MENTAL HEALTH LITERACY AND ATTITUDES OF HUMAN RESOURCE PRACTITIONERS IN SOUTH AFRICA

by

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DECLARATION

I, the undersigned, hereby declare that the work contained in this thesis is my own original work and that I have not previously in its entirety or in part submitted it at any university for a degree.

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ABSTRACT

Background: South African companies need to contend with numerous transformation and development issues since the country's re-entry into the international marketplace. One component that is receiving increasing attention is the wellbeing of employees in the drive to remain competitive within the global economy. This study argues that mental illness is a component of employee wellbeing that has been ignored, even though these conditions are highly prevalent and costly to businesses. The lack of recognition, research and information about mental illness in the workplace raises questions about the knowledge and orientation of human resource (HR) practitioners. This study therefore aimed to investigate and describe the mental health literacy and attitudes of HR practitioners in South Africa.

Methodology: This study had a descriptive purpose and employed a sample survey research design to distribute a mail questionnaire to a randomly selected sample of human resource practitioners registered with the South African Board for Personnel Practice (SABPP). The measuring instrument comprised mental health literacy and attitudes scales that have been extensively researched and reported to have sound psychometric properties. Three vignettes portraying mental disorders selected for their relevance to the business world (i.e., depression, panic disorder and alcohol abuse) were used as aids to achieving the research aim. A standard statistical package (SPSS 10.0) was utilised to determine descriptive and inferential statistics with an accepted 5% level of significance.

Results: A response rate of 31% was achieved yielding an equal distribution of responses across the study vignettes. HR practitioners who acted as respondents to this study were found to be illiterate regarding mental illness and to hold subtle negative attitudes towards the mentally ill. Less than 10% could recognise mental illness as opposed to the majority who regarded the behaviour in the vignettes as normal responses. Whereas just over a third could correctly name the diagnosis described in the vignettes, only 7% were able to identify panic disorder. Most respondents believed that psychosocial stress factors caused mental illness, while only 29% where of the opinion that biological factors had a role in the aetiology of mental illness. Respondents favoured psychological and lifestyle treatment strategies and opposed medical treatments, irrespective of the type of mental illness presented with. Although as a group respondents showed mainly positive attitudes towards the mentally ill, evidence was found that the commonly held myths of danger/violence and the irresponsible/ childlike nature of the mentally ill were adhered to.

Conclusions: The HR field should take cognisance of the reality of mental illness. Urgent steps need to be taken to adequately equip HR practitioners and students with both evidence-based knowledge and a positive orientation to enable the effective management of these conditions in the workplace. Attention should be given to addressing common mistruths and misconceptions, and to creating an awareness of the significant role that the HR practitioner can play in timeously recognising and appropriately dealing with employee mental health problems so that companies can benefit by the optimal utilisation of human resources.

OPSOMMING

Agtergrond: Suid-Afrikaanse maatskappye het te doen met verskeie transformasie- en ontwikkelings aangeleenthede sedert die land se terugkeer na die internasionale mark. Die welstand van werkers is 'n aspek wat toenemend aandag verkry met hierdie strewe om mededingend te bly in die globale ekonomie. Hierdie studie argumenteer dat geestessiekte as 'n komponent van werkerwelstand geïgnoreer word, alhoewel dit algemeen voorkom en besighede heelwat geld kos. Die beperkte herkenning, navorsing en inligting oor geestessiekte in die werkplek lei tot vrae omtrent die kennis en inslag van Menslike Hulpbron- (MH) praktisyns. Derhalwe, ondersoek en beskryf hierdie studie die kennis en houding jeens geestesgesondheid van MH-praktisyns in Suid-Afrika.

Metodologie: Hierdie studie se doel is beskrywend van aard en maak gebruik van 'n steekproef opname navorsingsontwerp. 'n Vraelys is gepos aan 'n ewekansig geselekteerde steekproef van MH-praktisyns wat geregistreer is by die Suid-Afrikaanse Raad vir Personeelpraktyk. Die meetinstrument bestaan uit geestesgesondheid kennis- en houdingskale wat ekstensief nagevors is en wat beskryf is om goeie psigometriese eienskappe te besit. Drie gevallestudies van geestessteurings relevant tot die besigheidswêreld (depressie, panieksteuring en alkoholmisbruik) is gebruik as hulpmiddels om die navorsingsdoelwit te bereik. Standaard statistiese sagteware (SPSS 10.0) is gebruik om beskrywende en afleidende statistiek te bepaal met 'n aangenome 5% vlak van betekenisvolheid.

Bevindings: Altesaam 31% van vraelyste is beantwoord en dit was eweredig verdeel tussen die verskillende gevallestudies. MH-praktisyns wat deelgeneem het aan hierdie studie het swak kennis omtrent geestessiekte en subtiele negatiewe houdings ten opsigte van persone met geestesiekte getoon. Minder as 10% kon geestessiekte identifiseer teenoor die meerderheid wat die gedrag in die gevallestudies as normaal beskou het. Net oor 'n derde kon die diagnose korrek benoem en slegs 7% kon panieksteuring korrek identifiseer. Meeste van die respondente het geglo dat psigososiale stresfaktore geestessiekte veroorsaak, terwyl net 29% van mening was dat biologiese faktore 'n rol speel in die etiologie van geestessiekte. Respondente het psigologiese en lewensstyl behandelingsmodaliteite verkies bo mediese behandeling en dit was onafhanklik van die tipe geestessteuring wat voorgekom het. Alhoewel die respondente as 'n groep hoofsaaklik 'n positiewe houding getoon het ten opsigte van persone met geestessiekte, was daar bewyse dat algemene mites ondersteun is en dat persone met geestessiekte beskou is as gevaarlik/aggressief en as onverantwoordelik/kinderlik.

Gevolgtrekkings: Die MH veld moet die realiteit van geestessiekte aanvaar. Dringende stappe moet geneem word om MH-praktisyns en studente te voorsien van uitkomsgebaseerde kennis en 'n positiewe houding sodat effektiewe hantering van hierdie toestande kan plaasvind in die werkplek. Algemene onwaarhede en miskonsepsies moet aangespreek word en die bewustheid van die betekenisvolle rol van die MH-praktisyn moet benadruk word. Geestesgesondheidsprobleme van die werker moet betyds herken word en toepaslik gehanteer word sodat maatskappye voordeel kan trek uit die optimale gebruik van menslike hulpbronne.

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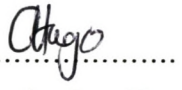

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Pay attention to what you are taught, and you will be successful; trust in the Lord and you will be happy.

[Proverbs 16:20]

DEDICATION

This study would not have been completed without the support, encouragement, motivation and assistance I had from Ms. Jane Metelo-Liquito. Jane, I would like to sincerely thank you for your interest in and enthusiasm for this study, for your faith in my ability to complete this task, and for meticulously proofreading each chapter and each re-write. Mostly though, I am indebted to you for taking on an additional load at the MHIC so that I could attend to my research. I therefore dedicate this thesis to you and would be honoured to proofread yours one day.

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"Organizations need people, and people need organizations"
(Wayne Cascio, 1995, p. 9)

INTRODUCTION AND OVERVIEW

1.1 Introduction

The modern world of work of the twentieth century has been replaced by a post-modern era of rapid change and uncertainty. This has necessitated a paradigm shift in the way organisations are conceptualised and managed. Previously regarded critical corporate values of efficiency and economies of scale have made way for new principles. Core values now emphasise teamwork, participation in global markets, and a customer-driven focus (Cascio, 1995; Carrell, Elbert, Hatfield, Grobler, Marx & van der Schyf, 1998).

Challenges to organisations on a global level have impacted on the role of the HR function. South African companies, after re-entry into the international community, face additional transformation and development issues, as will be briefly discussed below. This has lead to debate and action by the local HR field, in attempts to meet these challenges. Employee wellbeing is one of the areas that is being researched and addressed. However, this study argues that mental illness is a crucial component of wellbeing that is being ignored, even though mental illnesses have a significant impact on organisational success and ultimately, competiveness. This raises the question of the mental health literacy of HR practitioners, that is, a lack of knowledge and appropriate orientation towards mental illness.

1.1.1 The new world of work

The increasing *globalisation* of business has placed renewed pressure on companies to be competitive, on a local and global level. To survive, new concepts of management, organisation, and work have been introduced. Management has become more informational by focussing on knowledge, knowledge workers and learning organisation concepts, including intellectual capital (Brewster, Dowling, Grobler, Holland & Wärnich, 2000). Organisational structures have become leaner and meaner driven by cost-cutting concerns, and organisations are increasingly called on to be more adaptive to change, flexible, people-centred, and fluid (Cooper & Burke, 2002). The working life of employees has changed dramatically, leading to increased job insecurity, decreased morale, motivation, and loyalty. However, organisations continuously need to change to remain competitive.

An increasing body of knowledge is showing that a company's human resources (HR) can serve as a *competitive advantage* in this information era. The uniqueness of each organisation's HR profile can facilitate the implementation of value-creating strategies that cannot be simultaneously implemented or duplicated by competitors (Brewster et al., 2000). By recruiting, developing, and retaining the best talent available and by designing and implementing organisational structures to maximise the potential and performance of its people, companies can achieve superior performance and sustain competiveness (Dess & Picken, 1999).

The skills and cumulative learning of employees can be considered an asset if properly managed. The way people are managed has therefore received renewed attention given their important role in the success of businesses. The *process paradigm* is one of the new concepts regarding the contribution of HR to organisational performance. This approach regards HR processes as company-specific evolving mechanisms whereby employees are recruited, socialised, trained, evaluated, motivated and compensated (Amit & Belcourt, 1999). By developing and transferring knowledge throughout the entire company and by institutionalising learning, HR processes contribute towards the adaptability of the organisation and help to meet its changing needs. In this way, HR processes become a strategic asset in that they continually adjust in the way people are managed, enabling the effective implementation of organisational strategy.

The *human resource management (HRM) function* has changed dramatically in response to demands to play an active role in the success and competitiveness of organisations. New concepts such as total quality management, strategic HRM, international HR, leveraging human capital, and managing intellectual capital, to name but a few, have become the order of the day (Cascio, 1995; Cooper & Burke, 2002; Dess & Picken, 1999). Innovative HR approaches such as self-managed work teams, virtual teams, alternative workplace programmes, and virtual HRM have been designed and implemented to meet these challenges (Brewster et al., 2000).

1.1.2 Challenges to the South African HR function

South African companies, since entering this fast-paced global economy post-1994, need to compete with new developing markets, power blocs, and established international markets of the global village, in addition to being locally competitive in the products and services they provide (Carrell et al., 1998; Swanepoel, 1998). The challenge to the HR function is to attain, develop, motivate and maintain a quality workforce who can contribute to the company's bottom line and the South Africa economy as a whole. Coupled with this daunting task are the ***transformation and development issues*** facing local organisations. Not only does the challenge

of internationalised markets need to be addressed, but also that of worker productivity, quality improvement, the changing workforce, technology, downsizing, government policies and programmes, and the quality of working life.

The role and quality of the HR function with respect to each of these issues could be questioned due to the challenges they present to the HR profession. The HR field has responded by investigating the key issues facing business in South Africa and HR management in the quest to delineate the core HR roles and required HR competencies to meet these challenges (Sub-committee, 1999). Indeed, the very role of HR management has been critically analysed and proposals have been forwarded to redesign the HR role and re-engineer HR processes to meet the challenges of the new world of work (Grobler, 2001).

One of the most critical challenges is worker *productivity*. The South African workforce has one of the lowest productivity rates in the world (Grobler, Wärnich, Carrell, Elbert & Hatfield, 2002, p.18). This is further exacerbated by increased unit labour costs and the tendency to award salary increases even with decreased productivity levels (Grobler et al., 2002, p.19). To remain competitive, however, company structures and practices are changing. It is now realised that all workers must make the maximum contribution and that workplaces need to be democratised. Self-managed work teams, virtual teams, alternative workplace and telecommuting programmes are being introduced locally to increase employee commitment and productivity (Brewster et al., 2000; Odendaal & Roodt, 2002; Stewart, 2000).

