs or experiences that obtaining support result in disclosure. This study supports Munir and colleagues (2005) research findings. However, the authors note that one of the main problems in creating a positively responsive and supportive work environment is overcoming barriers to the disclosure and attitudes towards MHCs (Munir et al., 2005).

In addition, Jones and King (2014) highlight that the possibility of less support from immediate line managers and co-workers may also create barriers to the disclosure at work. However, it is also clear that the decision to disclose a CSI is complex and depends on an individual's assessment of the positive and negative consequences of disclosure within a given social context (Clair et al., 2005; Ragins et al., 2007). In the next section, the researcher discusses the perceived negative experience in respect of MHCs. Following this section, the ideas on perceived negative experiences are discussed.

## **2.10 Perceived Positive Experiences in Respect of MHC Disclosure**

In the extensive literature reviewed it is suggested that mental health-related knowledge, positive attitudes, and workplace practices improve positive experiences of MHCs

disclosure (Henderson, Williams, et al., 2013). A study by Beals et al. (2009) on stigma management of a CSI showed that participants reported through measures of social support and psychological wellbeing experiences of positive effects, self-esteem, and satisfaction with life.

Furthermore, disclosure can give a sense of freedom and empowerment, as well as encouraging others to disclose (McLaren, 2004; Ralph, 2002), which may help combat discrimination as people learn to interact on an equal footing (Corrigan et al., 2001; Gordon, 2005). In addition, Peterson, Barnes, and Duncan (2008) provided an overarching perspective on the benefits of disclosure including confidence in the job, capacity to regulate one's condition on the job, having learned how to manage one's illness, and feeling socially connected. Studies have found that when employees have prior knowledge of a CSI (e.g. sexual orientation), disclosure was related to improved ratings of job performance through reduced perceptions of awkwardness (Sabat et al., 2017).

Moreover, people who decide to disclose may gain reasonable work accommodations, for example, additional medical assistance from the organisation or the medical aid scheme, time off to attend medical appointments and changed work duties. Workplace accommodations may assist employees diagnosed with MHCs in maintaining performance in their roles and remaining in the workplace while seeking treatment and recovery (Krupa et al., 2009). Brohan et al. (2012) not only identified one of the reasons why people with a MHCs disclosed was to be accommodated in the workplace, but also to be a role model for others, to obtain support, and to be honest.

Employer attitudes are one of the behaviours that impact whether employees feel comfortable and trust others and the process of disclosing a CSI (Capell et al., 2016). Higher levels of psychological flexibility may influence individuals faced with a MHC disclosure dilemma and predict multiple work-related outcomes, including better mental health, better job performance, and an increased capacity to learn skills at work (Bond & Bunce, 2003; Bond &

Flaxman, 2006; Hayes et al., 2006). However, the disclosure decision is balanced by suggested perceived positive experiences associated with disclosure on the one hand and the perceived negative experience on the other.

### **2.11 Perceived Negative Experiences in Respect of Disclosure of MHCs**

Due to stigmatised perceptions and other perceived negative experiences many people with MHCs prefer not to disclose. Pressure not to disclose due to fear of discrimination has been highlighted in studies by Allen and Carlson (2003); Dalgin and Gilbride (2003); MacDonald-Wilson and Whitman, (1995); Ralph (2002); and Roberts et al., (1995). These studies offer a unique perspective, specifically to the current study because all the participants were already employed. Mental health stigma hinders people from openly discussing mental health issues, especially in relation to the labour market (Wheat et al., 2010).

For employers, MHCs may be associated with increased health care costs as well as productivity losses in the form of absenteeism, short-term disability absences and presenteeism (i.e. reduced on the job productivity days) (Burton et al., 2008). That said, many known barriers to disclosure for people living with a MHC, include possible loss of employment benefits, loss of opportunities for vocational experience, lack of career advancement, negativity about the cyclical nature and complexities of psychiatric illnesses, as well as the side-effects from medication (Pratt et al., 1999). Dalgine and Gilbridge (2003) noted that participants in their study all feared disclosure would have a negative impact on their job. Their negative perceptions included a change in the way they were supervised (being more closely monitored), isolation from co-workers, termination, not being hired at all, lack of opportunity for advancement and a need to work harder than others to prove their worth.

The advantage of non-disclosure (if successful) is that it is likely to be easier to find a job: on the back of statistics reported in the United Kingdom, 56% of people believe they have

been turned down for a job due to disclosure of MHCs (Mental Health Foundation, 2002). Moreover, people are less likely to suffer from stigmatisation and discriminatory behaviour when employed (Brohan et al, 2012; Wheat et al., 2010). So, there is more reason for people with MHCs to try to conceal their condition. A recent study by the United Kingdom-based organisation, Business in the Community (BITC), found that among UK-based employees who had disclosed mental health issues to an employer, showed that 15% faced dismissal, disciplinary action or demotion.

Failure to disclose means that there is the risk of employers finding out some other way, potentially undermining ongoing relationships, work performance and/or threatening employment (Ralph, 2002). These effects of non-disclosure can be long-lasting and can have a serious impact on the quality of life for individuals, their families, and careers (Bender & Kennedy, 2004). Table 1 below shows a summary of research reviewed on perceived negative experiences.

In addition, a systematic review of 17 studies that explored the disclosure beliefs and behaviours of individuals with mental health problems emphasized the complexity of their decisions and the significant role that stigma and discrimination play (Brohan et al, 2012). Given the perceptions concerning stigma and discrimination, it is important that employees faced with a MHC disclosure understand what their legal rights are.

**Table 1**

*Summary Table of Studies on Perceived Positive and Negative Experiences Owing to Decision to Disclose in the Workplace*

<b>Author</b>	<b>Construct</b>	<b>Sample</b>	<b>Findings</b>
---------------	------------------	---------------	-----------------

Henderson, Williams, et al. (2013)	Perceived positive experiences	A survey conducted with British employers (n=480 in 2006 and n=500 in 2009 and 2010).	Revealed improved public attitudes to mental illness. Reduction in experiences of discrimination in employment.
Rusch et al. (2014)	Perceived positive experiences	100 participants with mental illness in the UK.	Immediate positive effects Decreased stress and stigma Reduced self-stigma and other positive outcomes (e.g. psychological wellbeing )
Chaudior and Quinn (2010)	Perceived positive experiences	235 participants who lived with a Concealable stigmatised identity in the USA	Disclosure to close others experience positive reactions. People generally careful in choosing a supportive confidant. Less fear of disclosure and the higher self-esteem reported.
Beals et al. (2009)	Perceived positive experiences	102 gay and lesbian (CSII ) participants in the USA	Reported greater well-being. Perceived social support was a consistent predictor of well-being. Perceived social support mediator of the association between disclosure and well-being.
Major et al. (1990)	Perceived positive experiences	Subjects were 283 women living with a CSI i.e. abortion in the USA	Fully supported had lower levels of depression than people who received less than full support. People who chose not to disclose at all reported low levels of support

Peterson et al., 2011	Negative perceived experiences	22 employed participants in New Zealand.	Fear of discrimination; Legal, practical and moral pressures
Dalgin and Gilbride (2003)	Negative perceived experiences	Sample of 11 adult psychiatric previously hospitalised volunteers was employed in the USA	Concern about stigma, Fear from the general public about psychiatric labels
Henderson and Thornicroft (2009)	Negative perceived experiences	Every year from 2009 to 2011 in the UK. Targeted groups (medical students, trainee teachers, trainee head teachers, social inclusion officers) <sup>28</sup> local schemes promote mental and physical wellbeing, and 32 anti-discrimination initiatives	Mental illness (ignorance), cultural stereotypes and myths. Social mistreatment or material discrimination.

## 2.12 MHCs, Disclosure and the Legislation in the South African Workplace

On-going concern for the government is the huge increase in the prevalence of MHCs in the last ten years. The proportion of medical insurance claimants suffering from a MHC has increased significantly in the last decade to nearly 40% today compared with 25% in the mid-1990s, stress and other MHCs are now among the main causes of employee absence according to a management survey by the Chartered Institute of Personnel and Development (2016).

Furthermore, there has been a rise in legal costs related to MHCs and work-related legal cases. A recent study SADAG (2016) indicates that one in three employees suffer from depression, and those employees with depression (MHC) have taken off at least 18 days a year to treat the condition, as well as unproductive days. The conditions and rights of employees

and employers are gazetted in the policies; however, there is much potential for improved education and awareness for both the employee and employer, especially in the case of those employed in the highest echelons within organisations. Additionally, considerations on how employees and employers can leverage on legislative benefits may add to the research on the understanding of the dilemma of MHC disclosure in the workplace.

Brohan et al. (2012) highlighted that the better the knowledge and awareness of the relevant legislation on the employment of people with MHCs, the greater the compliance with these laws when making hiring decisions. Although everyone has the right to decent and productive working conditions of freedom, equity, security and human dignity (WHO, 2004), for people with diagnosed MHCs, achieving this right remains particularly challenging. Moreover, as highlighted in literature by the South African discourse on MHC disclosure and stigma paints a picture of fragmented employee support structures and policies in respect of mental health matters in the workplace (SADAG, 2016).

South Africa subscribes to international legal protocols regarding MHC disclosure as formulated by the World Health Organisation (WHO) and the International Labour Organisation (ILO). The ILO Convention no. 159 on Vocational Rehabilitation and Employment (Disabled Persons) (1983) establishes the principle of equal treatment and employment of workers with disabilities across the world (Gabriel & Liimatainen, 2000).

On 13 December 2006, the United Nations General Assembly adopted a comprehensive and integral international convention, which focused on the protection and promotion of the rights and dignity of persons with disabilities (United Nations Organisation, 2006) and its optional protocol. These came into force on 3 May 2008. These instruments demonstrate the international community's formal acknowledgment of the rights of people with all kinds of disabilities (including MHCs) to participate in all aspects of public life including work (Kanter, 2007). The United Nations Organisation (2006) sets the gold standard for moving from the

limited and prejudicial idea that people with disabilities should be treated as priority cases in need of medical intervention and social protection, to the principle that they have a right to full inclusion in society including in the work environment.

### **2.13 Relevant South African Legislation and its Understanding in Respect of MHCs**

The purpose of the South African Employment Equity Act (Act no. 55 of 1998) is to achieve equity in the workplace by promoting equal opportunity and fair treatment in employment through the elimination of unfair discrimination. Also, the implementation of affirmative action measures to redress the disadvantages experienced by designated groups, to ensure equitable representation in all occupational categories and levels in the workforce are enforced (South African Institute of Chartered Accountants, 2019). As defined in the EEA, people with disabilities are those who have long-term or recurring physical, including sensory or mental impairment which may limit their prospect of entry into or advancement in employment and should be protected against unfair discrimination and stigma in the workplace. It is undeniable that work plays a particularly important role in supporting psychosocial health and recovery from illness, and so work is seen as a major component of the right to attain the highest standard of psychosocial health (Holness, 2014).

In chapter 3 of the Act, which deals with affirmative action, it states: “Every designated employer must in order to achieve employment equity, implement affirmative action measures for people from designated groups in terms of this Act.” In addition to this and in terms of section 54(1) (a) of the EEA, the Code of Good Practice: Key Aspects on the Employment of People with Disabilities (the Code) is issued.

Equal participation in the workplace for persons with disabilities, including those with psychosocial disabilities (for example depression), is one of the participation rights enshrined in the South African Constitution's equality clause and other clauses promoting the protection

of freedom of trade, occupation, and profession, as well as the right to fair labour practices. The rights to a healthy environment, to adequate health, to bodily integrity, including psychological integrity, and to life and dignity collectively, give rise to a constitutional duty on the state to respect, protect, promote and fulfil the psychological wellbeing of the population, including in the workplace (Holness, 2014).

The EEA prohibits unfair discrimination based on disability and requires steps to be taken to promote equal opportunities. However, the Code and its companion, the Technical Assistance Guidelines on the Employment of Persons with Disabilities (TAG), have identified definitional difficulties and a lack of clarity of these guidelines as well as the fact that employers are ill-equipped to understand how to promote psychosocial health and safety in the workplace, and how to reasonably accommodate psychosocial illness (MHCs) through workplace adjustments or modifications (Holness, 2014). Thus, the South African Human Rights Commission (SAHRC) developed a toolkit for South African employers with the relevant pieces of legislation, namely the EEA and the TAG (South African Human Rights Commission, 2017). The common categories of disability and MHCs are highlighted in the toolkit which is available to employers in South Africa. The research identifies the need to close the gap between the said policies 'construction and the successful execution in the workplace.

In conclusion, a legal framework exists to protect the rights of people with MHCs both in the workplace and outside of it. The law can be a powerful tool, but as suggested in the literature review, the legislation alone is not enough to encourage employees to disclose their MHCs in the workplace. As such, drawing from the above literature review, the researcher suggests it is reasonable to expect that when (disclosure timing), to whom (disclosure target), the role of support sources and perceived experiences owing to disclosure are key

considerations for employees in understanding the disclosure of a MHC in the workplace. The following propositions were derived for the current study:

#### **2.14 Research Propositions**

**Proposition 1:** Disclosure of a MHC is more likely to occur (disclosure timing) whilst employed rather than during the selection process.

**Proposition 2:** The support of people (disclosure targets) with MHCs at work from colleagues, the Human Resources Department and immediate line managers is significantly lower than from people outside of work (spouse/partners, parents, siblings, children, and friends).

**Proposition 3:** Perceived positive experiences owing to the disclosure of a MHC to an immediate line manager are significantly different than to the Human Resource Department.

**Proposition 4:** Perceived negative experiences owing to the disclosure of a MHC to colleagues are significantly different from perceived negative experiences owing to disclosure to immediate line managers.