The changing, *diverse* demographics of the South African workforce present a formidable challenge, especially given the growing emphasis on worker competitiveness. More women, single parents, dual-career couples, minorities such as the disabled and previously disadvantaged group members are now within the workplace than ever before (Carrell et al., 1998; Grobler et al., 2002; Swanepoel, 1998). Diversity training programmes, flexible workplaces, family-friendly efforts and gender discrimination issues are being researched and receiving attention at work (Brink & de la Rey, 2001; Grobler, Erasmus & Kölkenbeck-Ruh, 2003; Rijamampianina & Maxwell, 2002). Companies are recognising that such interventions can reduce absenteeism, cut turnover, improve efficiency, and impact positively on the bottom line. Furthermore, they can contribute towards addressing employee commitment, loyalty and trust issues brought about by the drastic restructuring measures that have taken place in many companies.

Government has also made a huge impact on South African companies since the new democratic government was elected. The Labour Relations Act, No. 66 of 1995, the Basic

Conditions of Employment Act, No. 75 of 1997, the Skills Development Act, No. 97 of 1998, and the Employment Equity Act, No. 55 of 1998, to name but a few, hold implications for the way people are managed and therefore for the HR profession (Grobler et al., 2002, p. 23).

Continuous improvement is needed to meet worldwide competition. The international and local trend is therefore to *downsize*, trimming costs by laying-off workers at all levels of employment (Cascio, 1995; Cooper & Burke, 2002; Vermeulen, 2002). Adding value and contributing to the company bottom line are now requisites to surviving in this highly competitive and uncertain age. Total quality management and process re-engineering efforts are regarded as methods to assist with this continual search for improvement.

South African companies are realising that a company-wide culture of *quality* is needed to survive in the global economy (Brewster et al., 2000; Grobler et al., 2002; Swanepoel, 1998). A focus on error and accident free outputs that meet customer requirements are regarded as means to help lower costs and increase productivity. Training and development, teamwork, and employee involvement, are some of the methods employed to improve quality.

Advances in and the increasing use of *technology* have impacted on the skills and abilities employees need to meet organisational goals (Cooper & Burke, 2002). Employee re-education and training programmes are being researched and installed to increase skills in both basic and job-specific areas of functioning. Approaches such as just-in-time (JIT) learning, outcomes-based education (OBE), and performance support systems (PSS) are being investigated to meet the learning demands of the rapidly advancing and highly competitive world of work (Blignaut & Knoetze, 2002).

However, companies are also realising that by attending to the *quality of working life* (QWL) of employees, that is, meeting personal needs such as security, responsibility, and self-esteem, organisational performance can be improved and competiveness in the global market facilitated. Participation in decision-making, team-building, reducing worker anxieties, and making work more rewarding, have been found to increase productivity, morale and loyalty and to decrease absenteeism and turnover (Grobler et al., 2002; Harrison, 2000). Encouraging employees to have fun at work, for example by instituting theme days, recognising achievements, and so forth, may help to increase motivation and thereby productivity. The reasoning is that enjoying what you are doing can enhance mental health, alertness, and creativity.

The central theme in this post-modern era is thus one of continual change, competitiveness, learning, working in teams, and superior performance. The people of an organisation (i.e., HR)

are therefore required to continuously adapt, learn, to be productive, creative, motivated and loyal. This obviously requires certain capabilities, abilities, skills, experience, expertise, and orientation towards work from all employees. It may be argued that one of the components to being a learning, adapting, committed, productive worker is positive health or wellbeing.

1.1.3 The role and challenges of employee wellbeing

The wellbeing of employees is indeed increasingly being recognised as an issue deserving consideration in the drive to be successful and to remain *competitive* (Gerber, Nel & van Wyk, 1998; Newell, 1995; Sub-committee, 1999). The health and safety of workers is on the HR agenda and within subject textbooks, and is further promoted in the workplace by the work of the National Occupational Safety Association of South Africa (NOSA) (Gerber, 1998). Safety committees and practises are no longer the exception as these are government regulated (Grobler et al., 2002). Although an often neglected concern in the workplace, employee health and occupational diseases are receiving some attention (Carrell et al., 1998; Gerber et al., 1998). Wellness and employee assistance programmes (EAP's) are being implemented to attend to the personal troubles of employees which may interfere with their delivering optimal performance at work. There is every indication that managing the welfare of people will continue to be an HR issue in the future. Indeed, many have cited EAP's, quality of life and QWL, management of change, coping skills, and support forums as emerging and necessary future people practices (Alker & McHugh, 2000; Carrell et al., 1998; Freeman, 2003; Sub-committee, 1999).

Attending to the wellbeing of employees may be considered an *HR responsibility*, as managing a workforce that is capable of contributing at an optimal level is the core function of HRM (Swanepoel, 1998; Werther & Davis, 1996). Not attending to employee wellness is generally accepted as having the potential to impact negatively on the company bottom line. In an era where the HR function must now prove that it can add real, measurable economic value to the organisation and contribute towards success and competitiveness, employee wellness should be considered an HR priority. Attending to employee wellbeing may help to reduce employee healthcare costs and claims, absenteeism, accidents, and can contribute towards improving productivity, alertness, creativity, morale and loyalty (Carrell et al., 1998; Grobler et al., 2002; Newell, 1995; Swanepoel, 1998). HR practitioners should therefore be knowledgeable about employee wellbeing issues and be able to manage these effectively so that the workforce can be optimally utilised to reach company goals and ultimately achieve and sustain competitiveness.

Possible *causes of employee ill health* include poor lifestyle habits, infectious diseases, occupational diseases, and the legacy of Apartheid. Weight control, exercise and fitness, nutrition and cholesterol, cigarette smoking cessation, low back care, and stress management

programmes are being implemented by many local organisations, as is the international trend (Bellingham & Cohen, 1987; Carrell et al., 1998; Miner, 1992; Pieters, 1996). The role of the human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) is receiving considerable attention, both within research circles and the business world (Burton, 2001; Dorrington, Bourne, Bradshaw, Laubscher & Timæus, 2002; Gerber et al., 1998; Vinassa, 2002). Other infectious diseases such as tuberculosis have no less of an impact on employee wellbeing and perhaps have not yet received their due recognition, given the high prevalence figures and the difficulties of treatment (Kironde, 2002; van Rie, Warren, Richardson, Gie, Enarson, Beyers & van Helden, 2000). Asbestosis, contact dermatitis, asthma and other occupational diseases have recently been in the limelight and are being attended to by some companies, often as a result of pressure from employee groups and legal actions (Emmett, 2002; Fish, 2002; Harris & Kahwa, 2003). Inequalities of wealth and available resources due to the previous regime have contributed towards certain population groups being more susceptible to, for example, infectious and nutrition-related conditions, and even alcohol abuse (Andersson & Marks, 1988; London, 2000; McIntyre & Gilson, 2002).

Employee wellbeing not only implies good physical health, but also refers to the *mental and social wellbeing* of individuals (Gerber et al., 1998; Newell, 1995; Pieters, 1996; Swanepoel, 1998). Indeed, stress and burnout are common terms in the HR literature, academic debate and in the workplace (Bennet, 2001; Gerber, et al., 1998; Govender & Grundling, 1999; Strümpfer, 2003; van Zyl, 2002; Vinassa, 2003). Substance abuse, especially alcohol-related problems, has received attention since the first EAP's were initiated. These continue to impact on employee wellbeing, perhaps more so now than ever before (Carrell et al., 1998; Gerber et al., 1998; Grobler et al., 2002). Anxiety conditions such as posttraumatic stress disorder (PTSD) are also slowly being recognised and researched, particularly amongst high-risk groups such as the security and defence forces (Allen & Ortlepp, 2000; Dussich, 2003; Eagle, 2002). Suicide has received some research attention, again, mostly within the security and defence force work groups (Rothmann & van Rensburg, 2002).

HR practitioners should therefore be adequately informed about, *trained and orientated* in these possible causes of employee ill health. They should know how HIV/AIDS, asbestosis, hypertension, cholesterol, mental illness, et cetera, impact on employee wellbeing in order to be able to effectively manage the health of the workforce.

The focus of this study, however, is to address in particular the knowledge and expertise within the HR field in respect of ***mental illness***, not infectious or industrial diseases, or any of the abovementioned, although their significant impact is acknowledged.

1.1.4 Mental illness in the workplace: the overlooked component of wellbeing?

Given the challenges of the new era of work, it may be argued that the mental health of employees is one of the essential factors to their being a strategic asset and to serving as a competitive advantage. This is especially so when the emphasis is on teamwork, as the mental health of individual members may contribute towards an effective and productive team (Gmeiner & van Wyk, 2001). The question may therefore be asked whether HR practitioners have been adequately ***trained*** in mental illness matters. Also, given the role of HR practitioners in the new world of work, a positive ***orientation*** towards mental illness is required to not only manage these issues but also to make a durable, company-wide impression of the benefits to be derived by addressing these conditions.

However, there appears to be a *lack of recognition and research* by the HR field regarding mental illness in the workplace. A review of the literature reveals a paucity of information on this subject, with the majority of published work originating from the psychiatry and clinical or social psychology professions. The work that does express an HR point of view is almost solely limited to covering stress, burnout and substance abuse (i.e., primarily concerned with emotional wellbeing not mental illness). Although work has recently been published on posttraumatic stress disorder and suicide, these are few in number and limited to specific work populations. There is a *lack of information* on HR and the majority of mental illnesses. It may therefore be asked, what about the mood disorders (including major depressive disorder, bipolar mood disorder, dysthymia), anxiety disorders (including social phobia, panic disorder, obsessive-compulsive disorder), sleep disorders (including insomnia, hypersomnia), personality disorders (including paranoid, borderline, dependent and narcissistic personality disorders), psychotic disorders (including schizophrenia and schizoaffective disorder), and all the other mental conditions that do exist and need to be addressed?

A focus on wellbeing is important, however, there is increasing evidence that mental disorders per se impact on the company bottom line. The apparent lack of consideration of mental illness in the workplace may be short-sighted as mental illnesses are highly prevalent and costly. Ignoring the existence of mental illness in the workplace raises further questions about the level of so-called ***mental health literacy*** in HR practitioners (i.e., gaps in knowledge), as well as about possible stigmatisation of such illnesses (i.e., problematic attitudes).

Mental illness affects one in four people worldwide, and is one of the most important contributing factors to worldwide disease, disability and burden to society (Murray & Lopez, 1997; World Health Organisation (WHO), 2001b). A recent International Labour Organization

(ILO) study reports that 10% of office workers in Britain, the United States of America, Germany, Finland and Poland suffer from stress and burnout, but also mood and anxiety disorders (Medscape, 2000, p.1). Furthermore, a recent monograph published by the WHO and ILO reports that 20% of the adult working population suffers from some type of mental condition at any given time (Harnois & Gabriel, 2000, p.1).

Workplace effects of the prevalence of mental illness include loss in productivity, decreased motivation, increased absenteeism, increased staff turnover, early retirement, safety risks, accidents, disrupted relations, suicide and the cost of inadequate or inappropriate treatment (Conti & Burton, 1994; Kahn & Langlieb, 2003). Depression, for example, costs businesses in the United States of America an estimated $43 billion a year in treatment, lost earnings and productivity. Furthermore, this condition leads to 200 million lost working days a year (Greenberg, Stiglin, Finkelstein & Berndt, 1993, p.405). Anxiety disorders are estimated to cost an annual $42.3 billion in the Unites States of America, with $4.1 billion being indirect workplace costs (Greenberg, Sisitsky, Kessler, Finkelstein, Berndt, Davidson, Ballenger & Fyer, 1999, p. 427). Eighty eight percent of these workplace costs are attributable to lost productivity. However, mental illness can be effectively treated (WHO, 2001b).