### **3 Method**

This section describes the research design, sampling, data collection, research procedure, participants, measures, demographic characters and analysis techniques used in understanding diagnosed MHCs disclosure in the South African work context. The study uses primary data, this is in line with Panda et al. (2011) study on disclosure of a CSI based on support sources and perceived experiences of the disclosure.

#### **3.1 Research Design**

The exploratory sequential design allowed for a qualitative data phase to explore the subject matter and build to a second quantitative phase (Creswell, 2003). The qualitative phase was based on face-to-face interviews which lasted approximately 20 minutes each. The interview questions were based on the emergent theory and framework, while the answers were transcribed, and themes identified. Themes included support and perceived experiences owing to disclosing MHCs. This was used to create the final exploratory design instrument. A consequent online quantitative questionnaire was administered through Qualtrics (Qualtrics, Provo, UT, 2013). The online survey consisted of closed-ended questions and included an eligibility question. Thereafter, the data was transferred into a structured format using the IBM Statistical Package for Social Sciences (SPSS), version 24 (SPSS Statistics, 2014).

#### **3.2 Research Sampling**

In the case of the qualitative research design phase, participants were conveniently sampled (Creswell, 2003). The researcher required participants who were diagnosed and disclosed a mental health condition at work. Based on this knowledge, the researcher approached eight people in total. Three previous colleagues and two friends were willing and

agreed to participate in the interviews. The quantitative online survey was distributed to people affiliated with a South African non-profit organisation concerned with mental health issues. In this study, these sampling techniques were both a cost and time-effective way of selecting and obtaining a sample, given the resource limitation of the researcher.

### **3.3 Data Collection**

The online survey instrument was an attractive option for obtaining a sample of individuals who had disclosed a diagnosed MHC because it was confidential and, arguably, the most private way to collect data from participants who might have been diagnosed with a stigmatised illness (Carpenter, 2017). The application and structure of the final survey encouraged openness and transparency. The questions in the survey were aligned with a quantitative descriptive design since they focused on participants' opinions on the topical issue (i.e. disclosure of a diagnosed MHC) (Clark & Creswell, 2014). A Likert rating scale was used and most of the measures were rated on a 5-point scale ranging from 1 (totally disagree) to 5 (totally agree), unless stated otherwise. See Appendix A for the online questionnaire and the qualitative interview questions.

### **3.4 Procedure**

Ethical clearance was obtained from the Ethics in Research Committee of the Commerce Faculty at the University of Cape Town. A letter of consent, which formed part of the ethics application, was given to the five participants undergoing face-to-face interviews. The objective of the letter was to assure all participants of anonymity, confidentiality and the protection of the information in the research process. In the case of the face-to-face interviews, the consent letter was emailed to participants and the interview date, time and venue were

arranged and agreed upon. The consent letter contained information on the research objective, the researcher, and the research supervisor.

The same consent letter, along with the URL for the online survey on Qualtrics, was sent to candidates from the participating organisation: The South African Depression and Anxiety Group (SADAG). Given the nature of the study and, consequently, the private and confidential information shared by the participants on the MHC disclosure experiences, it was important to highlight that the research data would be treated with utmost confidentiality by the university's ethical code of conduct.

The online survey was developed using the themes identified from the face-to-face interviews and the guidelines of constructing a TPB questionnaire. The survey commenced with an eligibility question: "Have you disclosed a diagnosed mental health condition at work? (Examples include depression, bipolar mood disorder, schizophrenia, addiction, post-traumatic stress, anxiety, personality disorders, etc.)." Participants were then asked to answer "yes", "no" or "I have not been diagnosed with a mental health condition". Following the eligibility question, the purpose of the research, its confidentiality, voluntary and anonymous nature was explained. Demographic information was provided voluntarily, and the researcher's contact details were included should there have been any queries. Data collection took place over twelve weeks and the questionnaire took approximately 10 to 15 minutes to complete.

### **3.5 Participants**

The first stage of the research method comprised a formative interview carried out with five participants who had each confirmed with the researcher that they had disclosed a MHC at work. Four of the interviewees were female and one was a male. They declared their race as follows: two as Whites, two as Coloureds and one as a Black African. The interviewees were

between 35 to 55 years of age, had been employed for more than 10 years, and had all been living with a diagnosed mental health condition for five years and more.

349 participants responded to the online questionnaire, but 163 participants did not complete most of the questionnaire and were excluded from the final dataset. 189 answered "yes" to the eligibility question: "I have disclosed a diagnosed MHC condition", 55 answered "no" and 22 answered: "I have not been diagnosed with a MHC". Given the low response rate for the participants who reported "no" and "I have not been diagnosed with a MHC", the data was removed from the sample. The demographic variables for the online survey consisted of gender, race and age, tenure and number of years living with a MHC. After cleaning the data, the final sample for those who responded "yes" to having disclosed a diagnosed MHC totalled 109.

Table 2 below indicates that among the 109 respondents who had disclosed their diagnosed MHC at work, the majority (83.5%) were female. Whites (77%) were found to be the main racial group participating in this study and most of the respondents (34.9%) were between the ages of 30 to 40 years. Tenure of five to 10 years (24.5%) had the highest representation while most of the respondents (24.8%) had lived with a MHC for a period of 5 to 10 years. Refer to table 2 for a more exhaustive outlook on demographic data collected.

**Table 2**

*Frequencies and Percentages of Participants' Demographics*

<b>Demographic</b>	<b>Category</b>	<b>Frequencies</b>	<b>%</b>
Gender	Female	91	83.5
	Male	15	13.8
Race	Unspecified	3	2.7
	Black African	8	7.3
	Coloured	5	4.6
	Indian	4	3.7

	White	84	77.1
	Unspecified	8	7.3
Age	20-30	25	22.9
	30-40	38	34.9
	40-50	32	29.4
	60-70	3	2.8
	0-5	22	20.2
	5-10	27	24.8
	10-15	17	15.6
	15-20	17	15.6
	20-25	8	7.3
	25-30	6	5.5
	30 & above	7	6.3
	Unspecified	5	4.6
	0-5	22	20.2
	5-10	27	24.8
	10-15	17	15.6
Years living with a MHC	15-20	17	15.6
	20-25	8	7.3
	25-30	6	5.5
	30-35	2	1.8
	35-40	2	1.8

The age, tenure, and number of years living with a MHC were based on a free-response question. In Table 3 the summary indicates that respondents' mean age was 38.6 years ( $SD = 9.55$ ). In the case of this study, tenure refers to the total number of years the participant was employed, and the mean tenure was 13.1 years ( $SD = 9.7$ ). The data provided information on the number of years living with a MHC with a mean number of years 14.37 ( $SD = 10.8$ ). The minimum age was 22 and a maximum of 64 years, minimum tenure was 0 years and a maximum of 45 years. Among the participants, the minimum and a maximum number of years living with a MHC were 0 years and 55 years respectively.

**Table 3***Summary of MHC Disclosure Descriptive Statistics for Demographics*

<b>Demographic</b>	<b>N</b>	<b>Mean</b>	<b>S. Dev</b>	<b>Min</b>	<b>Max</b>
Age	107	38.589	9.548	22	64
Tenure	105	13.098	9.703	0	45
Years Living with MHC	104	14.375	10.798	0	55

Note: *N* = sample, S. Dev. = Standard Deviation, Min = Minimum, Max = Maximum.

### **3.6 Measures**

The preliminary formative face-to-face interviews shaped themes namely the perceptions of disclosure and the supportive people in disclosing a MHC. The researcher developed measures using the insights from the themes together with the guidelines used for developing direct questions of Ajzen's (2002) questionnaire construction document.

Henceforth, this study uses primary data, and the survey included questions about knowledge and perceptions of the participant's disclosure of a diagnosed MHC at work. This approach on constructing the measures is in line with a study that demonstrated success on the disclosure of schizophrenia (MHC) by Pahwa et al. (2017). The scales created and used can be found in Appendix B.

#### **3.6.1 The Occurrence of an MHC Disclosure (OMCD)**

This measure was used to determine the actual occurrence of disclosure of a diagnosed MHC at work. It was used to get a direct indication of when (disclosure timing) the disclosure by participants occurred to provide important insights into understanding MHC disclosure in the workplace. In the case of this study, the participants were asked to respond to the question:

"When did you disclose your mental health condition at work?"

The measure required respondents to select from a list of options, namely: during the selection process, on starting the job, 6-18 months after employment and on diagnosis (I was working when I was diagnosed).

### **3.6.2 Support of a MHC Disclosure (SMCD)**

Support of a diagnosed MHC disclosure was measured by identifying the people who had provided support to the employee and extent of the support; both at work (colleagues, line manager, Human Resource Department) and outside of work (spouse/partner, friend, spouse, sibling, and parent). Participants used a five-point Likert scale (1 = strongly disagree to 5 = strongly agree) to rate the level of support they received from each source.

### **3.6.3 Perceived Positive Experiences Owing to Disclosure (PPED)**

To measure participants perceived positive experiences as a result of disclosing their MHC at work, perceived positive outcomes that participants recalled they had experienced were provided. Participants were provided with a list of 8 perceived positive experiences and rated each one on the list using a five-point Likert scale (1 = strongly disagree to 5 = strongly agree). A sample of the positive outcomes experienced at work included: “appropriate accommodations and adjustment to my work”, “access to specialist support and medical benefits” and “opportunity to educate others about my condition”. Also, participants selected from a list of people at work to whom they had disclosed (that is. colleagues, immediate line manager and Human Resource Department). This was a separate measure included to determine to whom participants disclosed (disclosure target) and their associations with perceived positive experiences.

### **3.6.4 Perceived Negative Experiences Owing to Disclosure (PNED)**

To measure perceived negative experiences as a result of disclosure at work, participants were provided with a list of 12 perceived negative experiences. Participants rated each item of perceived negative outcomes experienced using a five-point Likert scale (1 = strongly disagree to 5 = strongly agree). A sample of items measuring perceived negative outcomes experienced at work included: “stigmatised (others formed a negative perception of me and my capabilities)” and “people had a negative perception that it impacted on my ability to perform my job”. In addition, participants selected from a list of people at work (disclosure target) to whom they had disclosed (i.e., colleagues, immediate line manager and Human Resource Department). This was a separate measure included to determine to whom participants disclosed and their associations with perceived negative experiences.

### **3.6.5 Demographic Characteristics**

Demographic variables were measured using single items. These variables included age, gender (male or female), race (Indian, White, Black African, Coloured, other or prefer not to answer), Participants had a free response option to report on age, tenure, and the number of years living with a MHC condition.

### **3.6.6 Statistical Analyses**

The data was analysed using the Software Package for Social Sciences (SPSS) version 24. Reliability analysis was conducted using Cronbach's alpha coefficient to measure the internal consistency of the items (Pallant, 2010). Where suitable, an exploratory factor analysis (EFA) was conducted using principal axis factoring. Kaiser-Meyer-Olkin (KMO) and Bartlett's test were conducted to ensure the data met the criteria for EFA. Cross-tabulations, descriptive analysis, and the Mann-Whitney U test were then used to test the research propositions.

## **4 Results**

In this section, the research findings are summarised. The section begins by examining the suitability of the measures. The results of the statistical analyses used to examine the propositions of the study are also discussed. The statistical analyses included examining the descriptive statistics, cross-tabulations, the chi-square test, factor analysis, and the Mann-Whitney U test. In addition, the section discusses the reliability of items produced, using Cronbach's Alpha.

### **4.1 Preliminary Analysis**

Before the data analyses, a set of initial analyses were conducted. The following scales were subjected to factor analysis: support in respect of MHC disclosure (SMCD), perceived positive experiences concerning disclosure (PPED), and perceived negative experiences owing to disclosure (PNED). The data was considered suitable for factor analysis when the Kaiser-Meyer-Olkin (KMO) measure was greater than .50, Bartlett's test of sphericity was significant and the p-value was less than .05 (Field, 2014). The KMO measure was used to determine sample adequacy and Bartlett's test of sphericity was used to determine inter-item correlations where applicable (Field, 2014). The underlying dimensions of the constructs were examined and Principal Axis Factoring (PAF) extraction method and rotation (Varimax with Kaiser Normalisation) were applied. Factors were retained if they had a factor loading  $> .40$ , based on Ware (1994)'s guidelines in their study on mental health. Cronbach's alpha was used to test the reliability of measures. Constructs with the Cronbach's alpha values greater than 0.7 were considered acceptable in assessing reliability (Bartholomew et al., 2011).

## 4.2 Factor Analysis

Factor analysis is a multivariate statistical method which assesses the dimensionality of a measure by clustering scale items to identify how many underlying theoretical constructs underlie the responses to the scale items in a particular sample (Field, 2014). In addition to determining the number of fundamental influences or dimensions underlying a scale, the goal of factor analysis is to quantify the extent to which each item is associated with each underlying dimension (termed as the size of the item's loading on a factor) (Roberts et al., 2006). If items hang together as expected then this is an indication that the scale has construct validity (Field, 2014). The preliminary analysis revealed that the set of items in the SMCD, PPED and PNED scales were appropriate for factor analysis. The KMO values were all above .50 and Bartlett's test of sphericity were all significant ( $p < .001$ ).

For the SMCD construct the results indicated significance ( $\chi^2 (28) = 283.401, p < 0.001$ ). The SMCD construct consisted of eight items measuring support in respect of disclosure at work and outside work. Rotations are recommended when factors correlate (Field, 2014). Furthermore, to ease interpretation, factors are rotated in such a way that items correlate most strongly with one factor and the least with any of the other factors. When conducting a PAF, several rotation methods can be used, one of which is Varimax Rotation and Kaiser Normalisation; an orthogonal rotation procedure (Field, 2014; Lani, 2017) was selected for this analysis. This procedure was deemed appropriate based on the assumption that factors do not correlate.

Two factors emerged, with 5 distinct items loading on factor 1 and two items loading on factors 2. Factor 1 would consist of support from spouse/partner, parent/sibling/s, child/ren, and friends as a result of disclosure and factor 2 would comprise of support from colleagues, the Human Resource Department and immediate line managers, as a result of the disclosure. The two-component structure explained 62.1% of the total variance. It was anticipated that factor

1, namely support owing to MHC disclosure at work (SMCDAW) i.e. Human Resource Department, immediate line managers and colleagues - would emerge and contributed 41.435% of the variance. Factor 2 namely support owing to MHC disclosure outside work (SMCDOW) i.e. Spouse/partner, parents, siblings, children and friends contributed 20.673% of the variance.

**Table 4**

*Factor Loadings for Exploratory Factor Analysis with Varimax Rotation of SMCD*

	Rotated Factor Loading	
	SMCDAW	SMCDOW
SMCDOW1 The following people have been SUPPORTIVE of my decision to disclose at work: Spouse/Partner		<b>.680</b>
SMCDOW2 The following people have been SUPPORTIVE of my decision to disclose at work: Parent/s		<b>.770</b>
SMCDOW3 The following people have been SUPPORTIVE of my decision to disclose at work: Sibling/s		<b>.780</b>
SMCDOW4 The following people have been SUPPORTIVE of my decision to disclose at work: Child/ren		<b>.664</b>
SMCDOW5 The following people have been SUPPORTIVE of my decision to disclose at work: Friends		<b>.512</b>
SMCDAW1 The following people have been SUPPORTIVE of my decision to disclose at work: Colleagues	<b>.820</b>	
SMCDAW2 The following people have been SUPPORTIVE of my decision to disclose at work: Human Resource Department	<b>.867</b>	
SMCDAW3 The following people have been SUPPORTIVE of my decision to disclose at work: Immediate Line Manager	<b>.879</b>	
Eigenvalues	3.315	1.654
Individual total variance (%)	41.435	20.673
Cumulative total variance (%)	41.435	62.108

Note.  $N=105$ , SMCDAW = Support owing to an MHC disclosure at work, SMCDOW= Support owing to an MHC disclosure outside work.

The eigenvalues were 3.32 and 1.65 respectively as seen in Table 4. The results indicate that SMCD is a bi-dimensional construct. All further analyses used SMCD as a separate scale: Support of a MHC owing to disclosure from those outside of work (SMCDOW) and support of a MHC owing to disclosure from those at work (SMCDAW).

The first round of factor analysis for PPED revealed that all items loaded onto two factors, with eigenvalues above 1.0 and explained 75.45% of the cumulative total variance. The sample size was found adequate as the KMO and Bartlett's test of sphericity produced criteria that supported the factor analysis. Two factors emerged from the EFA, each with eight items loading on both factors. However, two items loaded non-significantly, with factor loadings of .54 and .401, respectively. Item one PPED1 ("I experienced the following positive outcomes of disclosing at work: Access to specialist support and medical benefits") and item two PPED2 ("I experienced the following positive outcomes of disclosing at work: Appropriate accommodations and adjustment to work"). After the deletion of the two weak loaded items. The second round of factor analysis revealed that six items loaded onto one factor with an eigenvalue of 4.1 and explained 66.9% of the variance. The examination of the scree plot confirmed the PPED was uni-dimensional. Table 5 below presents the factor structure of PPEN.

**Table 5**

*Factor Loadings for Exploratory Factor Analysis of Perceived Positive Experience Owing to Disclosure Scale (PPED)*

		<b>PPED</b>
PPED1	I experienced the following positive outcomes of disclosing at work: Support from others for my condition	<b>.720</b>
PPED2	I experienced the following positive outcomes of disclosing at work: Sense of empowerment	<b>.803</b>
PPED3	I experienced the following positive outcomes of disclosing at work: Reduced stress from not concealing my condition	<b>.850</b>
PPED4	I experienced the following positive outcomes of disclosing at work: Opportunity to advocate about mental health issues	<b>.847</b>

PPED5	I experienced the following positive outcomes of disclosing at work: Opportunity to educate others about my condition	<b>.865</b>
PPED6	I experienced the following positive outcomes of disclosing at work: Sense of relief	<b>.816</b>
Eigenvalue		4.01
% Variance		66.93

Note. *N*= 103. PPED = Perceived positive experiences owing to disclosure

The factor analysis for PNED revealed that twelve items loaded onto one factor with an eigenvalue of 4.1 that explained 66.9% of the variance. The scree plot results confirmed the uni-dimensionality of PNED. Table 6 below presents the factor structure of PNED.

**Table 6**

*Factor Loadings for Exploratory Factor Analysis of Perceived Negative Experience Owing to Disclosure Scale (PNED)*

Note. *N* =103. PNED = Perceived negative experience

		<b>PNED</b>
PNED1	My competencies were questioned	<b>.775</b>
PNED2	Career prospects were limited	<b>.813</b>
PNED3	People had a negative perception that it impacted on work	<b>.880</b>
PNED4	Embarrassment	<b>.619</b>
PNED5	Stigmatised	<b>.918</b>
PNED6	Resulted in my being treated 'differently'	<b>.913</b>
PNED7	Increased surveillance of me by management work	<b>.788</b>
PNED8	The immediate manager was not understanding	<b>.755</b>
PNED9	Was viewed differently from others	<b>.912</b>
PNED10	My right to privacy would be violated	<b>.793</b>
PNED11	Discriminated against	<b>.879</b>
PNED12	Uneasy treatment from others	<b>.869</b>
Eigenvalue		8.27
% Variance		68.95

### 4.3 Reliability Analysis

Reliability analysis was conducted on the SMCD, SMCDOW, SMCDAW, PPED, PNED scales and the Cronbach alpha coefficients are reported. Cronbach's alpha values for SMCDOW and SMCDAT (Cronbach  $\alpha = .75$ ) and (Cronbach  $\alpha = .86$ ) respectively - showed acceptable internal consistency (Nunnally, 1978). The PPED (Cronbach  $\alpha = .91$ ) and PNED (Cronbach  $\alpha = .96$ ) also indicated good reliability. All scales thus indicated well to excellent internal consistency.

### 4.4 Descriptive Statistics

Table 7 indicates the descriptive statistics for support owing to MHC disclosure outside work (SMCDOW); support owing to MHC disclosure at work (SMCDAW); perceived positive experiences owing to MHC disclosure (PPED) and perceived negative experiences owing to MHC disclosure (PNED). The skewness and kurtosis of the variables were examined. Skewness indicates the symmetry of the distribution - the extent to which the distribution is skewed to have either too many low scores or too many high scores is shown in the distribution (Burns & Burns, 2008; Field, 2014). Kurtosis looks at the width and height of the distribution (Field, 2014). The further away the kurtosis and skewness values are from zero, the greater the likelihood that the data is not normally distributed (Field, 2014). Although many statistical analyses assume a normal distribution of data, it is acknowledged that this assumption is not often met in social sciences research. However, many of the parametric analyses in SPSS are rigorous and can still be used when this assumption is not strictly met (Egboro, 2015). Table 7 reports on the measures' means (*M*), standard deviations (*SD*), skewness and kurtosis of the data set analysed. The results of SMCDOW, SMCDAW, and PNED were all negatively skewed indicating higher scores in the distribution (Field, 2014). OMCD and PPED were positively skewed, indicating relatively lower scores in the distribution.

**Table 7***Descriptive Statistics of Scales under Investigation*

Scale	<i>M</i>	<i>SD</i>	Skewness	Kurtosis
1.OMCD	2.68	.83	.23	-.565
2.SMCDAW	3.13	1.01	-.582	-.305
3.SMCDOW	3.30	.80	-.461	.753
4.PPED	2.33	1.10	.599	-.742
5.PNED	2.86	1.14	-.024	-1.171

Note. *N*'s range from 98 to 108; *M* = Mean; *SD* = Standard Deviation; OMCD = Occurrence of a MHC disclosure; SMCDAW= Support owing to a MHC disclosure at work; SMCDOW= Support owing to MHC disclosure outside of work; PPED = perceived positive experiences in respect of MHC disclosure; PNED= perceived negative experience in respect of MHC disclosure.

In addition, the descriptive analysis of the data gathered through the questionnaire was subjected to frequency counts to measure the occurrence (disclosure timing) of MHC disclosure (OMCD) in the workplace. There were four options available to employees in respect of when disclosure occurred at work. The measures of interest for this construct were whether disclosure occurred during the selection process or six to eighteen months after employment. The results of the frequency distributions showed that the majority of respondents (44, 41.3%) disclosed their MHC after employment in relation to the respondents (9, 8.3 %) who disclosed during the selection process, see Table 8.

**Table 8**

*Descriptive Statistics Showing Frequencies for Occurrence (timing) of MHC Disclosure at Work*

MHC disclosure Occurrence/Timing	Frequency	Percentage
On diagnosis (I was working on diagnosis)	45	41.5%
During the selection process	9	8.3 %
On starting the job	11	10.1 %
6-18 months after employment	44	40.4 %
<b>Total</b>	109	100

*Note.* N=109, % = percentage

#### **4.5 Cross-tabulations**

A cross tabulation is a joint frequency distribution of cases based on two or more categorical variables. Displaying a distribution of cases by their values on two or more variables is known as contingency table analysis; one of the most used analytic methods in the social sciences. The joint frequency distribution can be analysed with the chi-square statistic ( $\chi^2$ ) to determine whether the variables are statistically independent or if they are associated (Michael, 2001).

##### **4.5.1 Cross- tabulation in Respect of Age, Tenure, When and to Whom Disclosed**

Cross-tabulations for the demographics, namely age and tenure were computed concerning when (disclosure timing) and to whom (disclosure target) the disclosure occurred. It is worth noting that in the present study, the researcher operationally identified tenure as the "total number for years employed". This could have potentially been understood as the overall number of years participants were employed and not the tenure with their current employer. Nonetheless, Gibson and Klein (1970) indicated in their study that age and tenure are highly related. The cross-tabulation results revealed that age and tenure did not show significantly different contributions to when disclosure occurred and to whom disclosed as seen in Table 9

and Table 10. The results from Pearson chi-square show the impact of age and when disclosure occurred to be statistically insignificant ( $p > 0.05$ ). This suggests that age and tenure is not a significant factor in respect to when participants disclose.

**Table 9**

*Cross-tabulation When did a MHC Disclosure Occur at Work (Age)*

		Age Group					Total	
			20<30	30<40	40<50	50<60	60<70	
<b>MHC disclosure occurrence</b>	On diagnosis (I was	n	10	15	15	3	1	44
	working when	%	40.0%	39.5%	46.9%	33.3%	33.3%	41.1%
	diagnosed)							
	During the selection	n	4	4	1	0	0	9
	process	%	16.0%	10.5%	3.1%	0.0%	0.0%	8.4%
	On starting the job	n	3	3	5	0	0	11
		%	12.0%	7.9%	15.6%	0.0%	0.0%	10.3%
	6-18 months after	n	8	16	11	6	2	43
	employment	%	32.0%	42.1%	34.4%	66.7%	66.7%	40.2%
	Total	n	25	38	32	9	3	107
		%	100%	100%	100%	100%	100%	100%

a. Chi ( $df$ ) = 9.673(12),  $p=0.645$

**Table 10***Cross- tabulation When an MHC Disclosure Occurred at Work (Tenure)*

<b>When Disclosed</b>	<b>Tenure Groups</b>								<b>Total</b>
	0 < 5	5 < 10	10 < 15	15 < 20	20<25	25< 30	30 < 35	40 < 45	
On diagnosis	6	11	7	6	8	6	1	0	45
	28.6%	45.8%	50.0%	35.3%	57.1%	60.0%	50.0%	0.0%	42.9%
During the selection process	4	1	1	2	0	0	0	0	8
	19.0%	4.2%	7.1%	11.8%	0.0%	0.0%	0.0%	0.0%	7.6%
On starting the job	2	3	1	2	1	0	0	0	9
	9.5%	12.5%	7.1%	11.8%	7.1%	0.0%	0.0%	0.0%	8.6%
6-18 months after employment	9	9	5	7	5	4	1	2	43
	42%	37.5%	35.7%	41.2%	35.7%	40.0%	50.0%	41.0%	100%

Note: Chi (*df*) =15.559(24), *p*=0.903

Furthermore, the relation between age and to whom participants disclosed at work was examined. The results of the cross-tabulation analysis indicated that majority of the respondents across all age groups disclosed their MHC to immediate line managers, followed by to the Human Resource Department and lastly to colleagues. The Pearson chi-square results in Table 11 showed that the relationship between age and to whom disclosed (disclosure target), were not statistically significant ( $p > 0.05$ ). This suggests that age is not a significant factor in deciding to whom the participants disclosed at work.