Local corresponding statistics may be extrapolated from studies undertaken in the developed and developing world (Harnois & Gabriel, 2000; Murray & Lopez, 1997; WHO, 2001b). However, given the complexities of the current South African working and living environment, it is possible that local mental illness prevalence and cost figures meet and even exceed those experienced internationally. It is therefore vital that business in South Africa acknowledges mental illness as having both a direct and indirect impact on productivity, work relations and workforce costs.

Moreover, the redesigning of the *HR function* should give adequate attention to promoting mental health and managing mental illness in the workplace. This includes providing trainee HR practitioners and students with suitable and adequate information to enable them to react in a positive and appropriate way when confronted with mental illness in the performance of their eventual HR duties. By addressing both knowledge and attitudes, mental health literacy levels can be increased and stigmatisation decreased. HR practitioners already in the field should be adequately equipped to deal with employee mental health and illness matters. This may necessitate training and re-education programmes to achieve the required level of expertise and orientation.

1.2 Problem outline

With reference to the above, mental illness in the workplace is thus regarded as a reality that needs to be effectively and adequately managed. Knowledge and understanding of mental illness is not a "nice to know" luxury but a necessity to achieving an optimally performing workforce and ultimately to obtaining strategic business goals and to remaining competitive. A positive attitude towards mental illness is also crucial to instituting and maintaining effective emotional wellness programmes in the workplace that address both mental health and illness.

The South African workforce is noted as posing many challenges to management and the HR profession. For example, productivity is not optimal, but indeed lags behind on most scores (Grobler et al., 2002). Admittedly, many contributing factors play a role. These may include poor selection techniques, inadequate training, insufficient or inappropriate compensation, labour disputes, lack of motivation and morale, to name but a few. However, there is persuasive data that mental illness plays a role in influencing low productivity rates and high labour costs (Conti & Burton, 1994; Greenberg et al., 1993; Greenberg et al., 1999; Harnois & Gabriel, 2000; Kahn & Langlieb, 2003). Mental health and illness matters may also be possible contributing or mediating factors to many of the challenges facing the HR profession today. This needs to be acknowledged, investigated, and optimally managed.

The person most suited to this task is the human resource practitioner, given the role and responsibilities of the HR function. It is required of the HR practitioner to have sufficient knowledge to identify possible mental illness and to be able to act in an appropriate manner. Furthermore, the HR practitioner should be receptive to mental illness, should be approachable and should have an attitude conducive to effectively managing mental illness. Cognisance also needs to be taken that the HR practitioner has, on most accounts, a staff function (Carrell et al., 1998). Management may reject advice given and recommendations made regarding employee mental illness issues if the attitude of the HR practitioner towards mental illness is negative. The HR practitioner should therefore not only be literate regarding mental health and illness matters, but should also have a positive view of mental illness and to managing these conditions in the workplace.

It is currently unknown what the knowledge and attitudes of HR practitioners are towards mental illness. In the light of the above discussion, it is clearly important that these be determined. This study sets out to address this void in current knowledge. The **research problem** is therefore summarised as:

What do human resource practitioners in South Africa feel, think and know about mental illness and the mentally ill?

1.3 Objectives of the study

Given the above, the main objective of this study is to investigate and describe the current mental health literacy and attitudes of human resource practitioners in South Africa. Also, to determine whether there are differences in mental health literacy regarding different types of mental illnesses, and if so, whether any HR practitioner characteristics are associated with these differences.

To achieve this main objective, the following **sub-objectives** are set:

1) To investigate and describe the *mental health literacy* of HR practitioners in South Africa
2) To investigate and describe the *mental health attitudes* of HR practitioners in South Africa
3) To investigate whether the mental health literacy of HR practitioners *differ* regarding different types of mental illnesses
4) To determine the *associations*, if any, between respondents' demographic and work characteristics and literacy levels regarding mental illness
5) To determine the *associations*, if any, between respondents' demographic and work characteristics and attitudes towards the mentally ill

1.4 Overview of the study

1.4.1 Chapter 2: HRM, the HR practitioner and mental illness

This chapter provides a brief overview of the human resource function within the organisation, including the roles and responsibilities of the HR practitioner. This is followed by a detailed motivation of the impact and relevance of mental illness in the current South African workplace. The importance of training human resource practitioners in mental health and illness matters is underlined by a description of the term "mental health literacy". This is followed by an explanation of the role of attitudes and stigma on behaviour in general and towards mental illness in specific. In view of this, the current status of mental health training in human resource management courses at South African training institutions is reviewed. The three conditions

surveyed in this study (i.e., depression, panic disorder, and alcohol abuse) are described and workplace considerations are highlighted.

1.4.2 Chapter 3: Research strategy and methodology

The guiding research problem and objectives of this study are discussed in this chapter. The study population, the sampling method and the measuring instrument are described in detail. A discussion of previous mental health literacy and attitude studies, including the use of vignettes, is followed by an explanation of the data capturing and analyses methods.

1.4.3 Chapter 4: Results and interpretations

The study results are presented and broadly discussed in chapter 4, with a description of the mental health literacy and attitudes of the respondents. Particular attention is given to the results from the three types of vignette used in the survey, namely that depicting depression, panic disorder and alcohol abuse.

1.4.4 Chapter 5: Conclusions and recommendations

A more refined analysis of results is given in this chapter. Within the background of the study aim, certain conclusions are arrived at and recommendations for further research are made. Finally, implications for HR training and practice are highlighted.

Chapter 2

"Work is man's strongest tie to reality"
(Sigmund Freud, 1856-1939)

HRM, THE HR PRACTITIONER AND MENTAL ILLNESS

2.1 Introduction

Mental illnesses are real, are highly prevalent and costly to society. Further more, they pose a considerable burden to the corporate world in the form of direct treatment costs and indirect productivity costs. It is well accepted that HRM is the business function concerned with the "people issues" in the organisation. The main purpose of human resource management is to ensure that organisational human resources are utilised and managed as effectively as possible. Given that people experience mental illnesses and that it significantly affects their functioning, managing these conditions in the workplace cannot be regarded as merely a "soft" wellness/social responsibility issue for HR (and indeed all management), but very much a "hard" issue which holds significant implications for the company bottom-line. This reality implies that the importance of mental health issues as well as the necessity for knowledge and understanding of mental illness must be appreciated by all HR practitioners.

This chapter provides an overview of the HR function, its roles and responsibilities and how these relate to the importance and impact of mental illness in the workplace. Mental illness is conceptualised and a distinction is made between the concepts health, illness, and disorder. Effective management of any issue requires knowledge of the issue being addressed and an understanding of all possible confounding factors. A systematic classification of mental disorders is therefore presented, followed by an account of the magnitude and impact of mental illness in the workplace. One of the most significant contributing factors to understanding the impact and burden of mental illness (and some would argue the most important factor) is the role that knowledge, attitudes and stigma play. The concept, mental health literacy, is therefore discussed and particular attention is given to describing stigma and to motivating why workplace mental health programmes should address this social phenomenon. Finally, the three mental disorders surveyed in this study are described and brought into the context of the workplace.

2.2 The HR function within the organisation

This study investigates the mental health literacy and attitudes of HR practitioners in South Africa. To meaningfully do so the field in which HR practitioners work, that is, the purpose, domain and scope of human resource management, needs to be explained.

2.2.1 Conceptualising human resource management

The purpose or main goal of HRM is to maximise organisational potential by means of the people (human resources) in the organisation (Wiley, 1992). Werther and Davis (1996) go one step further and add that HRM aims to improve the productive contribution that the people of an organisation make through utilising means that are strategically, ethically and socially acceptable. The desired result is organisational success, or, in other words, to fully utilise the human resources to achieve organisational goals and improve its competitive advantage (Grobler, 2001).

Numerous **definitions** are provided for HRM (Carrell et al.; 1998, Cascio, 1995; Grobler et al., 2002). Gerber et al. (1998) regard HRM as an applied management science that can be seen as a process concerned with obtaining an optimal fit between the individual, the job, the organisation, and the environment so that the employee achieves both good performance and satisfaction and the organisation meets its goals. Four key components are highlighted with this definition, namely the employee, the work itself, the organisation and the external environment. Whereas many other definitions found in the literature emphasise organisational effectiveness and optimal employee functioning and satisfaction, this particular understanding of HRM includes the environments in which organisations operate. Even though it is based on a definition originally provided by Hall and Goodale in the 1980's (Hall & Goodale, 1986), it is particularly relevant today and in line with two relatively new ways of thinking and practicing in the management of people, namely the human resource approach and strategic human resource management.

The **HR approach** gained favour in the 1970's following findings in the behavioural sciences that showed that it would be mutually beneficial to organisations and employees to manage people as *resources* and not solely as production factors or as beings motivated only by their emotions (Carrell et al., 1998, p.10). The basic principles of the HR approach include a belief that sound investment in people will ultimately lead to greater productivity; HR policies and practices should satisfy both the emotional and economic needs of employees; and that employees should be encouraged to develop to their full potential (Grobler et al., 2002). Therefore, a balance is maintained between achieving company goals and meeting the needs of

employees. Hence the often cited "our workers are our best asset" or "people are a company's most critical success factor".

The second relative newcomer to the science of people management that may be inferred from reading the HRM definitions of Gerber et al. (1998) and Hall and Goodale (1986), is **strategic human resource management**. Strategic human resource management places HRM firmly within the overall general strategic management of the organisation. The latter is determined by senior management's long-term, future-orientated view of organisational success within a complex, competitive, and changing environment (Swanepoel, 1998). Strategic management is a complex decision-making process that requires a thorough scanning and analysing of current and future environments in order to formulate an overall company mission and objective as well as a planned business strategy. This strategy includes utilising resources in the most effective manner, ensuring results that keep the company competitive in its environment (Carrel et al., 1998; Firer, 2002; Swanepoel, 1998).

A crucial element of strategic management is examining the environments (internal and external) for all possible variables that may play a role in determining the perfect fit between the organisation and its environment. This is often referred to as a SWOT-analysis and entails studying internal organisational strengths and weaknesses and external threats and opportunities (Swanepoel, 1998). If this is thoroughly and properly done, decisions and actions can be taken to ensure that the organisation as a whole is successful and competitive. As people are often key factors or variables in internal strengths and weaknesses and external threats and opportunities, it is often argued that SWOT-analysis and the resulting strategy formulation, organisational structures, and strategy implementation should regard the human resources-related component of management as an integral part of general strategic management (Carrell et al., 1998; Grobler et al., 2002). In this way, the organisation's strategic plans and needs are synchronised and fully integrated with the management of people. Organisational selection, recruitment and training practices can, for example, be tailored to meet company diversification strategy demands. Alternatively, these HR practices may be curtailed with a retrenchment or turnaround strategy.

Strategic human resource management therefore includes a comprehensive investigation of its environment, detailing not only the relevant aspects of the economic, social, political and technological environment but also that of its people. Such a process of methodical environmental scanning and analysing would arguably not be complete without considering the presence and impact of mental illness and the valuable role of mental health in optimal performance. More detail about this is given in the discussions below on mental health and

illness in the workplace, but suffice it to say that mental health and illness issues are an integral part of HRM and the general strategic running of business. Firer (2002) warns that the values, ethical beliefs, attitudes and business philosophies of managers have an important effect on strategy. If HR practitioners have a say and are involved with strategy formulation, as is the aim with strategic human resource management, then it is vital that they have a positive view of mental illness for it to be acknowledged and to take its rightful place within the overall purpose, mission, objectives and policies of the organisation.