**Table 11**

*Cross-tabulation to Whom did Employees Disclose (Age)*

<b>To whom disclosed</b>	<b>Age</b>					<b>Total</b>
	20 < 30	30 < 40	40 < 50	50 < 60	60 < 70	
Colleagues	0 0.0%	6 15.8%	3 9.4%	1 11.1%	0 0.0%	10 9.4%
Immediate Line manager	8 33.3%	15 39.5%	13 40.6%	5 55.6%	3 100.0%	44 41.5%
Human resource department	2 8.3%	2 5.3%	2 6.3%	1 11.1%	0 0.0%	7 6.6%
More than one of the people mentioned in the list	12 50.0%	15 39.5%	13 40.6%	2 22.2%	0 0.0%	42 39.6%
Others	2 8.3%	0 0.0%	1 3.1%	0 0.0%	0 0.0%	3 2.8%
	24 100.0%	38 100.0%	32 100.0%	9 100.0%	3 100.0%	106 100.0%

Note: Chi ( $df$ ) =14,722 (16);  $p=0.543$

**Table 12***Cross-tabulation to Whom Employees Disclosed (Tenure)*

<b>To whom disclosed</b>	<b>Tenure Groups</b>									<b>Total</b>
	0 < 5	5 < 10	10 < 15	15 < 20	20<25	25< 30	30 < 35	35<40	40<45	
Colleagues	2	0	1	3	2	1	0	1	0	10
	10.0%	0.0%	7.1%	17.6%	14.3%	10.0%	0.0%	100.0%	0.0%	9.6%
Immediate manager	7	11	3	7	7	4	1	0	2	42
	35.0%	45.8%	21.4%	41.2%	50.0%	40.0%	50.0%	0.0%	100.0%	40.4%
Human resource department	1	2	2	0	1	0	1	0	0	7
	5.0%	8.3%	14.3%	0.0%	7.1%	0.0%	50.0%	0.0%	0.0%	6.7%
More than one of the people mentioned in the list	8	11	8	7	4	4	0	0	0	42
	40.0%	45.8%	57.1%	41.2%	28.6%	40.0%	0.0%	0.0%	0.0%	40.4%
Others	2	0	0	0	0	1	0	0	0	3
	10.0%	0.0%	0.0%	0.0%	0.0%	10.0%	0.0%	0.0%	0.0%	2.9%
	20	24	14	17	14	10	2	1	2	104
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Note: Chi (*df*) =36,850 (32); *p*=0.254

#### **4.5.2 Cross-tabulation of Age, Tenure as a Result of Perceived Positive and Negative Experiences**

Furthermore, in understanding demographic factors concerning disclosure and perceived experiences, cross-tabulations were conducted between age and tenure and results showed no significant differences between PPED and age and PPED and tenure. In Table C1 in Appendix C, the Pearson chi-square results showed that age, tenure, and perceived positive experience of disclosure of a MHC were not statistically significant ( $p > 0.05$ ). This indicated that there was no significant difference in perceived positive experience across different age groups and tenures in the sample. In the case of perceived negative experiences owing to MHC disclosure, table C2 in Appendix C showed the chi-square values ( $p > 0.05$ ) for all the scales, indicating that there was no significance between age and tenure in respect of perceived negative experience as a result of the disclosure.

#### **4.5.3 The Mann-Whitney U Test**

The Mann-Whitney U tests for differences between two groups on a single, ordinal variable with no specific distribution (Mann & Whitney, 1947). The Mann-Whitney U test was conducted to investigate whether there were statistically significant differences in mean scores of perceived positive experiences owing to disclosure (PPED) between groups; immediate line managers and the Human Resource department. As the dependent variable was continuous and the independent variable was categorical (the subjects were not the same in both groups) and the data were not normally distributed, Mann-Whitney U Test, a non-parametric alternative to t-test, was deemed appropriate (Larson-Hall, 2010, p. 138). The Mann -Whitney U test results indicated (PPED) was not significantly different for immediate line managers ( $M= 26.40$ ) than for Human Resource department (  $M= 16.57$  ),  $U = 88.00$ ;  $p = 0.091 > .05$  (see Table 13).

Therefore proposition 3, namely perceived positive experiences owing to the disclosure of a MHC to an immediate line manager are significantly different than those owing to disclosure to the Human Resource Department is not supported.

**Table 13**

*Mann-Whitney U Test Results: Perceived Positive Experiences Owing to MHC Disclosure*

<b>Group</b>	<b>N</b>	<b>Mean Rank</b>	<b>Sum of Ranks</b>	<b>ZU</b>	<b>P*</b>
Immediate Manager	42	26.40	1109.00	88.000	91
Human Resource Department	7	16.57	116.00		

Note:  $N = 109$ ,  $P^* > 0.05$

In addition, The Mann-Whitney U test was used to examine whether there was a significant difference between the two groups namely colleagues and immediate line managers concerning perceived negative experiences (PNED). Although these mean values are different as indicated in table 14 they are not statistically different. As the Mann-Whitney U test concerning (PNED) indicated a non-significant difference between colleagues ( $M = 24.2$ ) and immediate line managers ( $M = 25.75$ ,  $U = 173.00$ ;  $p = .771 > .5$ ). Thus, contrary to expectations the result did not provide support for proposition 4, namely perceived negative experience (PNED) owing to the disclosure of a MHC to colleagues is significantly different than disclosing to immediate line manager.

**Table 14**

*Mann-Whitney U Test Results: Perceived Negative Experiences Owing to MHC Disclosure*

<b>Group</b>	<b>N</b>	<b>Mean Rank</b>	<b>Sum of Ranks</b>	<b>ZU</b>	<b>P*</b>
Immediate Manager	9	24.22	218.00	173.00	0.771
Human Resource Department	41	25.78	1057.00		

Note:  $P^* > .05$

The findings of this study supported the idea that the disclosure of a MHC is more likely to occur (OMCD) whilst employed rather than during a selection process. In respect of the

support of a MHC disclosure (SMCD), results indicate that support owing to the disclosure of a MHC outside of work (SMCDOW) was significantly different than support owing to disclosure at work (SMCDAW). Contrary to expectations, the perceived positive experiences owing to disclosure (PPED) from immediate line managers were significantly different than that from the Human Resource department findings and do not support proposition 3. The final expectation that perceived negative experiences owing to disclosure (PNED) to colleagues would be significantly different than disclosing to immediate line managers was not supported by the analysis. Hence, proposition 4 was not supported. In addition, the analysis showed no significant correlation between age and tenure concerning whom employees (disclosure target) disclosed to and when disclosure occurred (disclosure timing). Furthermore, there was no relation between PPED and age, PPED and tenure, PNED and age and PNED and tenure. Table 15 provides a summary of these findings.

**Table 15**

*Summary of Findings*

	<b>Proposition</b>	<b>Finding</b>
<b>Proposition 1:</b>	Disclosure of a MHC is more likely to occur whilst employed rather than during the selection process.	Supported
<b>Proposition 2:</b>	The support of people with MHCs at work from colleagues, the Human Resources Department and immediate line managers is significantly lower than from people outside of work (spouse/partners, parents, siblings, children, friends)	Supported
<b>Proposition 3:</b>	Perceived positive experiences owing to the disclosure of an MHC to an immediate line manager are significantly different than to the Human Resource Department.	Not supported
<b>Proposition 4:</b>	Perceived negative experiences owing to the disclosure of an MHC to colleagues are significantly different from perceived negative experiences owing to disclosure to immediate line managers	Not supported

## **5 Discussion**

This study aimed to gain an understanding of the disclosure of diagnosed Mental Health Conditions (MHCs) within the South African workplace. This section provides an overview of the results and discusses the findings concerning the propositions presented. Thereafter, the limitations and implications of the research are discussed and suggestions for future research are presented.

### **5.1 Contributions of the Present Study**

This is the first South African study aimed at understanding disclosure of a diagnosed MHC in terms of specific disclosure patterns, namely when (disclosure timing), to whom (disclosure target), sources of support and perceived positive and negative experiences of how various groups at work responded to the disclosure. The propositions upon which the study is based are outlined below, after which there is a discussion of the related findings.

### **5.2 Disclosure of a MHC is More Likely to Occur Whilst Employed Rather than During the Selection Process**

Firstly, disclosure timing was investigated to establish whether there were any significant patterns of disclosure occurrence. The descriptive analysis indicated that a significant majority of respondents (41.3 %) disclosed their MHC while they were employed rather than during the selection process (8.3%). In addition, age and tenure (total length of employment) were measured against the timing of disclosure. The cross-tabulation analysis indicated that an insignificant number of participants between the age of 20 to 50 years disclosed during the selection process; similarly, an insignificant number of participants in the 50 to 70-year age group disclosed during the selection process. In the case of tenure, the cross-tabulation analysis concerning when the disclosure of a MHC occurred showed that all the

tenure groups tended to disclose during employment rather than during the selection process. An insignificant few with tenure of between naught and 25 years disclosing during the selection process and no employees with a tenure of between 26 and 45 years disclosed during the selection process. From the results, it could be concluded that a significant majority of employees disclosed their MHC during employment rather than during the selection process.

Also, since ( $p > 0.05$ ) was statistically insignificant, there was no correlation between age and tenure concerning when disclosure occurred. Importantly, proposition 1, namely the disclosure of a MHC is more likely to occur whilst employed rather than during a selection process, is supported. This has proved consistent with the findings of previous studies that employees prefer to disclose after they have been employed rather than before employment (Banks et al., 2006; Ellison et al., 2003; Granger et al., 1997, Choi et al 2016). As, Goldberg et al., (2005) note, later disclosure in the workplace can be helpful in that it gives disclosers the time and opportunity to get to know their co-workers first. The results for proposition 1 support their supposition.

### **5.3 Work Colleagues, Immediate Line Managers and the Human Resources Department Offer Significantly Lower Support to People with MHCs Disclosure than People Outside of Work (Spouse/Partner, Parents, Siblings, Children, Friends)**

The support offered by people at work and outside of work to those who disclose a MHC was examined. To test proposition 2, the following statistical methods were used: factor analysis, descriptive statistics, and specifically mean results. Eight measures of support owing to the disclosure of a MHC at work were identified, factor analysis was carried out and the results extracted two factors. Factor 1 was “support at work” (SMCDAW), while factor 2 was “support from outside work” (SMCDOW). The overall mean for support at work ( $M = 3.16$ ) was less than that from support outside work ( $M = 3.31$ ). The results indicated that support

owing to the disclosure of a MHC at work is significantly lower than support from those outside work.

Although there is limited literature on the support from those at work compared to the support of those outside of work for people who have disclosed a MHC, this finding is consistent with the findings of some extant literature (Bos et al, 2009; Pahwa et al., 2017), thus indicating that people tend to disclose to friends and family members rather than to work colleagues. However, Ragins (2008) states that the disclosure decision is made within the powerful context of the support received in both work and non-work environments. Disclosing a diagnosis to a friend or family member, for example, is likely to involve different considerations relative to disclosure to an employer (Reavley & Jorm, 2014). The discourse on disclosure theories presented in this study indicates that disclosure of a MHC depends, in part, on how the discloser perceives the reaction of the disclosure target (Greene et al. 2006). Thus, if it is perceived that the disclosure target's support or response will be negative or neutral, the discloser may prefer not to disclose their MHC. The research is clear about the potential destructiveness owing to perceived negative experiences of people living with a MHC. Therefore, a vigorous research agenda is necessary to gain empirical understanding into how the negative perceptions such as stigma and discrimination may best be overcome to support those living with a diagnosed MHC, especially in respect of disclosure at work.

#### **5.4 Perceived Positive Experiences Owing to the Disclosure of an MHC to an Immediate Line Manager are Significantly Different than Those Owing to Disclosure to the Human Resource Department**

Limited studies have examined perceived positive experiences specifically owing to MHC disclosure between immediate line managers and the Human Resource Department. However, studies that investigated the idea of perceived positive experiences owing to disclosure include those by McLaren (2004); Ralph (2002); Corrigan et al. (2001); and Gordon

(2005). Peterson et al. (2008) provide research outcomes for an overarching perspective on meaningful factors in disclosure which may be associated with perceived positive experiences. Other studies also support the importance of positive experiences or responses owing to disclosure (Schultz et al, 2011; Brohan et al, 2012; Holness, 2014; Krupa et al, 2009).

In understanding the proposition of perceived positive experiences owing to the disclosure of a MHC to an immediate line manager are significantly different than those owing to disclosure to the Human Resource Department, descriptive statistics and the Mann-Whitney U test was used. The results did not support the proposition as results indicated that the perception of positive experiences owing to disclosure of a MHC to an immediate line manager was not statistically significantly different than in the case of disclosure to the Human Resource Department, given that all the measures indicated a result  $p > 0.05$  from the Mann-Whitney U test.

In addition, the results indicated moderate mean scores for perceived positive experiences of the disclosure identified in the current study. The mean was highest for PPED1 "Support from others for my condition" (M = 2.50 SD = 1.345). Other mean results were PPED2 "Sense of empowerment" (M = 2.21, SD 1.35); PPED3 "Reduced stress from not concealing my condition" (M = 2.48, SD = 1.37); PPED4 "Opportunity to advocate about mental health issues" (M = 2.38, SD = 1.60); PPED6 "Opportunity to educate others about my condition" and PPED6 "Sense of relief" (M = 2.47; SD = 1.42). It may be assumed on the back of the literature reviewed that perceived positive experiences in respect of disclosure are related to support from the disclosure target. The disclosure target in the case of the current study is the immediate line manager, the Human Resource department and colleagues. This is consistent with studies indicating that support from the disclosure target is a significant predictor of disclosure in the workplace (Munir et al., 2005).

In view of this, the idea of support on the back of the outcome of proposition 2 in this study, namely, support is lower from those at work (SMCDAW) with that outside work (SMCDOW). The researcher suggests that support play an important part in the perceived positive experiences from the disclosure target.

### **5.5 Perceived Negative Experiences (PNED) Owing to the Disclosure of an MHC to Colleagues are Significantly Different from Perceived Negative Experiences Owing to Disclosure to Immediate Line Managers**

Limited studies have examined perceived negative experiences owing to the disclosure of MHCs to colleagues and line managers. However, negative perceptions like the perception of stigma and discrimination have been confirmed in multiple studies and include studies by Thornicroft et al. (2009); Wahl (1999); Lasalvia et al. (2013); and Schultz et al. (2011). Other studies (Wheat et al., 2010; Pratt et al., 1999) confirm disclosure's negative perceptions of a change in supervision (being more closely monitored); lack of opportunity for advancement and a need to work harder than others to prove one's worth. Dalgin and Gilbride (2003) highlight concerning outcomes of disclosure but more particularly, draw on disclosure having a negative impact on the job supporting the notion of perceived negative experiences owing to disclosure. In a study by Taylor and Altman (1987), results indicated that if costs are higher than rewards, there will be negative relational outcomes.