With this awareness of internal and external environmental impacts, it may be useful to look at a more local understanding of HRM. Another comprehensive definition of human resource management, and one that is specific to industry in South Africa, is that provided by a sub-committee within the Steering Committee concerned with formulating education and training standards for HRM in South Africa. This sub-committee was established and set to task to design a conceptual framework for the standards and qualifications needed to fulfil the South African Qualifications Authority's core HRM competencies. The Sub-Committee, after consultation with relevant stakeholders and steering committee members, concluded that HRM should be regarded as a sub-field of Business, Commerce and Management Studies and that it is concerned with all activities relating to the management of people as employees. More specifically, it describes HRM as:

- All the dimensions, strategies, factors, principles, operations, practices, functions, activities and methods related to the management of people as employees in any type of organisation (including small and micro enterprises and virtual organisations);
- All the dimensions related to people in their employment relationships, and all the dynamics that flow from it (including in the realisation of the potential of individual employees in terms of their aspirations);
- All aimed at adding value to the delivery of goods and services, as well as to the quality of work life for employees, and hence to ensure continuous organisational success in transformative environments (Sub-Committee, 1999, p. 6).

This study adheres to both the Hall and Goodale definition of HRM as refined by Gerber et al. (1998), as well as the one provided by the Sub-Committee (1999). From this, it is accepted therefore that **HRM** is the business function concerned with optimally utilising and preserving the human component and employee relations in business to the mutual benefit of the organisation and its individual employees, within environmental complexities and challenges. It is argued that mental illness is a reality in the business world, and should therefore be

acknowledged and incorporated within human resource management policies and practises, as well as receive top-level support through integration in strategic management planning and decisions. Not to do so would be short-sighted and go against the principles of the human resource approach and strategic HRM.

2.2.2 HRM objectives and the external environment

To reach its purpose of optimally utilising people to achieve organisational goals in line with overall organisational strategy, the HRM function is regarded as being guided by four main objectives (Werther & Davis, 1996). These may be described as:

1) *Organisational objective*: to contribute towards organisational effectiveness by serving the rest of the organisation. This includes assisting line management to achieve organisational objectives through effective employment of people, who ultimately remain the responsibility of line management (more about the staff versus line function in the discussion below).
2) *Functional objective*: to make a contribution that is appropriate to the organisation's need without wasting or overexerting resources. HRM policies and practices should be lead by organisational demands and not be more or less sophisticated than required.
3) *Societal objective*: to balance the response to the needs and challenges of society with the negative impact of these demands on the organisation. Thus, to react in an ethically and socially responsible way but to also minimise the impact of this on the organisation.
4) *Personal objective*: to assist all employees in reaching their potential and attaining personal goals provided that this maximises the employee's contribution to the organisation. To maintain, retain and motivate the workforce are thus key areas within this objective.

When the four HRM objectives are met HRM reaches its main purpose for existing by contributing towards organisational success and competitiveness through its people. To do so effectively though, it needs to take cognisance of and incorporate mental health and mental illness issues when addressing all four of these objectives. Line management should be advised on the potential role mental illness may play in workplace problems (see 2.3.4), in order to effectively manage employee performance (organisational objective). It is in the best interest of any company to promote mental health to ensure that the human resources are optimally available to be effectively and efficiently put to use to obtain organisational success (functional objective). This is not only socially responsible behaviour (societal objective), but also contributes towards guaranteeing each individual's maximum contribution towards the

organisation as a holistically healthy being who can pursue personal goals that are in support of organisational goals (personal objective).

Regarding the organisational objective though, it is well accepted that strategic HR problems are the responsibility of every manager in the organisation who deals with people and are not the sole domain of HR practitioners (Carrell et al., 1998; Gerber et al., 1998; Grobler et al., 2002). Indeed, Miner (1985) in his writings on what a manager is, emphatically states that dealing with people is an important aspect of general managerial work. He agrees with the approach of Henry Mintzberg (Miner, 1985, pp. 2-3) who defines managerial work in terms of the roles that managers play, such as figurehead, leader, spokesperson, entrepreneur and resource allocator. All these managerial roles are either interpersonal in nature or deal with people to a large extent.

The **HR function** in an organisation (be it an individual HR practitioner working in a small company or a complete HR department in a large firm) therefore has a *staff* function in that it provides a specialised service to the entire organisation and advises line management on HR matters (Carrell et al., 1998). However the HR function also has *functional authority* in that it may make the final decision in certain specific situations within its specialisation. HR's functional authority is, however, still subject to review by top management (Gerber et al., 1998; Werther & Davis, 1996). Nonetheless, it may, for example, issue enforceable instructions to ensure that HR policies and procedures are correctly applied in other departments. With the shift to the human resource approach and the general acceptance of the importance of strategic management, some are of the opinion that the boundaries between staff and line function are blurred and will be of even less importance in the future, where all managers will have general responsibilities (Swanepoel, 1998). Nonetheless, it is imperative that HR practitioners have a sound knowledge of all aspects impacting on employee productivity and relations (including mental illness) to serve in this staff function and ultimately reach its objectives.

To comprehensively understand and outline the true scope of HRM, it is necessary to review the **transformation and development issues** impacting on the HRM function, as mentioned in chapter 1. This is supported by the significance awarded to external environmental factors in the principles of strategic human resource management and by the recognition of the environment in the definition of HRM, as used in this study. This is particularly true for South Africa, where industry is in a post-1994 transformation stage following the disbanding of the boundaries to enter and compete in the global marketplace. Local businesses are therefore under pressure to be competitive with both national and international markets in order to survive (Grobler et al., 2002). The Sub-Committee (1999) concerned with formulating HRM

competencies and standards in South Africa summarises the key transformation and development issues influencing the HRM function as follows:

- Knowledge management including the obtaining and securing of knowledge
- Organisational memory, i.e., knowledge in large organisations for future application and use
- Reconciliation management
- Work creation (as opposed to job creation)
- Managing the transfer of HRM functions and skills to line management
- Marketing of HRM to line management
- Developing conceptual approaches to HRM
- Multi-skilling and/or multi-tasking
- Increased societal responsibility
- Managing people in virtual work environments
- Focus on deliverables rather than do-ables
- Developing additional means to assessing HRM
- Appreciation and assessment of intellectual capacity
- Moving HRM from a business partner to a business itself, i.e., managing HRM as a business unit
- Advisor / consultant to line management (Sub-committee, 1999. p. 7)

The Sub-Committee's list of transformation and development issues are further support for taking on a human resource approach and following the principles of strategic human resource management. Meeting the demands and challenges of the future necessitates that each of these issues receives adequate attention. Again, it is imperative that mental health and illness issues be included for the HRM function to be able to fulfil its purpose and objectives now and in the future. The HR practitioner needs to adequately equip him- or herself regarding mental health and illness issues to be able to effectively integrate the HR function within the general strategy so that it can address current and future needs through its human resources. It is of course acknowledged that other areas of knowledge and expertise are needed to do this, but mental health literacy remains an important component of the total package of knowledge and expertise a HR practitioner should bring to the company to fulfil the HR function effectively. Also, to advise line management on the optimal utilisation of human resources requires acknowledging the impact of mental illness and being able to give sound advise on managing this in the workplace. Surely, the reputation of HRM as a staff function relies on giving accurate, timely, relevant and proactive advise? Mental health literacy, amongst various other knowledge bases, is needed to fill this requirement. Moreover, given the shift in focus of HRM, that is, more

involvement in the overall strategic management of the organisation, and the increased involvement of line management in human resource management, as well as having to interest line management in HRM (or, to "market" HRM as mentioned above), a positive attitude towards mental illness is required of HR practitioners for this crucial component of HRM to be acknowledged and taken on by line management.

2.2.3 HRM activities

Given its main purpose and the demands set by environmental issues, the field of HRM goes about meeting its objectives by means of various activities. Carrell et al. (1998, p. 11) note that there are roughly 64 different activities that can be assigned to the HR function solely or jointly with other departments in the organisation. These can be grouped into three core categories of activities (Gerber at al., 1998; Grobler, 2001):

1) Provision of human resources
2) Maintenance of human resources
3) Development of human resources

Each of these key categories comprises various sub-activities. The first core activity of HR provisioning includes activities such as selection, recruitment, induction and career management. HR maintenance includes compensation and benefits administration, labour relations, affirmative action/ equal employment opportunity issues and employee services (including health and wellness programmes). The third core group of HR activities deal with the training, development and performance management of human resources. See Table 2.1 for a detailed listing of all the currently known and acknowledged HR activities as adapted by Carrell et al. (1998, p. 12) and Grobler (2001, pp. 2-3) from the original list as provided within a Bulletin to Management of the Bureau of National Affairs in Washington DC in the United States of America.

Table 2.1 Human resource activities

Interviewing	Job analysis	Organisational development
Vacation/leave processing	Award/recognition programmes	Productivity/motivation programmes
Insurance benefits administration	Complaint procedures	Thrift/savings plan administration
Recruiting	Skills training of non-management	Incentive pay plans
Personnel record keeping/ information systems	Supervisory training	Relocation services
Promotion/transfer/separation processing	Security/property protection	Career planning/ development
Induction/orientation	Safety training/OHSA compliance	Food service/cafeteria
Wage/salary administration	Employee communications/ publications	University recruiting
Worker's compensation administration	Public/media relations	Suggestion system
EE compliance/affirmative action	Risk management/business insurance	**Health/wellness programmes**
Unemployment compensation	Human resource forecasting/ planning	Attitude surveys
Job descriptions	Travel/ transportation services	Outplacement services
Payroll administration	Community relations/ contribution programmes	Pre-retirement counselling
Performance appraisal of management	Management development	**In-house medical services**
Disciplinary procedures	Pension/retirement plan administration	Library
Purchasing	Tuition aid/scholarships	Flexible benefits plan administration
Job evaluation	Recreational/social programmes	Union/labour relations
Performance appraisal of non-management	Pre-employment testing	Flexible-spending account administration
Administration services	Executive compensation	Profit-sharing plan administration
Maintenance/janitorial services	Office/clerical services	Mergers and acquisitions
Exit interviews	**Employee assistance plan/ counselling**	Stock plan administration
International HR administration	Child-care centre	

(Adapted from Carrell et al., 1998, p. 12; Grobler, 2001, pp. 2-3)

On closer inspection of the complete list of the 64 recognised HR activities it is clear that HRM currently neglects issues of mental health/illness. Nowhere is specific reference made to promoting mental health or managing mental illness in the workplace. Indeed, all literature perused after an extensive search on the topic of HR activities reveal an obvious ignorance or lack of recognition of the vital role mental health and illness plays in the management of people

at work. All that is found are the rather broad "health/wellness programmes" and "in-house medical services" activities which may (but in most instances probably do not) include mental health/ illness. The "employee assistance plan/counselling" activity may include addressing mental health or illness issues. However, since its inception employee assistance, delivered through employee assistance programmes (EAP's), focussed on alcohol abuse (Grobler et al., 2002). Modern-day EAP's have a broader scope and include identifying and resolving work and personal problems that have a negative impact on work performance. Therapy and counselling is provided (or referrals made) for all types of substance abuse, marital, family and financial problems, and stress (Swanepoel, 1998). Whether any attention is given to mental illnesses such as the mood and anxiety disorders, is not known. Given the well documented purpose and objectives of HRM as mentioned in every textbook on the subject and within this study ad nauseum, as well as the strongly advocated principles of the two approaches in current favour with HRM, it is surprising that HRM so blatantly ignores a major contributing factor to people's problems in the workplace that impacts so significantly on the company's bottom line: that is, mental illness. Perhaps if one were to inspect how HRM is practiced, that is, the HR practitioner at work, one would find some acknowledgement of the importance of mental health/ illness issues in the workplace.

2.2.4 The HR practitioner: roles and competencies

For the purpose of this study, **HR practitioners** are defined as all employees, irrespective of their qualifications, level of professional registration, or position, who deal with human resource activities of obtaining, developing and maintaining people in the workplace. It is recognised, though, that all managers are ultimately responsible for the people under their supervision, and certain previously considered traditional HR activities are now the responsibility of line management or jointly managed by HR and other functional managers (Grobler et al., 2002). Nonetheless, many core HR activities remain the exclusive responsibility of HR practitioners. These include compensation and benefits issues, employee services, affirmative action and equal employment opportunity, job analysis, pre-employment testing and attitudes surveys (Carrell et al., 1998). Persons concerned with these activities are thus considered for the purposes of this study as HR practitioners.