In this study, perceived negative experiences owing to disclosure were examined to understand the disclosure of a MHC in the workplace. All the perceived negative experiences measures were statistically insignificant at a 5% level as seen in the Mann-Whitney U test. This led to the rejection of proposition 4, namely that perceived negative experiences owing to disclosure to colleagues are significantly different than in the case of disclosure to immediate line managers. Despite the inferential output, the mean ranks from the Mann-Whitney U test indicated higher scores for immediate line managers than for colleagues: PNED1 “My

competencies were questioned” (immediate line manager M = 28.45; colleagues M = 23.30); PNED2 “Career prospects were limited“ (immediate line manager M = 27.79, colleagues M = 23.60); PNED4 “Embarrassment” (immediate line manager M = 27.00, colleagues M = 21.33); PNED5 “Stigmatised” (immediate manager M = 27.44, colleagues M = 25.10 ); PNED6 “Resulted in my being treated ‘differently’” (immediate line manager M = 28.07, colleagues M = 25.00), PNED7 “Increased surveillance of me by management” (immediate line manager M = 27.20, colleagues M = 23.55); PNED8 “Immediate manager was not understanding” (immediate line manager M = 27.90, colleagues M = 23.15); PNED9 “Was viewed differently from others” (immediate line manager M = 27.76, colleague M = 23.75), PNED10 “My right to privacy would be violated” (immediate line manager M = 26.59; colleagues M = 26.06);PNED11 “Discriminated against” (immediate line manager M = 27.57, colleagues M = 24.55); PNED12 “Uneasy treatment from others (immediate line manager M = 27.27, colleagues M = 25.85).

Notably, PNED3 “People had a negative perception that it impacted on my ability to perform” (immediate line managers M= 26.93, colleagues M=27.30) was the only measure where the mean for the immediate line manager was lower than for colleagues. This result may be due to the double negative wording in question, namely, “I experienced the following negative outcomes of disclosing my mental health condition at work: people had a negative perception that it impacted on my ability to perform”. Due to this potential ambiguity, the question may have been misunderstood and consequently, the responses may be inconsistent compared to those for the other eleven measures of PPED. However, the overarching results indicate that the perceived negative experience owing to disclosure is not significantly different in the case of colleagues than in the case of line managers. Moreover, breaking down negative perceptions like stigma may provide the type of open and supportive culture that enables staff

to be honest about the MHCs to access support and to enjoy a healthy working life (Deloitte, 2017).

## **5.6 Limitations and Suggestions for Future Research**

Disclosure of a diagnosed MHC in the workplace remains an underdeveloped area of research and this study aimed to contribute to the body of knowledge in this area. The following section outlines suggestions for future research based on the limitations identified in this study. This study utilised primary data by way of an online questionnaire. However, there are several limitations associated with this type of data source: although the assumption is that the data collected was accurate and intentional manipulations negated (Lewis-Beck et al., 2003). Because data were collected using an online survey hosted by the online communication infrastructure of an independent NPO, there was no control over the data collection process. If questions were misinterpreted or not fully completed, no changes could be made. The completion of the survey was not compulsory. This may have resulted in sample selection bias as participation was voluntary. One cannot determine whether there would have been a difference between those who responded and those who chose not to respond. Using online anonymous surveys as a data collection method carry the risk various response biases (Lewis-Beck et al., 2003).

It is recommended that the sample size be considered since the sample size of 109 was not adequate to examine the four propositions that were presented in this study. Hence, future researchers using a larger sample size should be able to produce and test more reliable and statistically inferential results. Another limitation was that the concepts of employee mental illness, mental disability, mental health condition, mental wellness and mental wellbeing were used interchangeably; hence creating room for potential misconceptions on what a mental health condition is in the current study. The questions in the study did, however, give examples

of MHCs but since with so many mental health conditions, it was impossible to label them all. Neither did the researcher examine what kind of mental health condition the respondent had disclosed. Therefore, a free-range question, such as, "with what kind of mental health condition have you been diagnosed" may have added further value to this paper, especially since the South African discourse on MHCs is fragmented (SADAG, 2016). Furthermore, limited studies in South Africa of this nature concerning specific MHCs (e.g. Bipolar disorder) within the workplace are available.

Additionally, the research specifically did not ask respondents to identify the reasons why participants had disclosed their MHC at work, due to the sensitive and confidential nature of this information. Since this information may have added more depth to an understanding of MHC disclosure. So, for example, people diagnosed with a MHC namely depression may be more prone to disclose compared to people with addiction.

Furthermore, given the complex nature of capturing disclosure in authentic workplace contexts, it may be the case that researchers are better able to manipulate disclosure timing or gauge confidantes' reactions using experimental designs (Cheung et al., 2017).

This research has set the foundation for future researchers as it provides an opportunity to investigate further on MHC disclosure patterns and experiences, specifically the impact of key disclosure targets at work (i.e. immediate line managers, the Human Resource Department and colleagues). This study utilized a cross-sectional design, which presents certain limitations since it cannot establish cause-and-effect relationships, only associations (Sedgwick, 2014). It is recommended that future researchers conduct longitudinal studies to examine possible time lag effects (Burns & Burns, 2008; Field, 2014). In the case of some of the propositions, no inferential statistics were used to assess the significance of the outcomes given the limitations concerning the measures used and the small data sample. Therefore, to analyse the propositions, descriptive statistics such as the mean were used as a basis from which to draw conclusions.

Owing to this key limitation of the study, future researchers should consider propositions and measurements that allow for inferential testing and analysis to obtain increased credibility in conclusions.

## **5.7 Implications of the Present Study**

This present study has filled the research gap on understanding MHC disclosure, specifically concerning disclosure patterns (when and who), the reactions of those to whom the employee with a MHC disclosed and the perceived experiences of the participants who disclosed their MHC at work. Therefore, this study has contributed to the existing literature on disclosure of a MHC at work, particularly in the South African context.

The study examined how the participants with a MHC perceived the response of different groups at work (immediate line managers, Human Resource Department and colleagues) and outside of work (spouse/partner, siblings, parents and friends) to the disclosure. Disclosure patterns with regards to when (disclosure timing) and to whom (disclosure target), support owing to disclosure and perceived positive and negative perceptions in respect of disclosure were examined. The results of the study showed that most employees do not disclose their mental health conditions during the selection process but rather after they have been employed. However, no rigorous statistical method was used to assess the significance of the outcome. Descriptive analysis was computed, and the mean frequencies and standard deviation were the measures of comparison. The results implied that the employees are hesitant to disclose their mental health conditions during the selection process. Many reasons have been highlighted in the literature for the failure to disclose before employment including the fear that it might reduce the candidate's chances of getting the job.

The analysis showed that the support in respect of MHC disclosure at work is significantly lower than outside of work. The results may indicate that those outside work

(spouse/partner, children) show genuine support based on trusted relationships as compared to less significant work relationships. Given the closer personal relationships with people outside of work and the emotional connection and intimacy of these relationships, it is not surprising that there is less support from those at work.

Contrary to expectations, in the case of the proposition 3 and 4, firstly that the perceived positive experience owing to disclosure to immediate line managers would be significantly different than in the case of disclosure to The Human Resource Department. Secondly, that the perceived negative experience owing to disclosure to colleagues would be significantly different than in the case of disclosure to immediate manager. The results revealed that there was no significant difference found for propositions 3 and 4, henceforth these propositions were not supported in this study. The outcomes of these propositions is in line with the literature about a need to close the gap of perceived lack of good supportive working relationships between immediate line manager, Human Resource Departments and the employees in the organisation, specifically with respect to mental health conditions disclosure. Other factors considered included, despite the expectation that immediate managers in alignment with Human Resource Departments should be the custodians of employee mental health awareness and promotion. Given their position in the organisation, these specific groups at work should contribute to the overall wellness of employees at work. Specifically, since the discourse of the far-reaching negative impacts of mental illnesses at work and the considerations on business success identified in the field of OHP. Furthermore, the results may support what the literature has identified as a gap between having MHC policies and processes and the poor implementation of these policies in organisations. This may mean that the lack of appropriate implementation of policies and processes may affect employees' attitudes toward their work environments and relationships.

Furthermore, important to note from the literature reviewed, an organisational culture that fosters and promotes employee wellness may consequently lead to more open conversations about mental health issues in the workplace. This is in line with other studies that suggest that disclosure can increase awareness, influence organisational culture, and create social and organisational change (Bowen & Blackmon, 2003; Creed & Scully, 2000; Meyerson & Scully, 1995).

These conversations, if driven by an organisational culture which inculcates employee mental health as a critical imperative will not only contribute to immediate line managers and human resource departments fulfilling leadership roles in this area. Moreover, it is suggested that it may lead to all employees in the organisation to adopt positive attitudes toward mental health matters. Such a favourable organisational culture that is conducive to promoting employee mental health may contribute to employees feeling less fearful and more comfortable about disclosing their MHC to those at work. More importantly, organisational cultures that embrace and foster employee mental health in the workplace, has indicated successful organisational outcomes, such as increased productivity and better profits (WHO, 2019b)

## **6 Conclusion**

There has been an increase in research on the disclosure of a diagnosed MHC at work over the last decade. However, there is limited documented research on this topic in the South African work context. This study identified notable findings in the patterns of the when and to whom (timing and target) of disclosure, support, negative and positive experiences owing to the disclosure of MHCs. Further research is necessary to empirically examine with adequate inferential statistics ways in which disclosure occurs over time and across each unique identity group. Also, the settings, support, and perceptions of the employees and those affected by MHCs disclosure at work should be examined empirically.

Moreover, this study has indicated that disclosure of a MHC at work is not a "one size fits all" process. This study can be used as a foundation for other researchers to build upon in understanding the disclosure of MHCs. It may be beneficial for future researchers to build on this understanding of MHCs concerning the nuances inherent to specific MHCs such as depression, bipolar disorder and so on. Also, researchers should apply and test models that capture the dynamic processes and environments in which MHC disclosure at work occurs. On the back of this, organisational HR policies and processes should be a central point of consideration in these processes and environments.

It is hoped that this research may assist employees and employers in creating safe working environments in which employees can feel comfortable and empowered to bring their full, authentic selves to work. Further, it is hoped that organisations will develop strategic organisational policies that include procedures such as mental health interventions which can create encouraging disclosure opportunities for employees. It is clear from the literature that disclosure of a MHC may reap positive benefits for both the employer and the employee.

The researcher suggests that if mental health policies, processes, and interventions are well conceptualised and implemented by leaders in organisations, it may become a competitive

advantage for those organisations. The advocacy and promotion of a mentally healthy workforce underpinned by an overarching organisational culture and strategy that embraces and promotes employee mental health, in general, has shown success in organisations.

Another by-product of promoting safe disclosure opportunities at work is the potential benefits concerning the organisation's employment equity position in terms of affirmative action as noted in the literature. Because on permission, the employee/s who discloses a diagnosed MHC at work may be reported through policy as a person/s working with a disability in terms of EEA and the Broad-Based Black Economic Empowerment Act 53 of 2003 (BBBEE Act). Organisations that comply are rewarded BBBEE points. The more BBBEE points an organisation has the higher its BBBEE rating, and the more enticing that business is as a service provider or supplier (BBBEE Act, 2003).

This study is clear about the potential destructiveness of disclosure experiences in the lives of people living with a MHC. Therefore, the research agenda in this area must be vigorous in the pursuit of understanding and obtaining insight into how prejudice and discrimination concerning MHCs might best be dismantled and overcome. Understandably, this will take time but as noted above, as well as elsewhere in the literature (Shih, 2004; Thoits, 2011), individuals with concealed stigmatised identities (MHCs) can disclose them, can overcome the consequences of the disclosure, and lead positive, optimistic lives.

In short, it is hoped that MHC disclosure encouragement may lead to more positive and healthy work experiences and ultimately more fulfilling and successful outcomes for both employees and employers. These conclusions are in line with a recent study by the Deloitte (2017) which affirms that organisations are starting to see mental health as a priority and recognise that it is important for recruiting and retaining the talent of the future, and that good mental health and wellbeing is linked to strong business performance.

## References

- Afifi, T., & Steuber, K. (2009). The revelation risk model (RRM): Factors that predict the revelation of secrets and the strategies used to reveal them. *Communication Monographs*, 76(2), 144-176. <https://doi.org/10.1080/03637750902828412>
- Afifi, T. D. (2003). 'Feeling caught' in stepfamilies: Managing boundary turbulence through appropriate communication privacy rules. *Journal of Social and Personal Relationships*, 20(6), 729-755. <https://doi.org/10.1177/0265407503206002>
- Afifi, T. D., Olson, L. N., & Armstrong, C. (2005). The Chilling Effect and Family Secrets: Examining the Role of Self Protection, Other Protection, and Communication Efficacy. *Human Communication Research*, 31(4), 564-598. <https://doi.org/10.1093/hcr/31.4.564>
- Ahmad, A., Sabat, I., & King, E. (2018). The upsides of disclosing your religion, sexual orientation, or parental status at work. *Harvard Business Review*, 12, 2-12.
- Ajzen, I. (1985). From intentions to actions: A theory of planned behavior. In J. Kuhl, J. Beckmann (Eds.) *Action Control* (pp. 11-39). Springer. [https://doi.org/10.1007/978-3-642-69746-3\\_2](https://doi.org/10.1007/978-3-642-69746-3_2)
- Ajzen, I. (1991). The theory of planned behaviour. *Organisational Behavior and Human Decision Processes*, 50 (2) 179-211. [https://doi.org/10.1016/0749-5978\(91\)90020-T](https://doi.org/10.1016/0749-5978(91)90020-T)
- Ajzen, I. (2002). *Constructing a TB questionnaire: Conceptual and methodological considerations*. <https://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.601.956&rep=repl&type=pdf>
- Allen, S., & Carlson, G. (2003). To conceal or disclose a disabling condition? A dilemma of employment transition. *Journal of Vocational Rehabilitation*, 19(1), 19-20.
- Altman, I., & Taylor, D. A. (1973). *Social penetration: The development of interpersonal relationships*. Holt, Rinehart & Winston.
- Armitage, C. J., & Conner, M. (2010). Efficacy of the theory of planned behavior: A meta-analytic review. *British Journal of Social Psychology*, 40(4), 471-499. <https://doi.org/10.1348/014466601164939>

- Banks, B. R., Novak, J., Mank, D. M., & Grossi, T. (2006). Disclosure of a psychiatric disability in supported employment: An exploratory study. *International Journal of Psychosocial Rehabilitation*, *11*(1), 69-84
- Bartholomew, D., Knotts, M., & Moustaki, I. (2011). *Latent variable models and factor analysis: A unified approach* (3rd ed.). John Wiley & Sons.
- Bateman, C. (2015). Mental health under-budgeting undermining SA's economy. *South African Medical Journal*, *105*(1), 7-8. <https://doi.org/10.7196/SAMJ.9166>
- Beals, K. P., Peplau, L. A., & Gable, S. L. (2009). Stigma management and well-being: The role of perceived social support, emotional processing, and suppression. *Personality and Social Psychology Bulletin*, *35*(7), 867-879. <https://doi.org/10.1177/0146167209334783>
- Bender, A., & Kennedy, S. (2004). Mental health and mental illness in the workplace: diagnostic and treatment issues. *HealthcarePapers*, *5*(2), 54-68. <https://doi.org/10.12927/hcpap..16824>
- Blank, A. A., Harries, P., & Reynolds, F. (2015). 'Without occupation you don't exist': Occupational engagement and mental illness. *Journal of Occupational Science*, *22*(2), 197-209. <https://doi.org/10.1080/14427591.2014.882250>
- Bond, F. W., & Bunce, D. (2003). The role of acceptance and job control in mental health, job satisfaction, and work performance. *Journal of Applied Psychology*, *88*(6), 1057-1067. <https://doi.org/10.1037/0021-9010.88.6.1057>
- Bond, F. W., & Flaxman, P. E. (2006). The ability of psychological flexibility and job control to predict learning, job performance, and mental health. *Journal of Organizational Behavior Management*, *26*(1-2), 113-130. [https://doi.org/10.1300/J075v26n01\\_05](https://doi.org/10.1300/J075v26n01_05)
- Bos, A. E., Kanner, D., Muris, P., Janssen, B., & Mayer, B. (2009). Mental illness stigma and disclosure: Consequences of coming out of the closet. *Issues in Mental Health Nursing*, *30*(8), 509-513. <https://doi.org/10.1080/01612840802601382>
- Bowen, F., & Blackmon, K. (2003). Spirals of silence: The dynamic effects of diversity on organizational voice. *Journal of Management Studies*, *40*(6), 1393-1417. <https://doi.org/10.1111/1467-6486.00385>

- British Psychological Society (2017). *Psychology at work: Improving wellbeing and productivity in the workplace*. <https://thepsychologist.bps.org.uk/volume-2018/january-2018/bringing-healthy-workplace-heart-government>
- Brohan, E., Slade, M., Wheat, K., Henderson, C., Malcolm, E., Clement, S., Barley, E., & Thornicroft, G. (2012). A systematic review of beliefs, behaviors and influencing factors regarding disclosure of a mental health problem in the employment context. *BMC Psychiatry*, *12*(1), 1-14. <https://doi.org/10.1186/1471-244X-12-11>
- Brunner, R. (2007). *Exploring disability disclosure amongst college and university staff in Scotland*. Equality Forward.
- Burns, R. P., & Burns, R. (2008). *Business research methods and statistics using SPSS*. SAGE Publications Ltd.
- Burton, W. N., Schultz, A. B., Chen, C., & Edington, D. W. (2008). The association of worker productivity and mental health: A review of the literature, *International Journal of Workplace Health Management*, *1*(2), 78-94. <https://doi.org/10.1108/17538350810893883>
- Capell, B., Tzafrir, S. S., & Dolan, S. L. (2016). The disclosure of concealable stigmas: Analysis anchored in trust. *Cogent Psychology*, *3*(1), 1121066. <https://doi.org/10.1080/23311908.2015.1121066>
- Carpenter, A. (2017). *Information management as a behavior examined through the context of mental health* [Unpublished doctoral dissertation]. Rutgers University-School of Graduate Studies.
- Caughlin, J. P., & Golish, T. D. (2002). An analysis of the association between topic avoidance and dissatisfaction: Comparing perceptual and interpersonal explanations. *Communication Monographs*, *69*(4), 275–295. <https://doi.org/10.1080/03637750216546>
- Chartered Institute of Personnel and Development. (2016). *Absence management survey*. <https://www.cipd.co.uk/knowledge/fundamentals/relations/absence/absence-management-surveys>

- Chaudoir, S. R., & Fisher, J. D. (2010). The disclosure processes model: Understanding disclosure decision making and post disclosure outcomes among people living with a concealable stigmatized identity. *Psychological Bulletin*, *136*(2), 236-256. <https://doi.org/10.1037/a0018193>
- Chaudoir, S. R., Fisher, J. D., & Simoni, J. M. (2011). Understanding HIV disclosure: A review and application of the Disclosure Processes Model. *Soc Sci Med*, *72*(10), 1618–1629. <https://doi.org/10.1016/j.socscimed.2011.03.028>
- Chaudoir, S. R., & Quinn, D. M. (2010). Revealing concealable stigmatized identities: The impact of disclosure motivations and positive first-disclosure experiences on fear of disclosure and well-being. *Journal of Social Issues*, *66*(3), 570–584. <https://doi.org/10.1111/j.1540-4560.2010.01663.x>.
- Checton, M. G. (2010). *Health disclosure decision-making: The role of prognosis and symptom uncertainty in ongoing disclosure to a spouse about a heart-related condition* [Unpublished doctoral dissertation]. Rutgers, The State University of New Jersey.
- Cheung, H. K., Lindsey, A., Sabat, I. E., & Ahmad, A. S. (2017). When gay men and lesbian women disclose their sexual orientation. *Academy of Management Proceedings (Vol. 2017, No. 1, p.10690)*. <https://doi.org/10.5465/AMBPP.2017.10690abstract>.
- Choi, S. Y., Venetis, M. K., Greene, K., Magsamen-Conrad, K., Checton, M. G., & Banerjee, S. C. (2016). Planning a stigmatized nonvisible illness disclosure: Applying the disclosure decision-making model. *The Journal of Psychology*, *150*(8), 1004–1025. <https://doi.org/10.1080/00223980.2016.1226742>
- Clair, J. A., Beatty, J., & MacLean, T. (2005). Out of sight but not out of mind: Managing invisible social identities in the workplace. *Academy of Management Review*, *30*(1)78–95. <https://doi.org/10.2307/20159096>
- Clark, V. L. P., & Creswell, J. W. (2014). *Understanding research: A consumer's guide*. Pearson Higher Ed.
- Corrigan, P. W., & Rao, D. (2012). On the self-stigma of mental illness: Stages, disclosure, and strategies for change. *The Canadian Journal of Psychiatry*, *57*(8), 464–469. <https://doi.org/10.1177/070674371205700804>

- Corrigan, P.W., River, L., Lundin, R.K., Penn, D.L., Uphoff-Wasowski, K., Campion, J., Mathisen, J., Gagnon, C., Bergman, M., Goldstein, H. & Kubiak, M.A. (2001). Three strategies for changing attributions about severe mental illness. *Schizophrenia Bulletin*, 27, 187 – 195
- Creed, W. D., & Scully, M. A. (2000). Songs of ourselves: Employees' deployment of social identity in workplace encounters. *Journal of Management Inquiry*, 9(4), 391-412. <https://doi.org/10.1177/105649260000900410>
- Creed, W. E. D. (2003). Voice lessons: Tempered radicalism and the use of voice and silence. *Journal of Management Studies*, 40(6), 1503–1536. <https://doi.org/10.1111/1467-6486.00389>
- Creswell, J. W. (2003). *Research design: Qualitative, quantitative, and mixed methods approaches*. Sage Publications.
- Dalgin, R. S., & Gilbride, D. (2003). Perspectives of people with psychiatric disabilities on employment disclosure. *Psychiatric Rehabilitation Journal*, 26(3), 306-310. <https://doi.org/10.2975/26.2003.306.310>.
- Davidson, L., Chinman, M., Sells, D., & Rowe, M. (2006). Peer support among adults with serious mental illness: a report from the field. *Schizophrenia Bulletin*, 32 (3), 443-450. <https://doi.org/10.1093/schbul/sbj043>
- De Choudhury, M., & De, S. (2014). Mental Health Discourse on reddit: Self-Disclosure, Social Support, and Anonymity. *Proceedings of the International AAAI Conference on Web and Social Media*, 8(1), 71-80. <https://ojs.aaai.org/index.php/ICWSM/article/view/14526>
- Deloitte. (2017). *At a tipping point? Workplace mental health and wellbeing*. The Deloitte Centre for Health Solutions
- Derlega, V. J., Winstead, B. A., Folk-Barron, L., & Petronio, S. (2000). Reasons for and against disclosing HIV-seropositive test results to an intimate partner: A functional perspective. In S. Petronio (Ed.), *Balancing the secrets of private disclosure* (pp. 53–69). Erlbaum
- Derlega, V. J., Winstead, B. A., Greene, K., Serovich, J., & Elwood, W. N. (2004). Reasons for HIV disclosure/nondisclosure in close relationships: Testing a model of HIV–

- disclosure decision making. *Journal of Social and Clinical Psychology*, 23(6), 747-767. <https://doi.org/10.1521/jscp.23.6.747.54804>
- Derlega, V. J., Winstead, B. A., Mathews, A. & Braitman, A. L. (2008). Why does someone reveal highly personal information? Attributions for and against self-disclosure in close relationships. *Communication Research Reports*, 25(2), 115-130. <https://doi.org/10.1080/08824090802021756>
- Dewa, C. S., & McDaid, D. (2011). Investing in the mental health of the labor force: epidemiological and economic impact of mental health disabilities in the workplace. In I. Z. Schultz, & E. S. Rogers (Eds.), *Work accommodation and retention in mental health* (pp. 33-51). Springer.
- Ebrahim, Z. (2019). *Mental illness among employees is on the rise: can workplace wellness programmes help?* Health24. <https://www.news24.com/health24/lifestyle/healthy-workplace/employee-wellbeing/mental-illness-among-employees-is-on-the-rise-can-workplace-wellness-programmes-help-20190713-2>
- Egboro, F. O. (2015). The implications of parametric and non-parametric statistics in data analysis in marketing research. *International Journal of Humanities and Social Science*, 5(6), 74-83.
- Elliott, M., & Doane, M. J. (2015). Stigma management of mental illness: Effects of concealment, discrimination, and identification on well-being. *Self and Identity*, 14(6), 654-674. <https://doi.org/10.1080/15298868.2015.1053518>
- Ellison, M. L., Russinova, Z., MacDonald-Wilson, K. L., & Lyass, A. (2003). Patterns and correlates of workplace disclosure among professionals and managers with psychiatric conditions. *Journal of Vocational Rehabilitation*, 18(1), 3-13.
- Field, A. (2014). *Discovering statistics using IBM SPSS Statistics*. SAGE Publications Ltd.
- Fishbein, M., & Ajzen, I. (1975). *Belief, attitude, intention and behavior: An introduction to theory and research*. Addison-Wesley.
- Flett, R. (2012). To tell or not to tell? Managing a concealable identity in the workplace, *Vulnerable Groups & Inclusion*, 3(1), 1-10, <https://doi.org/10.3402/vgi.v3i0.16145>

- Follmer, K. B., Sabat, I. E., & Siuta, R. L. (2019). Disclosure of stigmatized identities at work: An interdisciplinary review and agenda for future research. *Journal of Organizational Behaviour, 41* (2), 169 -184. <https://doi.org/10.1002/job.2402>
- Foy, R., Francis, J. J., Johnston, M., Eccles, M., Lecouturier, J., Bamford, C., & Grimshaw, J. (2007). The development of a theory-based intervention to promote appropriate disclosure of a diagnosis of dementia. *BioMedical Central Health Service Research, 7*, 202-215.
- Gabriel, P., & Liimatainen, M. R. (2000). *Mental health in the workplace*. International Labour Office.
- Garcia, J. A., & Crocker, J. (2008). Reasons for disclosing depression matter: The consequences of having ego system and ecosystem goals. *Social Science & Medicine, 67*(3), 453-462. <https://doi.org/10.1016/j.socscimed.2008.03.016>
- General Medical Council. (2015). *Supporting medical students with mental health conditions*. General Medical Council.
- Gibson, J. L., & Klein, S. M. (1970). Employee attitudes as a function of age and length of service: A reconceptualization. *Academy of Management Journal, 13*(4), 411-425.
- Gignac, M. A. M., & Cao, X. S. (2009). Should I tell my employer and coworkers I have arthritis? A longitudinal examination of self-disclosure in the work place. *Arthritis & Rheumatism-Arthritis Care & Research, 61*(12), 1753–1761. <https://doi.org/10.1002/art.24889>
- Goldberg, S. G., Killeen, M. B., & O'day, B. (2005). The disclosure conundrum: How people with psychiatric disabilities navigate employment. *Psychology, Public Policy, and Law, 11*(3), 463-500. <https://doi.org/10.1037/1076-8971.11.3.463>
- Goldman, H. H., & Grob, G. N. (2006). Defining ‘mental illness’ in mental health policy. *Health Affairs, 25*(3), 737-749. <https://doi.org/10.1377/hlthaff.25.3.737>
- Gordon, S. (2005). *The power of contact*. Case Consulting
- Granger, B., Baron R., & Robinson, S. (1997). Findings from a national survey of job coaches and job developers about job accommodations arranged between employers and people with psychiatric disabilities. *Vocational Rehabilitation 9*(3), 235–251