The above discussion on HRM criticised the obvious lack of attention given to mental health/ illness in the scope of the HR function. However, when looking at the role and work of HR practitioners per se, mental health and illness issues may come to light.

Much has been written about the various **roles** HR practitioners need to take on to be able to perform the activities assigned to them. Roles most often cited include that of catalyst, change

agent, advisor/consultant, diagnostician, auditor/ controller and service provider (Gerber et al., 1998; Grobler, 2001; Swanepoel, 1998). Wiley (1992) neatly and comprehensively summarises the numerous HR roles into three categories of activities, namely those associated with the strategic process, those related to legal aspects, and those that come to play when dealing with operational aspects (see Figure 2.1).

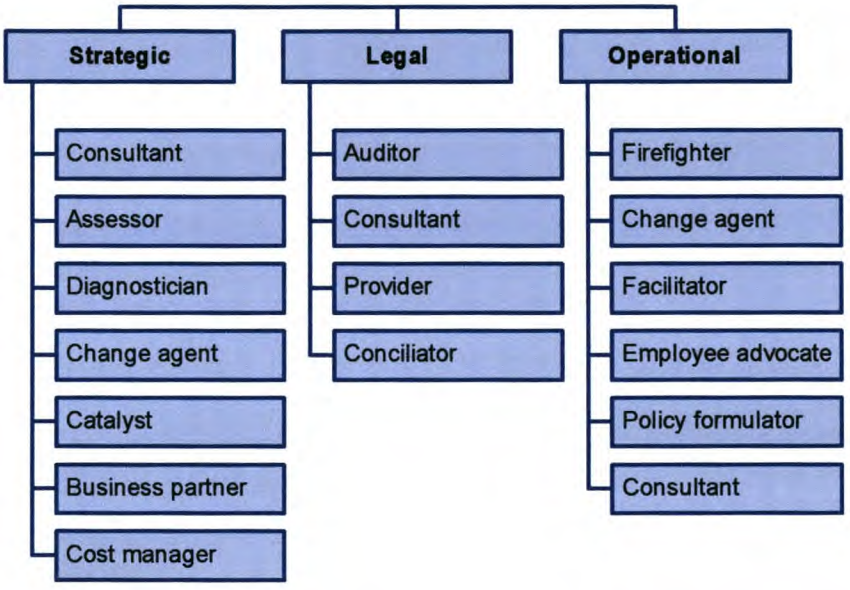

Figure 2.1 HR roles associated with three categories of activities

(Adapted from Wiley, 1992, p. 28)

The first category of HR roles grouped under the heading ***strategic process***, reflects the expansion in organisational role of HR practitioners from primarily personnel administrators to now being considered partners in the strategic planning process (Wiley, 1992). During strategic planning, the HR practitioner plays a consultant role by advising management and helping to formulate objectives for specific business strategies. For example, advise management on how to bring about change during an organisational development plan. The role of assessor requires the HR practitioner to have ready access to key information. This role entails scanning the internal and external variables impacting on the business environment and being able to give accurate information to management about the workforce regarding the match between what the company needs to achieve its strategic plans and what the workforce can provide. In the diagnostician role the HR practitioner applies problem-solving techniques to deal with the challenges and problems of implementing strategy. By applying relevant HR research methods the practitioner must be able to distinguish causes from symptoms and develop appropriate

solutions. The HR practitioner should also be able to anticipate external trends and changes that may impact on organisational procedures and practices. This falls under the role of change agent, where the HR practitioner analyses problems in the organisation and uses this information to develop programmes to serve as the basis for strategic planning. Strategic change often brings about relationship problems between line management and employees. In the catalyst role HR practitioners develop human relations policies and practices to be implemented by line management and hereby contribute towards maintaining desirable organisational environments. When the HR practitioner becomes part of the management team, he or she plays a business partner role. This takes the HR perspective to within the circle of general management and encourages participative decision-making between the line and staff functions, leading to a shared responsibility for business matters. One of these is cost containment, and the HR practitioner is responsible for reducing costs of one of the most costly, yet valuable, business factors. Employee costs attributed to, for example, salaries, wages, benefits and illnesses, rise steadily and it is essential to keep these costs within strategic goals.

Mental health and illness are variables to be considered in each of the seven HR roles associated with the strategic process. The prevalence and impact of mental illness in the workplace, as well as the value of promoting and maintaining good mental health amongst employees (World Federation for Mental Health, 2000, 2001), underscores the importance of HR practitioners being knowledgeable in these matters. This is especially so regarding the consultant, assessor, diagnostician, change agent and cost containment roles. Mental illnesses are on the increase both within the general population and those of working age, lead to problems in the workplace and can be extremely costly, especially if not appropriately and timeously managed (Harnois & Gabriel, 2000). Ignoring or neglecting mental illness impacts both directly and indirectly on the company bottom-line. These conditions can also affect relations within the organisation, or pose as hindrances to change being successfully implemented (Kahn & Langlieb, 2003). See 2.3.4 for more information on this. However, good employee mental health could contribute towards general wellbeing and play a role in healthy relations and efficient performance.

According to Wiley's (1992) breakdown of HR roles, the second category of HR activities encompasses a group of specific roles that are associated with the ***legal issues*** HR practitioners have to deal with. Current knowledge on government regulations and legislations is crucial to fulfilling these roles, particularly regarding equal employment opportunity (EEO), health and safety, conditions of employment and the like. The role of auditor within this category entails monitoring and evaluating company HR policies and practices to ensure that they are effective and comply with the relevant legal standards and rules. Also, to ensure that managers follow company policy and procedure regarding matters such as EEO and hereby reduce the risk of

employee-related lawsuits. The consultant role entails providing management with advise, information and guidance on employment laws and related company practises, such as affirmative action and incentive programmes. The provider role, especially, demands that the HR practitioner remain updated about employment legislature and HR knowledge as it is within this role that he or she facilitates the accomplishment of company policies and practices. Topics such as EEO, government contracts and HR planning are of note here. Company goals and employment laws may at times be in conflict and it is then necessary for the HR practitioner to take on a conciliator or peacemaker role. Wiley notes that within this role the HR practitioner needs to acknowledge the different interest groups and power structures involved, such as during labour union and contract negotiations. A balance needs to be maintained between conflicting needs and the rights of all parties, with decisions based on fact, not subjective criteria.

To effectively fill these roles that are associated with legal issues, the HR practitioner must be aware of legislation and government regulations regarding the employment of persons with mental illness. For example, the Employment Equity Act, No. 55 of 1998 (Department of Labour, 1998) makes provision for persons with disabilities, including mental disability. The Department of Labour, together with the Employment Equity Commission, issued a Code of Good Practice: Disability (Department of Labour, 2001) to guide employees in employment matters concerning the disabled. Although the Code of Good Practice is not enforceable, it does not offer any legal obligations that are not already covered by the Act. It is meant to be a guideline, and offers assistance with matters such as identifying and eliminating barriers that could lead to unfair disability discrimination, as well as on how to implement affirmative action measures to promote equitable representation of the disabled in the workplace. It would thus serve the HR practitioner well to study these guidelines so as to be able to play the legal process roles of auditor, consultant, provider and conciliator.

The third set of roles that HR practitioners need to take on are those related to performing the typical HR activities as listed in Table 2.1, that is: liaising with management about employee relations policies and practices, and ensuring employees work towards fulfilling company goals. According to Wiley's (1992) breakdown of ***business operations*** roles, the first one is that of firefighter. This role requires a reactive stance where the HR practitioner deals with problems and situations on the demands of others. This may include having to contend with employee relation problems such as absenteeism and turnover. In the change agent role the HR practitioner is proactive and takes on a more creative management style. Past experiences need to be analysed for trends so that plans can be made to successfully lead the company in the future regarding employee matters. Also, analysis of past problems should help with the

creation of new procedures to tackle future problems. The facilitator role utilises human relations theory-based techniques to help employees adjust to change, for example counselling during retrenchments. With the growing emphasis on job satisfaction and quality of work life, as well as the increasing numbers of women and older workers, Wiley contends that the HR practitioner is often called on to play the employee advocate role. The policy formulator role entails initiating internal changes following external changes in the industry and government environments. Such changes need to be written up in policy and are often necessary to coordinate and motivate employees to work towards meeting company goals. The HR practitioner is therefore responsible for seeing to it that all employee-related policies are current and in line with external demands.

It may be argued that not one of the roles associated with the operational aspects of HRM can be optimally fulfilled without also having a sound knowledge of mental health and illness issues. Mental health is a major determining factor in healthy human relations and quality of life (WHO, 1999, 2001b). As a component of general wellbeing, it also contributes to optimal functioning and performance. Mental illness, on the other hand, can lead to poor work performance and relational problems, and is a factor to be reckoned with regarding the company's environment and culture, as well as when dealing with external and government regulations (Harnois & Gabriel, 2000; Kahn & Langlieb, 2003). The HR practitioner will therefore need to be literate in mental illnesses and actively promote good mental health in the workplace to make an efficient contribution to the strategic, legal and operational business of the organisation. Again, the literature fails to make mention of mental health and illness aspects of managing people when describing the various roles assigned to HR practitioners.

Wiley (1992) adds that it is important to note that these roles often overlap and that the HR practitioner more often than not fills various roles at any given time. Nonetheless, the ultimate aim is to get employees to work as a significant whole towards achieving organisational objectives and success. Swanepoel (1998) explains further that irrespective of the role, the emphasis is on adding value to the organisation. This "added value", given the purpose of the HR function, could be interpreted as improving the organisation's competitive advantage through utilising and managing human resources as effectively as possible (Grobler et al., 2002) and thereby adding real, measurable economic value to the company (Swanepoel, 1998). To be a strategic business partner, as the current trend of strategic human resource management dictates, HR practitioners need to be accountable for business results. They need to be "active players and partners in the challenge of making organisations more competitive and successful" (Swanepoel, 1998, p. 22).

It could be argued, given the purpose, objectives, assigned activities and roles of HR practitioners, that a critical component of answering this challenge would be to improve the productive contribution of employees to the organisation while at the same time reducing employee-related costs. Miner (1985) maintains that there are four aspects of **work performance** that relate to organisational goals and profitability, namely:

1) Quality of work
2) Quantity of work
3) Time spent on the job
4) Cooperation in attaining organisational goals (Miner, 1985, p. 10)

Individual work performance is therefore a complex product and is influenced by a range of factors derived from both within the individual employee and from the external environment. Failure to perform, or ineffective performance, is in turn, also the result of an interaction of internal and external factors (Miner, 1985). The challenge to the HR practitioner is to determine the cause(s) of ineffective performance and then to manage this so that the individual, as part of the workforce, contributes towards organisational effectiveness and success. Internal, or individual, factors of poor performance are said to include intellectual deficiency relative to job requirements, emotional problems, problems involving motivation, and physical deficiency impeding on job requirements. External factors include family or relational problems, conflicts with the work group, problems relating to the company and its various components, and conflicts between the job and the demands of society such as values and norms. Finally, Miner also lists situational problems such as the work itself or actions of groups that influence the worker but to which the worker does not belong.

It is heartening to see Miner acknowledge "emotional problems" in his list of causes or factors contributing towards ineffective performance. In earlier writings (Miner, 1963), he distinguishes between emotional and mental disorders, mentions the types of emotional disorders (psychosis and neurosis) and explains how personality traits and disorders, alcoholism, psychotic, mood and anxiety disorders affect performance. Also, he goes on to give advice on how best to manage these in the workplace. Even though he uses archaic terminology and facts, he brings mental illness to the attention of the HR practitioner in a way that is still relevant today. A few other writers have contributed to this body of knowledge aimed at guiding management in promoting mental health at work and effectively managing mental illness in order to reach organisational success. Granted, some wrote from a social psychiatry (McLean & Taylor, 1958) or clinical psychology (Kornhauser, 1965, Miner, 1963) point of view, yet all were concerned with maintaining a productive workforce who meets company

objectives. Thus, for the HR practitioner to fill many of the modern-day roles as described by Wiley (1992) and others, and to ultimately meet the purpose of HRM, it is necessary to heed Miner's words:

> Corrective action, if it is to accomplish its goal more frequently than pure luck would allow, must be predicated on a thorough understanding of the factors causing the difficulty. The manager must become in one sense a diagnostician. He must devote time and effort to determining what it is that has produced the poor performance. Only then is he in a position to prescribe an appropriate solution. Intelligent corrective action must be based on a comprehensive knowledge of the factors which have created and perpetuated the failure. This is the *raison d'être* of performance analysis.
>
> (Miner, 1963, p. 1)

Therefore, looking at the **competency** requirements of a HR practitioner, one would expect that mental health literacy and a positive attitude towards mental illness would be included. In the words of Miner (1963), the HR practitioner must understand and have comprehensive knowledge of the factors that cause ineffective performance to be able to take corrective action. Carrell et al. (1998) view as skill requirements leadership qualities (e.g., ability to influence top management), management skills (e.g., ability to innovate and delegate), administrative skills (e.g., ability to administrate typical HR daily activities) and technical skills (e.g., ability to recruit, interview and negotiate). Because of the already mentioned shift in focus in HRM, that is, less administrative and more of a business partner in the strategic management of the organisation (Grobler, 2001), it is only to be expected that the required HR skills are changing too. Indeed, the Sub-Committee entrusted with conceptualising the standards and design of qualifications for HRM competencies identified the following skills as critical for the modern and future HR practitioner:

- Project management
- Consulting skills
- Entrepreneurship
- Self management
- Communication skills
- Facilitation skills
- Presentation skills

- Skills for transforming groups into self-directed mutually controlled high performing work teams
- Trans-cultural skills
- Mediation and arbitration skills
- Financial skills
- Problem-solving
- Diagnostic skills (Sub-committee, 1999, p. 7)

Although no direct mention is made here of mental health literacy, the above is merely a broad outline of HR skills and it is possible that, for example, knowledge of mental illnesses be included in the diagnostic, problem-solving, and consulting skills or that promoting mental health be viewed as a component of the skills needed to create effective work teams. The Sub-Committee provides no further details than to list the above. Swanepoel (1998) provides a more comprehensive outline of competencies required of HR practitioners that includes all aspects of competency, namely education, training, application and values (see Table 2.2 for a summary). Research conducted by the Human Science Research Council (HSRC) on behalf of the South African Board for Personnel Practice (SABPP) shows that even with the shift in focus, the traditional competencies in knowledge, skills, orientation or attitudes required of HR practitioners in South Africa remain applicable. However, certain skills will need to be enhanced and a change in focus will be necessary to effectively practice in the future. Important future requirements will be the ability to adapt to changing environments and having a life-long learning orientation, continuously working at increasing knowledge and improving skills bases (Swanepoel, 1998).

Table 2.2 HR practitioner competencies

Education Knowledge base	**Training** Skills base	**Application** Experiential base	**Values** Behavioural base
Social Sciences: Industrial psychology Industrial sociology Industrial/labour law	***Functional:*** Research methodology Measurement Assessment systems design Mentoring Consulting	***Employee Level:*** Recruitment/selection Career management Termination Retirement planning HR policies/ procedures Job evaluation Compensation management EAP/Occupational health	***Professional:*** Systemic thinking Objectivity Innovation Accountability Integrity Flexibility Assertiveness

Table 2.2 continued

Business Sciences:	***Managerial:***	***Group Level:***	***Interpersonal:***
Business management Economics Accounting Statistics Computer systems	Leadership Planning Budgeting Communication Negotiating Marketing/promotion Change management Monitoring Reporting	Team development Conflict management Participation Matrix management Cross-cultural environment Trade union relationships Collective bargaining	Respectfulness Recognition Responsiveness Empowerment Consultation
		Organisational Level: Business planning Succession planning Organisation design Corporate values Employee motivation	***Managerial:*** Customer focus Quality focus Cost focus Results focus

(Adapted from Swanepoel, 1998, p. 60)

It may be suggested that part of this adapting to the demands of the environment and the need for continuous professional development should incorporate that specific attention be given to mental health and illness. Looking at Swanepoel's ***competency model***, where competence = education + training + application + values, the following may be proposed:

HR practitioners should build a knowledge base that includes mental health and illness issues; should be trained (skills base) in identifying possible mental illness as one of the causal factors in ineffective performance; should be able to apply this newly gained knowledge and skills (experiential base) by appropriately referring "problem" employees and effectively managing mental illness as well as promoting mental health in the workplace (this could be part of the already recognised employee assistance or occupational health programmes); and have a positive attitude (behavioural base) towards mental illness. The latter would include being approachable, setting a positive example in language and behaviour when handling mental illness matters, advocating mental health promotion and ensuring management's support in all mental health/illness matters. Ultimately then, the HR practitioner should work towards creating and maintaining a work environment that is favourable towards and does not stigmatise mental illness. This should not be seen as a "soft" aspect of HRM, but should be considered an important and critical "hard" matter in that mental illness can impact both directly and indirectly on the company bottom line – it will hinder the HR profession's attempts at adding real, measurable economic value to the company if not appropriately addressed.

Furthermore, HR practitioners are often, due to their involvement in and responsibility for the people factor in organisations, as well as the fact that they have been (or are supposed to be) trained in human behaviour, held responsible for all behavioural issues in the workplace. This includes the so-called deviant or problem behaviours, as described by McLean and Taylor (1958), Levinson (1964), Kornhauser (1965), Miner (1966) and Follmann (1978). Also, seeing as many of them are in possession of "psychology" (including Industrial Psychology) as a major subject in their graduate and post-graduate studies, lay people regard them as "psychologists". The lack of knowledge regarding the extent of training, skills, and abilities of these "psychologists", as well as the fact that many lay people are not even sure of the difference between a psychologist and psychiatrist (von Sydow & Reimer, 1998), further complicates the HR practitioner's role. As they are often the only so-called "behavioural scientists" in the workplace, it becomes even more essential that HR practitioners should be knowledgeable about all aspects of human behaviour, including mental illness.

Perhaps, then, it would be useful to take a closer look at what mental health and illness entail, how this impacts on the world of work and what issues need addressing from a HR point of view.

2.3 Mental illness: A worldwide reality

This study argues that mental illness is a reality in the world of work and deserves attention from HR practitioners, just like other challenges and issues effecting employee wellbeing and efficiency. The following section therefore takes a closer look at the concept mental illness, the conditions most often encountered and their impact on the workplace.

2.3.1 Conceptualising mental illness

Any attempt at describing mental illness would not be complete without first looking at what is meant by mental health. These two concepts are not opposite poles but should rather be regarded as points on a continuum (US Department of Health & Human Services, 1999). Mental health is an integral part of general ***health***, which the WHO views as not merely the absence of disease or ill-health but a complete state of physical, mental and social wellbeing (WHO, 1999). Simply put, ***mental*** health is a state of wellbeing where the person can make a meaningful contribution to his or her community because of successful mental functioning. This entails being able to work productively, adapt to life stresses and cope with adversity, have fulfilling relationships with other people, and realise own abilities. Being mentally healthy is crucial to thinking, communicating, learning, skills development, emotional growth, resilience and self-esteem – all of which form the basis of an individual's successful contribution to community and society, including the workplace. Concepts of mental health are therefore

readily identifiable, such as autonomy, self-actualisation of intellectual and emotional potential, competence, and perceived self-efficacy. However, providing a comprehensive, universal definition of mental health is more difficult and some would add almost impossible (Cowen, 1994; US Department of Health & Human Services, 1999; WHO, 2001b). This is because the meaning of being mentally healthy is subject to different interpretations which are influenced by values. Values differ from one culture to another, and also within cultures from one individual to another (Cowen, 1994). One may safely assume though that mental health encompasses more than a lack of mental illness.

Mental ***illness*** is a term that refers collectively to all diagnosable mental disorders, which in turn are health conditions characterised by abnormalities in mental functions. These mental functions are all mediated by the brain and include cognition, emotion, mood, and higher integrative aspects of behaviour such as interacting socially or planning future activities (US Department of Health & Human Services, 1999). A mental *disorder* is conceptualised as a clinically significant behavioural or psychological syndrome (i.e., a group of signs and symptoms) or pattern that is associated with present distress or disability or that presents a significant increased risk of death, pain, suffering or loss of freedom to the individual (American Psychiatric Association (APA), 1994). Furthermore, such a syndrome or pattern should not merely be an expected or culturally acceptable response to a particular event but should currently be viewed as the expression of behavioural, psychological or biological dysfunction in the individual. In short then, mental disorders are clinically significant psychological or behavioural syndromes that are associated with distress or disability and are not just an expected response to a particular situation (such as death in the family) or deviant behaviour (for example political or religious) or limited to conflict between a person and society. As with most illnesses, mental disorders are caused by a combination of biological, psychological and environmental factors. The more severe mental disorders are primarily diseases in which a malformation of the brain or a malfunctioning of its complex electrochemical processes mediates distorted thinking, feelings and behaviour (WHO, 2001b).

It is possible for someone to have some signs and symptoms of mental illness without these being of sufficient intensity or duration to meet the full criteria of a mental disorder. For example, in the initial stages after the death of a loved one a person may experience signs and symptoms of bereavement without meeting the criteria of a diagnosable mental disorder (APA, 1994). In such a case the person's condition may be referred to as a "mental health ***problem***" (US Department of Health & Human Services, 1999). Mental health problems may be associated with distress and warrant early intervention in order to prevent the development of a

legitimate, potentially life-threatening mental disorder such as depression, which could even result in death through suicide.

This study focuses on diagnosable mental disorders and therefore uses the collective term mental illness. It recognises though that the HR practitioner will often be confronted with broader mental health problems in his or her everyday working environment. Many of these mental/ emotional and psychosocial problems have the potential to disrupt work and negatively influence the work environment. For this reason, it may be useful to briefly discuss some of the mental health and psychosocial problems that commonly occur in the workplace. Incidentally, early literature on mental health and industry focussed almost solely on what was termed the "troubled" or "problem" employee, referring to the employee who did not perform to standard due to what was noted as emotional, mental, personality or intellectual problems (McLean & Taylor, 1958; Levinson, 1964; Kornhauser, 1965; Miner, 1966; Follmann, 1978). Our understanding of mental illness has progressed much since these early works. Nonetheless, they remain a good starting point to understanding the importance and impact of mental illness on work performance as well as the importance of work in promoting and maintaining good mental *health*. Indeed, the WHO in its groundbreaking and first ever report on mental health highlights the interplay between work and mental health (WHO, 2001b). Even though work and the workplace do not necessarily always play a role in the aetiology of mental illness, it is an important component of mental health and particularly of rehabilitation and reintegration after mental illness. Mental health and work was deemed so important and inter-related to modern living that for the first time the World Federation for Mental Health (WFMH) used the same theme for two consecutive years during its annual international awareness campaign. The theme for World Mental Health Day of 2000 and 2001 was therefore officially recognised and celebrated as *Mental Health & Work* (WFMH, 2000, 2001).