- Greene, K. (2009). An integrated model of health-disclosure decision making. In T. D. Afifi & W. A. Afifi (Eds.), *Uncertainty and information regulation: Theories and applications* (pp. 226–253). Routledge.
- Greene, K., & Faulkner, S. L. (2002). Expected versus actual responses to disclosure in relationships of HIV-positive African American adolescent females. *Communication Studies*, 53(4), 297-317. <https://doi.org/10.1080/10510970209388595>
- Greene, K., Derlega, V. J., & Mathews, A. (2006). Self-disclosure in personal relationships. In A. L. Vangelisti, & Perlman, D. (Eds.), *The Cambridge handbook of personal relationships* (pp. 409-427). Cambridge University Press.
- Greene, K., Magsamen-Conrad, K., Venetis, M. K., Checton, M. G., Bagdasarov, Z., & Banerjee, S. C. (2012). Assessing health diagnosis disclosure decisions in relationships: Testing the disclosure decision-making model. *Health Communication*, 27(4), 356-368. <https://doi.org/10.1080/10410236.2011.586988>
- Harnois, G., Gabriel, P. (2020). *Mental health and work: Impact, issues and good practices [WHO/MSD/MPS/00.2]*. World Health Organization.
- Hayes, S. C., Luoma, J. B., Bond, F. W., Masuda, A., & Lillis, J. (2006). Acceptance and commitment therapy: model, processes and outcomes. *Behaviour Research and Therapy*, 44(1), 1–25. <https://doi.org/10.1016/j.brat.2005.06.006>
- Henderson, C., & Thornicroft, G. (2009). Stigma and discrimination in mental illness: Time to change. *The Lancet*, 373(9679), 1928-1930. [https://doi.org/10.1016/S0140-6736\(09\)61046-1](https://doi.org/10.1016/S0140-6736(09)61046-1)
- Henderson, C., Brohan, E., Clement, S., Williams, P., Lassman, F., Schauman, O., Dockery, L., Farrelly, S., Murray, J., Slade, M., & Thornicroft, G. (2013). Decision aid on disclosure of mental health status to an employer: feasibility and outcomes of a randomised controlled trial. *The British Journal of Psychiatry*, 203(5), 350-357. <https://doi.org/10.1192/bjp.bp.113.128470>
- Henderson, C., Williams, P., Little, K., & Thornicroft, G. (2013). Mental health problems in the workplace: Changes in employers' knowledge, attitudes and practices in England 2006-2010. *The British Journal of Psychiatry*, 202(s55), s70-s76. <https://doi.org/10.1192/bjp.bp.112.112938>

- Holness, W. (2014). Equal recognition and legal capacity for persons with disabilities: Incorporating the principle of proportionality. *South African Journal on Human Rights*, 30(2), 313-344. <https://doi.org/10.1080/19962126.2014.11865111>
- Honey, A. (2004). Benefits and drawbacks of employment: Perspectives of people with mental illness. *Qualitative Health Research*, 14(3), 381-395. <https://doi.org/10.1177/1049732303261867>
- Irvine, A. (2011). Something to declare? The disclosure of common mental health problems at work. *Disability & Society*, 26(2), 179-192. <https://doi.org/10.1080/09687599.2011.544058>
- Jemmott III, J. B., Heeren, G. A., Sidloyi, L., Marange, C. S., Tyler, J. C., & Ngwane, Z. (2014). Caregivers' intentions to disclose HIV diagnosis to children living with HIV in South Africa: a theory-based approach. *AIDS and Behavior*, 18(6), 1027- 1036. <https://doi.org/10.1007/s10461-013-0672-0>
- Jones, A. M. (2011). Disclosure of mental illness in the workplace: A literature review. *American Journal of Psychiatric Rehabilitation*, 14(3), 212-229. <https://doi.org/10.1080/15487768.2011.598101>
- Jones, K. P. (2017). To tell or not to tell? Examining the role of discrimination in the pregnancy disclosure process at work. *Journal of Occupational Health Psychology*, 22(2), 239-250. <https://doi.org/10.1037/ocp0000030>
- Jones, K. P., & King, E. B. (2014). Managing concealable stigmas at work: A review and multilevel model. *Journal of Management*, 40(5), 1466-1494. <https://doi.org/10.1177/0149206313515518>
- Jones, K. P., King, E. B., Gilrane, V. L., McCausland, T. C., Cortina, J. M., & Grimm, K. J. (2016). The baby bump: Managing a dynamic stigma over time. *Journal of Management*, 42(6), 1530-1556. <https://doi.org/10.1177/0149206313503012>
- Kanter, A. S. (2007). The promise and challenge of the United Nations Convention on the rights of persons with disabilities. *Syracuse J. Int'l L. & Com*, 34, 287-321.
- Kelly, A. E. (2002). *The psychology of secrets*. Kluwer Academic/Plenum.

- Keyes, C. L. (2006). Mental health in adolescence: Is America's youth flourishing? *American Journal of Orthopsychiatry*, 76(3), 395-402. <https://doi.org/10.1037/0002-9432.76.3.395>
- Keyes, C. L. (2014). Mental health as a complete state: How the salutogenic perspective completes the picture. In G. F. Bauer, & Hammig, O. (Eds.), *Bridging occupational, organizational and public health* (pp. 179-192). Springer.
- Knobloch, L. K., & Carpenter-Theune, K. E. (2004). Topic Avoidance in Developing Romantic Relationships: Associations with Intimacy and Relational Uncertainty. *Communication Research*, 31(2), 173–205. <https://doi.org/10.1177/0093650203261516>
- Krupa, T., Kirsh, B., Cockburn, L., & Gewurtz, R. (2009). Understanding the stigma of mental illness in employment. *Work* 33(4), 413-425. <https://doi.org/10.3233/WOR-2009-0890>
- Lani, J. (2017). *Conduct and interpret a factor analysis*. <http://www.statisticssolutions.com/factor-analysis>
- Larson-Hall, J. (2010). *A guide to doing statistics in second language research using SPSS*. Abingdon.
- Lasalvia, A., Zoppei, S., Van Bortel, T., Bonetto, C., Cristofalo, D., Wahlbeck, K., Bacle, S. V., Van Audenhove, C., Van Weehgel, J., Reneses, B., Germanavicius, A., Economou, M., Lanfredi, M., Ando, S., Sartorius, N., Lopez-Ibor, J., Thornicroft, G., & The ASPEN/INDIGO Study Group. (2013). Global pattern of experienced and anticipated discrimination reported by people with major depressive disorder: a cross-sectional survey. *The Lancet*, 381(9860), 55-62. [https://doi.org/10.1016/S0140-6736\(12\)61379-8](https://doi.org/10.1016/S0140-6736(12)61379-8)
- Lepore, S. J., Ragan, J. D., & Jones, S. (2000). Talking facilitates cognitive–emotional processes of adaptation to an acute stressor. *Journal of Personality and Social Psychology*, 78(3), 499.
- Lerner, D., & Henke, R. M. (2008). What does research tell us about depression, job performance, and work productivity? *Journal of Occupational and Environmental Medicine*, 50(4), 401-410. <https://doi.org/10.1097/JOM.0b013e31816bae50>

- Lewis-Beck, M., Bryman, A. E., & Liao, T. F. (2003). *The Sage encyclopedia of social science research methods*. Sage Publications.
- MacDonald-Wilson, K. L., Russinova, Z., Rogers, E. S., Lin, C. H., Ferguson, T., Dong, S., & MacDonald, M. K. (2011). Disclosure of mental health disabilities in the workplace. In I. Z. Schultz, & E. S. Rogers (Eds.), *Work accommodation and retention in mental health* (pp. 191-217). Springer.
- Major, B., Cozzarelli, C., Sciacchitano, A. M., Cooper, M. L., Testa, M., & Mueller, P. M. (1990). Perceived social support, self-efficacy, and adjustment to abortion. *Journal of personality and social psychology*, 59(3), 452.
- Mak, W. W., Ng, A. C., Mo, P. K., & Chong, E. S. (2010). Coming out among lesbians, gays, and bisexual individuals in Hong Kong: Application of the theory of planned behavior and the moderating role of attitudinal ambivalence. *Sex Roles*, 63(3-4), 189-200. <https://doi.org/10.1007/s11199-010-9778-2>
- Malachowski, C. (2015). *An organizational study of mental health in the workplace* [Unpublished doctoral dissertation]. University of Toronto.
- Mann, H. B., & Whitney, D. R. (1947). On a test of whether one of two random variables is stochastically larger than the other. *The Annals of Mathematical Statistics*, 50-60.
- Marino, C., Child, B., & Campbell K. V. (2016). Sharing Experience Learned Firsthand (SELF): Self-disclosure of lived experience in mental health services and supports. *Psychiatric Rehabilitation Journal*, 39(2), 154-160. <https://doi.org/10.1037/prj0000171>
- Marrs, S. A., & Staton, A. R. (2016). Negotiating difficult decisions: Coming out versus passing in the workplace. *Journal of LGBT Issues in Counseling*, 10(1), 40-54. <https://doi.org/10.1080/15538605.2015.1138097>
- Martin, A., Sanderson, K., & Cocker, F. (2009). Meta-analysis of the effects of health promotion intervention in the workplace on depression and anxiety symptoms. *Scandinavian Journal of Work, Environment & Health*, 35(1), 7-18. <https://doi.org/10.5271/sjweh.1295>

- McDaid, D., Curran, C., & Knapp, M. (2005). Promoting mental well-being in the workplace: a European policy perspective. *International Review of Psychiatry*, 17(5), 365-373. <https://doi.org/10.1080/09540260500238397>
- MacDonald-Wilson, K., & Whitman, A. (1995). Encouraging disclosure of psychiatric disability. *American Rehabilitation*, 21(1), 15-19.
- McDowell, C., & Fossey, E. (2015). Workplace accommodations for people with mental illness: A scoping review. *Journal of Occupational Rehabilitation*, 25(1), 197-206. <https://doi.org/10.1007/s10926-014-9512-y>
- McLaren, K. (2004). Work in practice: Best practice employment support services for people with mental illness. Wellington: Platform. In I. Z. Schultz, & E. S. Rogers (Eds.), *Work accommodation and retention in mental health* (pp. 191-217). Springer.
- Memish, K., Martin, A., Bartlett, L., Dawkins, S., & Sanderson, K. (2017). Workplace mental health: An international review of guidelines. *Preventive Medicine*, 101, 213-222. <https://doi.org/10.1016/j.ypmed.2017.03.017>
- Mental Health Foundation (2002). *Out at work. A survey of the experiences of people with mental health problems within the workplace*. Mental Health Foundation.
- Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, 129(5), 674–697. <https://doi.org/10.1037/0033-2909.129.5.674>
- Meyerson, D. E., & Scully, M. A. (1995). Tempered radicalism and the politics of ambivalence and change. *Organization Science*, 6(5), 585–600. <https://doi.org/10.1287/orsc.6.5.585>
- Michael, R. S. (2001). *Cross tabulation & chi square*. <https://docplayer.net/20853199-Crosstabulation-chi-square.html>
- Munir, F., Leka, S., & Griffiths, A. (2005). Dealing with self-management of chronic illness at work: predictors for self-disclosure. *Social Science & Medicine*, 60(6), 1397-1407. <https://doi.org/10.1016/j.socscimed.2004.07.012>
- Occupational Health and Safety Act 85 (1993)*. South Africa.