Further support for the recognition of the role of work in promoting mental health is the document that was jointly produced by the WHO and the ILO entitled *Mental health and work: Impact, issues and good practice* (Harnois & Gabriel, 2000). Herein it is repeatedly emphasised that work is important for individual mental health, that the workplace can be a vehicle for promoting mental health, and that the mentally ill should be returned to work, with certain accommodations made, as a matter of urgency after a period of mental illness. Furthermore, because mental illnesses cause disability and have numerous workplace implications, management should include mental health promotion and address mental illness within workplace wellness programmes. Given the above review of HRM in this study, it would appear that industry has been slow to react to these recommendations. Indeed, little evidence was found that mental health/illness has been incorporated into the currently endorsed HR

activities, roles and required competencies. Enough evidence exists that mental illness is impacting on the business world, legislation (e.g., the Employment Equity Act) requires that the mentally ill be accommodated, and various organisations have published or have freely available information that could assist in effectively addressing mental illness or promoting mental health (e.g., ILO, WFMH, WHO). Yet, HR appears to disregard the importance of mental health/illness or to take reactive steps to addressing mental illness and proactively promoting mental health in the workplace.

Looking closer at the broader emotional and psychosocial problems in the workplace, the HR practitioner may be called on to address the following common occupational and organisational problems as summarised in Table 2.3. This is not intended to be an extensive list but serves merely as a brief outline of some of the possible emotional wellness topics to be addressed in the workplace. Knowledge of promoting and maintaining good mental health, as well as education in the social sciences as endorsed by Swanepoel (see Table 2.2), could equip the HR practitioner to effectively deal with most of these problems. These may be roughly divided into two categories, namely ***occupational concerns*** and ***organisational issues*** (Kahn & Langlieb, 2003). The former includes the emotional and mental impact of occupational concerns such as retrenchment, executive stress and supervisor personality or management style. The latter acknowledges the complex interaction between unique organisational characteristics such as organisational culture and structures and the unique emotional characteristics of employees, for example personal values and family needs. Although these problems are not the primary focus of this study, they need to be appropriately managed in order to prevent the possible development or exacerbation of mental illnesses such as depression, substance abuse and anxiety disorders.

Table 2.3 Common workplace emotional and psychosocial problems

Occupational concerns	Executive emotional health	Executive coaching and leadership development, narcissism, competition, paranoia, rigidity, repression of emotional distress.
	Job loss and unemployment	Self-esteem changes, dealing with loss, role changes. Guilt, helplessness, bitterness, fear, distrust, increased workload of those who remain at work.
	Working abroad	Culture shock syndrome, repatriation syndrome, adjustment problems.
	Office politics	Dealing with hidden agendas, boundary issues, competition, aggressive/difficult managers, uncooperativeness, attitudes towards authority.
Organisational issues	Leadership and corporate culture	CEO personality and emotional IQ.
	Organisational change	Adapting to change, dealing with loss, personal values and security issues.
	Family problems effecting work	Loss of family support and depleted emotional energy, impaired judgement, anger. Interfering family needs, unmet family needs.
	Physical and comorbid mental illness	Medical illness such as chronic pain, heart disease, AIDS, chronic fatigue, cancer and the associated stress, life changes and depression.
	Psychosocial issues	Financial problems, relationship issues, major life changes.
	Emotional crisis at work	Disasters (e.g., floods, earthquakes, terrorist attacks, shootings), work site crises (e.g., accidents, fires, death of leaders), dealing with dangerous or suicidal behaviour of colleagues.
	Violence in the workplace	Verbal, emotional, sexual or physical hostile acts towards employees, clients, customers or the organisation. Includes organisational obstructionism, sexual abuse, assaults, defamatory communications.

(Adapted from Kahn & Langlieb, 2003, pp. 91-328)

2.3.2 Classification of mental disorders and review of those relevant to the workplace

From the above it is clear that many emotional and psychosocial problems may be encountered in the workplace, which the HR practitioner can be called on to deal with. This study, however, focuses on diagnosable mental ***disorders***, collectively referred to as mental illnesses.

Systematic classification of the various mental illnesses assists with the effective management thereof as it facilitates distinguishing between disorders, which in turn, is essential for effective treatment. Also, classification creates a common language, which in turn aids communication and directs referral to appropriate professional care. The two most important internationally recognised systems for classifying psychiatric diagnoses are the International Classification of Disease (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM) (Kaplan & Sadock, 1997). The **ICD** is compiled and produced by the WHO, whereas the DSM is a production of the APA. The current ICD, published in 1992, is the 10th revision (referred to as the ICD-10) of the original and consists of a comprehensive classification system for both medical conditions and mental disorders. It is the official disease classification system in use across the globe. However, some countries make use of other systems to aid in the classification and diagnosis of *psychiatric conditions*. The **DSM** is the official system in the United States. Most academic institutions in South Africa also prefer to use the DSM in clinical and research practice. The DSM has undergone numerous revisions since the first edition in 1952 (APA, 1994, p. xvii). The most recent edition is the revised version of the DSM-IV (fourth edition).

This study utilises the **DSM-IV** in all its methodology and discussions. The DSM historically provides more stringent diagnostic criteria for more mental disorder categories than the ICD, although more recent editions of the ICD have increased in coverage of mental illnesses. Nonetheless, researchers use the DSM-IV as it offers more detailed diagnostic criteria whereas the ICD-10 is oversimplified in this regard. The DSM-IV is a comprehensive classification system that uses a descriptive approach, that is, it aims to describe the manifestations of mental disorders without placing too much emphasis on the causes or development of disease (Kaplan & Sadock, 1997). Diagnosis is therefore based on specific diagnostic criteria for each specific mental disorder. The diagnostic criteria include a list of features that must be present/ be applicable for a diagnosis to be made. The validity and reliability of these criteria are sound and are backed by numerous research studies and clinical evidence. Furthermore, the DSM-IV provides a systematic description of a host of associated features for each disorder including prevalence, risk and predisposing factors, complications and differential diagnosis.

A ***5-axial classification system*** is used to comprehensively evaluate persons with a mental disorder along several variables (Kaplan & Sadock, 1997) (see Table 2.4). All mental disorders fall within Axes I and Axis II, which cover all (a) clinical disorders and (b) personality disorders and mental retardation respectively. Stein, Seedat, Niehaus, Pienaar and Emsley (2002) note that Axis I disorders are all of an episodic nature while Axis II conditions are more enduring and lifelong. It is possible for a person to have a diagnosis on both Axis I and Axis II, for example have borderline personality disorder and be diagnosed with major depressive disorder. All medical conditions that are present together with the mental disorder(s) at the time of evaluation are listed on Axis III, for example infectious diseases. Axis IV codes environmental and psychosocial stress factors such as financial, support system or occupational problems that may have contributed to the development of or worsen the mental disorder in question. Finally, Axis V rates the overall functioning of the person on a 100-point scale where a score of 100 refers to superior functioning (i.e., mentally healthy). This is referred to as the global assessment of functioning (GAF) scale and, in line with the conceptualisation of mental disorder as used in this study, places diagnosis on a continuum of mental health and mental illness (APA, 1994). The multi-axial system therefore ensures a holistic approach and helps to individualise the most effective and appropriate treatment strategy.

Table 2.4 The 5-axial classification system of the DSM

Axis	Variable
Axis I:	The main clinical (psychiatric) diagnosis.
Axis II:	Personality disorders/traits, and mental retardation.
Axis III:	Coexisting medical conditions that have potential relevance to the management of the patient.
Axis IV:	Psychosocial and environmental problems that may play a role in the development or exacerbation of the psychiatric disorder.
Axis V:	Degree of impairment in social, occupational and psychological functioning currently, and in the past year.

(APA, 1994, pp. 25-31)

Mental disorders are grouped into broad ***categories*** within the DSM system. These include the mood disorders (e.g., major depressive and bipolar disorders), the anxiety disorders (e.g., panic and posttraumatic stress disorders), the psychotic disorders (e.g., schizophrenia), and personality disorders (e.g., paranoid and borderline personality disorders). See Table 2.5 for a full list of categories with selected diagnoses within each. Symptoms of a specific diagnosis often overlap

with that of other disorders in the same category, or with those of another category. For example, difficulty in concentrating is one of the symptoms of major depression as well as of dysthymia (both mood disorders) but also occurs in posttraumatic stress disorder and generalised anxiety disorder (both anxiety disorders). The DSM helps to make an accurate diagnosis in such instances by being specific about when to make a diagnosis and what other factors may play an influencing role (Stein et al., 2002). It even makes provision for diagnostic uncertainties by supplying specific rules to be applied when the full criteria for a particular diagnosis are not met or when sufficient information is not available to make a definitive diagnosis (Kaplan & Sadock, 1997).

Table 2.5 DSM-IV diagnostic categories with selected psychiatric diagnoses

Main diagnostic category	Examples of disorders within category
Disorders usually first diagnosed in infancy, childhood, or adolescence	Mental retardation Learning disorders Attention deficit and disruptive behaviour disorders
Delirium, dementia, and amnestic and other cognitive disorder	Delirium Dementia of Alzheimer's type Vascular dementia
Mental disorders due to a general medical condition (GMC) not elsewhere classified	Catatonic disorder due to a GMC Personality change due to a GMC
Substance-related disorders	Alcohol use disorders Cannabis use disorders Cocaine use disorders
Psychotic disorders	Schizophrenia Schizophreniform disorder Schizoaffective disorder
Mood disorders	Depressive disorders Bipolar disorders
Anxiety disorders	Panic disorder Obsessive-compulsive disorder Posttraumatic stress disorder
Somatoform disorders	Somatization disorder Conversion disorder Pain disorder
Factitious disorders	Factitious disorder with predominantly psychological signs and symptoms Factitious disorder with predominantly physical signs and symptoms
Dissociative disorders	Dissociative amnesia Dissociative fugue Dissociative identity disorder
Sexual and gender identity disorders	Sexual dysfunctions Paraphilias Gender identity disorders
Eating disorders	Anorexia nervosa Bulimia nervosa

Table 2.5 continued

Sleep disorders	Dyssomnias Parasomnias
Impulse-control disorders not elsewhere classified	Intermittent explosive disorder Kleptomania Pyromania
Adjustment disorders	Adjustment disorder with depressed mood Adjustment disorder with anxiety
Personality disorders	Paranoid personality disorder Antisocial personality disorder Narcissistic personality disorder

(APA, 1994, pp. 13-24)

Of particular importance to the ***world of work*** are perhaps the mood, anxiety, psychotic, personality, and substance-related disorders. The mood, anxiety and substance-related disorders are also the categories represented by this study. Vignettes portraying a diagnosis within each of these three categories were drawn up using DSM-IV criteria and employed during the survey phase of this study (see chapter 3). The three diagnoses covered (i.e., major depressive disorder, panic disorder and alcohol abuse) are described in more detail later in this chapter.

1. ***Mood disorders:*** The mood disorders are characterised by disturbances in mood, being either elevated (referred to as mania) or down (depression) (Stein et al., 2002). They are associated with significant distress and interfere with social, occupational and interpersonal functioning. These conditions are very common, and are reported to effect up to 11.3% of the general population during a 12-month period, or 19.3% during an entire lifetime (Kessler, McGonagle, Zhao, Nelson, Hughes, Eshleman, Wittchen & Kendler, 1994, p. 12). The mood disorders include major depressive disorder (major depression), dysthymic disorder (less severe form of depression but of a chronic nature), bipolar disorder (manic-depressive), and cyclothymia (less severe but long-term form of bipolar disorder) (APA, 1994). Common symptoms of the mood disorders generally include changes in activity level, cognitive abilities, speech, sleep, appetite, sexual activity and biological rhythms (Kaplan & Sadock, 1997). Persons with depression report a loss of interest in usual activities, decreased energy, feelings of guilt, concentration problems and thoughts of death or even suicide. Depression is frequently referred to in modern lay language as "burnout" (Kahn & Langlieb, 2003). Those with mania act, think, speak and seem to do everything faster, bigger and more elaborately than usual. They need less sleep, are more active, appear to be on a "high", and have an increased self-esteem with ideas of grandiosity and being able to take on all.