- Omarzu, J. (2000). A disclosure decision model: Determining how and when individuals will self-disclose. *Personality and Social Psychology Review*, 4(2), 174-185. [https://doi.org/10.1207/S15327957PSPR0402\\_05](https://doi.org/10.1207/S15327957PSPR0402_05)
- Pahwa, R., Anthony, F., John, S., Brekke., & Eric, R. (2017). Mental illness disclosure decision making. *American Journal of Orthopsychiatry*, 87(5), 575-584. <https://doi.org/10.1037/ort0000250>
- Pallant, J. (2010). *SPSS survival manual: A step by step guide to data analysis using SPSS* (4th ed.). McGraw-Hill.
- Pachankis, J. E. (2007). The psychological implications of concealing a stigma: A cognitive-affective-behavioral model. *Psychological Bulletin*, 133(2), 328–345. <https://doi.org/10.1037/0033-2909.133.2.328>
- Pearson, V., Ip, F., Hui, H., & Yip, N. (2003). To tell or not to tell; disability disclosure and job application outcomes. *Journal of Rehabilitation*, 69(4), 35-38.
- Peterson, D., Barnes, A., & Duncan, C. (2008). *Fighting shadows: Self-stigma and mental illness*. Mental Health Foundation.
- Peterson, D., Currey, N., & Collings, S. (2011). You don't look like one of them: disclosure of mental illness in the workplace as an ongoing dilemma. *Psychiatric Rehabilitation Journal*, 35(2), 145-147. <https://doi.org/10.2975/35.2.2011.145.147>
- Petronio, S. (1991). Communication boundary management: A theoretical model of managing disclosure of private information between married couples. *Communication Theory*, 1, 311–335. <https://doi.org/10.1111=j.1468-2885.1991.tb00023.x>
- Petronio, S. (2002). *Boundaries of privacy: Dialectics of disclosure*. State University of New York Press.
- Petronio, S., Reeder, H. M., Hecht, M. L., & Ros-Mendoza, T. M. (1996). Disclosure of sexual abuse by children and adolescents. *Journal of Applied Communication Research*, 24, 181–199. <https://doi.org/10.1080=00909889609365450>
- Petronio, S. (2004). Road to developing communication privacy management theory: Narrative in progress, please stand by. *Journal of Family Communication*, 4(3-4), 193-207. <https://doi.org/10.1080/15267431.2004.9670131>

- Pistole, M. C. (1993). Attachment relationships: Self-disclosure and trust. *Journal of Mental Health Counseling, 15*(1), 94–106.
- Pratt, C. W., Gill, K. J., Barrett, N. M., & Roberts, M. M. (1999). *Psychiatric recovery*. Academic Press
- Qualtrics, I. (2013). *Qualtrics*. Provo
- Ragins, B. R. (2008). Disclosure disconnects: Antecedents and consequences of disclosing invisible stigmas across life domains. *Academy of Management Review, 33*(1), 194-215. <https://doi.org/10.2307/20159383>
- Ragins, B. R., Singh, R., & Cornwell, J. M. (2007). Making the invisible visible: Fear and disclosure of sexual orientation at work. *Journal of Applied Psychology, 92*(4), 1103-1118. <https://doi.org/10.1037/0021-9010.92.4.1103>
- Ralph, R. (2002). The dynamics of disclosure: Its impact on recovery and rehabilitation. *Psychiatric Rehabilitation Journal, 26*(2), 165–172. <https://doi.org/10.2975/26.2002.165.172>
- Reavley, N. J., & Jorm, A. F. (2014). Willingness to disclose a mental disorder and knowledge of disorders in others: changes in Australia over 16 years. *Australian & New Zealand Journal of Psychiatry, 48*(2), 162-168. <https://doi.org/10.1177/0004867413495317>
- Republic of South Africa. (1998). *Employment Equity Act, No. 55 of 1998*. Government Gazette, 400(19370).
- Republic of South Africa. (2003) *Broad-Based Black Economic Empowerment Act No. 53 of 2003*. Government Gazette, 463(25899).
- Roberts, M., Rotteveel, J., & Manos, E. (1995). Mental health consumers as professionals: Disclosure in the workplace. *American Rehabilitation, 21*(1), 20.
- Roberts, P., Priest, H., & Traynor, M. (2006). Reliability and validity in research. *Nursing standard, 20*(44), 41-45. <https://doi.org/10.7748/ns2006.07.20.44.41.c6560>
- Rodriguez, R. R., & Kelly, A. E. (2006). Health effects of disclosing secrets to imagined accepting versus nonaccepting confidants. *Journal of Social and Clinical Psychology, 25*(9), 1023-1047. <https://doi.org/10.1521/jscp.2006.25.9.1023>

- Rusch, N., Müller, M., Ajdacic-Gross, V., Rodgers, S., Corrigan, P., & Rössler, W. (2014). Shame, perceived knowledge and satisfaction associated with mental health as predictors of attitude patterns towards help-seeking. *Epidemiology and Psychiatric Sciences*, 23(2), 177-187. <https://doi.org/10.1017/S204579601300036X>
- Sabat, I. E., Lindsey, A. P., King, E. B., Ahmad, A. S., Membere, A., & Arena, D. F. (2017). How prior knowledge of LGB identities alters the effects of workplace disclosure. *Journal of Vocational Behavior*, 103, 56-70. <https://doi.org/10.1016/j.jvb.2017.09.001>
- Sassin, J. E. (2011). *Disclosing an invisible disability during the interview process: A qualitative study*. Sage
- Schultz, I. Z., Milner, R. A., Hanson, D. B., & Winter, A. (2011). Employer attitudes towards accommodations in mental health disability. In I. Z. Schultz, & E. S. Rogers (Eds.), *Work accommodation and retention in mental health* (pp. 325-340). Springer.
- Sedgwick, P. (2014). Cross sectional studies: advantages and disadvantages. *BMJ*, 348, g2276. <https://doi.org/10.1136/bmj.g2276>
- Seeman, M. V. (2009). Employment discrimination against schizophrenia. *Psychiatric Quarterly*, 80(1), 9-16. <https://doi.org/10.1007/s11126-008-9089-8>
- Shih, M. (2004). Positive stigma: Examining resilience and empowerment in overcoming stigma. *The ANNALS of the American Academy of Political and Social Science*, 591(1), 175-185.
- Smith, S. A., & Brunner, S. R. (2017). To reveal or conceal: using communication privacy management theory to understand disclosures in the workplace. *Management Communication Quarterly*, 31(3), 429-446. <https://doi.org/10.1177/0893318917692896>
- Steuber, K. R., & Solomon, D. H. (2011). Factors that Predict married partners' disclosures about infertility to social network members. *Journal of Applied Communication Research*, 39(3), 250-270. <https://doi.org/10.1080/00909882.2011.585401>
- South African Depression and Anxiety Group. (2016). *Making mental health matter in the workplace*. <https://www.sadag.org/images/newsletter/July16.pdf>

- South African Human Rights Commission. (2017). *Disability toolkit: A quick reference guide & monitoring framework for employers*. SAHRC.
- South African Institute of Chartered Accountants, (2019). *Employment equity act*. SAICA. <https://www.saica.co.za/Technical/LegalandGovernance/Legislation/EmploymentEquityActNo55of1998/tabid/3041/language/en-ZA/Default.aspx>
- Substance Abuse and Mental Health Services Administration (2008). *Self-disclosure and its impact on individuals who receive mental health services*. [http://store.samhsa.gov/product/Self-Disclosure-and-Its-Impact-on-Individuals\\_Who\\_Receive-Mental-Health-Services/SMA08-4337](http://store.samhsa.gov/product/Self-Disclosure-and-Its-Impact-on-Individuals_Who_Receive-Mental-Health-Services/SMA08-4337)
- Taylor, D. A., & Altman, I. (1987). Communication in interpersonal relationships: Social penetration processes. In M. E. Roloff & G. R. Miller (Eds.), *Interpersonal processes: New directions in communication research* (pp. 257–277). Sage Publications, Inc.
- Thoits, P. A. (2011). Resisting the stigma of mental illness. *Social Psychology Quarterly*, 74(1), 6-28. <https://doi.org/10.1177/0190272511398019>
- Thornicroft, G., Brohan, E., Rose, D., Sartorius, N., Leese, M., & INDIGO Study Group. (2009). Global pattern of experienced and anticipated discrimination against people with schizophrenia: a cross-sectional survey. *The Lancet*, 373(9661), 408-415. [https://doi.org/10.1016/S0140-6736\(08\)61817-6](https://doi.org/10.1016/S0140-6736(08)61817-6)
- United Nations Organisation. (2006). *Convention on the rights of people with disabilities and optional protocol*. <https://www.un.org/disabilities/documents/convention/convoptprot-e.pdf>
- Vickerstaff, S., Phillipson, C., & Wilkie, R. (Eds.). (2011). *Work, health and wellbeing: The challenges of managing health at work*. Policy Press.
- Wahl, O. F. (1999). Mental health consumers' experience of stigma. *Schizophrenia Bulletin*, 25(3), 467-478. <https://doi.org/10.1093/oxfordjournals.schbul.a033394>
- Ware J. (1994). *SF-36 physical and mental health summary scales: A user's manual*. The Health Institute, New England Medical Center.

- Wheat, K., Brohan, E., Henderson, C., & Thornicroft, G. (2010). Mental illness and the workplace: conceal or reveal? *Journal of the royal society of medicine*, 103(3), 83-86. <https://doi.org/10.1258/jrsm.2009.090317>
- Williams, H., Clarke, R., Fashola, Y., & Holt, G. (1998). Diogenes' syndrome in patients with intellectual disability: a rose by any other name? *Journal of Intellectual Disability Research*, 42(4), 316-320. <https://doi.org/10.1046/j.1365-2788.1998.00132.x>
- World Health Organization. (2004). *The World health report: 2004: Changing history*. World Health Organization.
- World Health Organization (2018). *Mental health: Strengthening our response*. <https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response>
- World Health Organisation (2019a). *The World Health Organisation (WHO) Global Mental Health Action Plan 2013-2020*. <https://www.who.int/news-room/events/detail/2019/10/10/default-calendar/world-mental-health-day-2019-focus-on-suicide-prevention>
- World Health Organisation (2019b). *Mental Health in the workplace*. [https://www.who.int/mental\\_health/in\\_the\\_workplace/en/](https://www.who.int/mental_health/in_the_workplace/en/)
- Yap, M. B., Wright, A., & Jorm, A. F. (2011). The influence of stigma on young people's help-seeking intentions and beliefs about the helpfulness of various sources of help. *Social Psychiatry and Psychiatric Epidemiology*, 46(12), 1257-1265. <https://doi.org/10.1007/s00127-010-0300-5>

## **Appendices**

### **Appendix A**

Measures utilized in the study

#### **Occurrence of MHCs disclosure (OMCD)**

When did you disclose your mental health condition?

#### **Occurrence of MHCs disclosure scale:**

1. 6-18 months after employment
2. During the selection process
3. On diagnosis (I was working when I was diagnosed)
4. On starting the job

#### **Support of MHCs disclosure**

The following people have been SUPPORTIVE of my decision to disclose at work:

#### **Support of MHCs disclosure at work scale:**

1. Colleagues
2. Immediate Line Manager
3. HR department

#### **Support of MHCs disclosure outside of work scale**

1. Spouse/Partner
2. Parent/s
3. Sibling/s
4. Child/ren
5. Friends

### **Perceived Positive experiences owing to MHCs disclosure scale**

I experienced the following positive outcomes of disclosing at work:

1. Access to specialist support and medical benefits
2. Appropriate accommodations and adjustment to my work
3. Support from others for my condition
4. Sense of Empowerment
5. Reduced stress from not concealing my condition
6. Opportunity to advocate about mental health issues
7. Opportunity to educate others about my condition
8. Sense of relief

### **Perceived negative experiences owing to MHCs disclosure scale**

I experienced the following positive outcomes of disclosing at work:

1. My competencies were questioned
2. Career prospects were limited
3. People had a negative perception that it impacted on my ability to perform
4. Embarrassment
5. Stigmatized
6. Resulted in me being treated 'differently'
7. Enhanced surveillance of me by management D
8. Immediate manager did not understand
9. Was viewed differently from others

10. Was viewed differently from others

11. Discriminated against

12. Uneasy treatment from others

## **Appendix B**

Face to face preliminary exploratory interview questions:

### **Screening questions:**

1. Have you ever been diagnosed with a mental health condition? Examples include depression, bipolar mood disorder, schizophrenia, addiction, post- traumatic stress, and anxiety and personality disorders?
2. Have you ever disclosed of your condition to family members?
3. Have you disclosed your condition to friends?
4. Have you disclosed your condition at work?
5. To whom have you disclosed your condition at work?
6. When have you disclosed of your condition at work?

### **Perceived experiences owing to disclosure outcomes of MHCs disclosure**

1. What do you think are the advantages of disclosing your mental health condition at work? (Probe for the following: ICAS, work colleagues, managers, supervisors or HR)
2. What do you think are the disadvantages of disclosing your mental health condition at work?
3. When do you think is the most appropriate time to disclose of you mental health condition at work?
4. What else come to mind when you think of disclosing your mental health condition to your people at work?

## **Supportive peoples in MHCs disclosure**

When it comes to disclosing of your Mental Health condition at work, there may be individuals or groups who would think you should or should not do this.

1. Please mention the individuals or groups who would approve or think you should disclose your mental health condition
2. Please mention the individuals or groups who would not approve or think you should not disclose your mental health condition
3. Sometimes, when we are not sure what to do, we look to see what others are doing. Do you know people at work who have or are MOST likely to disclose the mental health condition?
4. Do you know people at work who have not and are LEAST likely to disclose the mental health condition?

## **Perceived positive and negative experiences of MHCs disclosure**

1. What do you think are factors or circumstances that would make it easy or better enable you to disclose your mental health condition at work?
2. What do you think are factors or circumstances that would make it difficult for you to disclose your mental health condition at work?

## Appendix C

Table C1

*Chi-Square Tests Chi-Square Tests for perceived positive experiences (PPED) and Age*

	Value	df	Asymptotic Significance(2- sided)
Pearson Chi-Square	76.453 <sup>a</sup>	88	.805
Likelihood Ratio	72.714	88	.880
Linear-by-Linear Association	1.864	1	.172
N of Valid Cases	101		

a. 114 cells (99.1%) have expected count less than 5. The minimum expected count is .01.

Table C2

*Chi-Square Tests for perceived positive experiences (PPED ) and Tenure*

	Value	df	Asymptotic Significance(2- sided)
Pearson Chi-Square	157.958 <sup>a</sup>	176	.832
Likelihood Ratio	130.451	176	.996
Linear-by-Linear Association	.027	1	.870
N of Valid Cases	99		

a. 207 cells (100.0%) have expected count less than 5. The minimum expected count is .01.

Cross Tabulations Chi square results concerning age and tenure for perceived positive experiences owing to disclosure (PPED) and perceived negative experiences ( PNED) owing to disclosure :

Table C3

*Chi-Square Tests for perceived negative experience (PNED) and age*

	Value	df	Asymptotic Significance(2-sided)
Pearson Chi-Square	191.756a	152	.016
Likelihood Ratio	150.630	152	.516
Linear-by-Linear Association	.561	1	.454
N of Valid Cases	94		

a. 195 cells (100.0%) have expected count less than 5. The minimum expected count is .03.

Table C4

*Chi-Square Tests for perceived negative experience owing to MHC disclose and Tenure*

	Value	df	Asymptotic Significance(2-sided)
Pearson Chi-Square	295.331a	259	.060
Likelihood Ratio	203.374	259	.996
Linear-by-Linear Association	.050	1	.824
N of Valid Cases	92		

a. 304 cells (100.0%) have expected count less than 5. The minimum expected count is .01.