2. ***Anxiety disorders***: The anxiety disorders are characterised by excessive, acute anxiousness, irrational fears and avoidance of situations related to the source of the anxiety (Oosthuizen, Niehaus & Stein, 2002). It is important to distinguish normal anxiety from pathological anxiety, as normal anxiety has an adaptive function and is necessary to survive. It alerts of impending danger or threat and leads to actions to avoid pain, harm or death (Kaplan & Sadock, 1997). Pathological anxiety, on the other hand, can be seen as an inappropriate response to a given stimulus. The anxiety disorders as a group are the most prevalent of all mental disorders. According to the National Comorbidity Survey (NCS) undertaken by Kessler et al. (1994, p. 12) 17.2% of the general population will suffer from an anxiety disorder during any given year and 24.9% during their lifetime. The different anxiety disorders include panic disorder (sudden onset of an intense fear attack accompanied by somatic symptoms), social anxiety disorder (also called social phobia and entails fear of embarrassment or humiliation in social situations), posttraumatic stress disorder (re-experiencing, arousal and avoidance symptoms following a life-threatening event), obsessive-compulsive disorder (repetitive, uncontrollable thought patterns and/or actions), generalised anxiety disorder (persistent, excessive worry with somatic symptoms), and specific phobias (fear and avoidance of a particular object or situation) (APA, 1994). Somatic (body) symptoms that often occur with anxiety disorders include dizziness, heart palpitations, diarrhoea, tremors, tight chest, perspiration, "butterflies" in the stomach, tingling in extremities and restlessness (Kaplan & Sadock, 1997). The anxiety disorders, previously known as neurosis before their biological bases was understood, are often referred to in today's modern lifestyle as "stress" (Kahn & Langlieb, 2003). Left untreated, these conditions may lead to other anxiety disorders, depression or substance abuse as a form of self-medication (Oosthuizen et al., 2002). Early diagnosis and appropriate management are therefore vital.

3. ***Psychotic disorders***: The psychotic disorders are characterised by a loss of contact with reality, including experiencing delusions (erroneous beliefs usually of a religious, grandiose or persecutory nature) and hallucinations (distortion or exaggeration of perception, e.g., seeing, hearing or feeling things that others cannot) (Kaplan & Sadock, 1997). These conditions are relatively less common than other mental disorders, with a reported lifetime prevalence of between 0.05 and 1% (APA, 1994. pp. 282-303). The psychotic disorders include schizophrenia (psychotic disturbance lasting at least 6 months), schizophreniform disorder (similar to schizophrenia except duration less than 6 months), schizoaffective disorder (like schizophrenia but with characteristics of mood

disorder), delusional disorder (persistent false beliefs of persecution or jealousy), and brief psychotic disorder (subjective emotional turmoil following a psychosocial stressor) (Emsley, 2002b). Common symptoms, other than delusions and hallucinations, include disorganised thinking, speech or behaviour, blunted emotion, catatonic motor behaviours such as decreased reactivity to the environment and rigid posture (Kaplan & Sadock, 1997). Many myths surround the psychotic disorders, e.g., that schizophrenia equates a split personality (these are in actual fact two distinct diagnoses) or that sufferers are always violent. This adds to the personal suffering, stigmatisation and discrimination of patients and families affected by these conditions (Emsley, 2002b). Psychotic disorders, especially schizophrenia, are associated with significant occupational and social functioning impairment, and financial burden. Mistruths and misconceptions only add to the societal burden of these conditions and should therefore be actively combated.

4. ***Personality disorders***: The personality disorders are characterised by fixed patterns of behaviour and subjective experience that are considered deviant by the culture in which the individual finds him-/herself, are inflexible, pervasive and lead to considerable distress or impairment (APA, 1994). The onset of personality disorders is usually in adolescence or early adulthood and they remain stable over time. They are present in about 6 to 13% of the general population (Fainman, 2002, p. 238). It is important to note though that these conditions frequently co-occur with other mental disorders (i.e., are comorbid), especially the mood, anxiety, somatization and eating disorders. Personality disorders are grouped into three clusters, namely the odd-eccentric Cluster A types (e.g., paranoid schizoid and schizotypal personality disorders); the dramatic-emotional Cluster B types (e.g., anti-social, borderline, histrionic and narcissistic personality disorders); and the anxious-fearful Cluster C types (e.g., avoidant, dependent, and obsessive-compulsive personality disorders) (APA, 1994). The symptoms of personality disorders can adapt to and alter the environment, and are not experienced as deviant by the individual with the condition (Kaplan & Sadock, 1997). Rather, such persons feel no anxiety about their maladaptive behaviour, which can complicate treatment and management.

5. ***Substance-related disorders***: Substance-related disorders include conditions associated with the taking of drugs or alcohol, the side-effects of medications, or exposure to toxins (APA, 1994). These disorders are divided into two groups, namely the substance use disorders (covers dependence and abuse), the substance-induced disorders (includes substance intoxication and withdrawal, and substance-induced delirium, dementia,

psychotic, mood, anxiety and sleep disorders). Dependence refers to the physiological effects of numerous episodes of substance use (tolerance or withdrawal) and the substance-seeking behaviours and related activities of pathological use (Kaplan & Sadock, 1997). Substance abuse, however, is characterised by at least one symptom indicating that substance use is interfering with a person's life, for example repeated absenteeism or poor performance at work (APA, 1994). These conditions are common amongst the general population with 11.3% meeting criteria in a year and 26.6% over their lifetime (Kessler et al., 1994, p. 12). The different substance-related disorders include dependence, abuse or induced conditions related to the use of alcohol, amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, nicotine, caffeine and sedatives/hypnotics/anxiolytics (APA, 1994). These conditions are highly comorbid with other psychiatric diagnoses, that is, occur at the same time in a single person. Kaplan and Sadock (1997, p. 384) report that 76% of men and 65% of women with a substance abuse or dependence diagnosis also have a current other psychiatric condition. Comorbidity rates are highest with other substance-related disorders, anti-social personality disorder, major depression, dysthymia and phobias. Often this is because patients revert to substances as a form of self-medication instead of consulting professional care. This compounds the already high costs and adverse impact of mental illness to the individual and to society as a whole.

2.3.3 Extent of the problem

Mental disorders are extremely **common** amongst the general population in both developed and developing countries. Indeed, according to the WHO, more than one in four (25%) people worldwide will suffer from a mental or behavioural disorder sometime in their lives. This means 450 million people worldwide are currently suffering from one or more of these conditions (WHO, 2001b, pp. 19, 23). To fully comprehend the magnitude of these conditions, it may be useful to first look at what measures epidemiologists use in determining health statistics. Most of the literature on this topic refers to "prevalence" figures, although some also use the term "incidence". It may be confusing when reading papers on the epidemiology of mental disorders to find what would appear to be contradicting figures. It is important therefore to note which measure is being reported on. Incidence refers to all new cases of a condition which occur during a specific period of time, while prevalence refers to all new and existing cases of a condition observed at a point in time or during a period of time (US Department of Health & Human Sciences, 1999). The figure of 25% mentioned above is a prevalence figure. Prevalence rates differ depending on whether they include all persons with a condition at some point in time (point prevalence), at any time during a specific period in time (period prevalence), or at any time during their lifetime (lifetime prevalence). Given this, the WHO

reports that while more than a quarter of the world's population will develop a mental or behavioural disorder during their entire lifetime (lifetime prevalence), 10% of adults have a neuropsychiatric condition (point prevalence). In other words, 450 million people currently suffer from depression, schizophrenia, epilepsy, alcohol and other drug use disorders, posttraumatic stress disorder, obsessive-compulsive disorder, Alzheimer's and other dementias, panic disorder, and primary insomnia (WHO, 2001b, p. 23).

Prevalence rates also differ depending on the definition of disorders and rating scales employed (e.g., ICD versus DSM), the population included (e.g., including only certain age brackets, gender, demographic groups) and amongst certain settings (e.g., primary care patients, general population, developing or developed countries). The WHO Report (2001b) provides a general overview of prevalence combining figures from a wide range of methodological sound international studies covering various population groups. Two of the most frequently cited large-scale general population studies based on DSM criteria are the Epidemiologic Catchment Area (ECA) programme and the National Comorbidity Survey (NCS). Both were conducted in the United States of America. However, due to the large representative samples included and the strict adherence to the scientific research process, both are internationally recognised as being appropriate to generalise to most population groups. Furthermore, the ECA has been and the NCS is currently being extended to a range of countries, and this work shows cross-national similarities.

The National Institute of Mental Health (NIMH) of the United States conducted the ECA program during the 1980's (Robins, Helzer, Weissman, Orvaschel, Gruenberg, Burke & Darrel, 1984; Weissman, Leaf, Tischler, Blazer, Karno, Bruce & Florio, 1988). A probability sample of 18 572 households from five communities in the United States provides data on the prevalence of mental disorder in adults aged 18 years and older (Weissman et al., 1988, p. 142). The ECA programme estimates that between 29 and 38% of the general population will suffer from a mental disorder in their lifetime (Robins et al., 1984, p. 952). Note this is for persons 18 years of age and older, therefore of employable age.

The NCS was a congressionally mandated survey designed to be nationally representative of all states in America and covering the non-institutionalised civilian population during the early 1990's. A stratified, multistage area probability sample surveyed 8098 persons aged 15 to 54 years in the 48 coterminous states (Kessler et al., 1994, p. 9). The NCS found that 48% of respondents interviewed reported having experiencing a diagnosable mental illness at some time in their lives and 30% reported a 12-month prevalence (Kessler et al., 1994, pp. 10-11). Psychiatric disorders with the most commonly reported lifetime and 12-month prevalence rates

were major depression (17%; 10%) and alcohol dependence (14%; 7%). However, as a group, the substance use disorders and the anxiety disorders were slightly more prevalent than the mood disorders, with the anxiety disorders showing a higher 12-month prevalence than all other groups of mental disorders (Kessler et al., 1994, p. 10).

National, representative ***South African prevalence*** figures are not known, although various smaller population-specific studies have been reported on. One study surveying a rural coloured community in the Western Cape randomly selected 481 adults and found a weighted overall psychiatric morbidity of 27.1%, with the majority (24%) of cases identified as either depressive or anxiety disorders (Rumble, Swartz, Parry & Zwarenstein, 1996, p. 997). Other studies provide prevalence figures for, for example, clinic-based populations (Freeman, 1991) or specific racial and community populations (Bester, Weich & Gagiano, 1991). One such community study amongst African adults in a rural Kwazulu Natal community found a weighted prevalence of 23.9% for depressive and generalised anxiety disorders (Bhagwanjee, Parekh, Paruk, Petersen & Subedar, 1998, p. 1142). Major depression and dysthymia, either as single diagnosis or as coexisting conditions, had a combined point prevalence of 20.2% while that for generalised anxiety disorder was 3.7% (Bhagwanjee et al., 1998, p. 1143). These figures correspond with Rumble at al.'s (1996) weighted overall and condition specific results for depressive and anxiety disorders. However, both these studies report a higher overall prevalence of psychiatric conditions than found in other developing countries (Harding, Arango, Baltazar, Climent, Ibrahim, Ladrido-Ignacia, Srinivasa Murphy & Wig, 1980) or in industrialised countries such as the already mentioned NCS and ECA findings. Bhagwanjee et al. (1998) warn against comparing prevalence rates across different studies because of the compromising variance arising from different study designs, case definitions, populations sampled, instruments employed, and statistical treatment of data.

With reference to ***working populations***, a recent ILO survey reveals that 10% of office workers in Britain, the United States, Germany, Finland and Poland suffer from depression, anxiety, stress and burnout (Medscape, 2000, p.1). In a study of British workers seeking counselling within employee assistance programmes (EAP's), it was found that 86.6% of these experienced significantly high levels of psychiatric problems (Arthur, 2002, p. 69). This raises the possibility that many employees complaining of stress and burnout may, in fact, be suffering from a diagnosable mental disorder such as depression or one of the anxiety disorders. This corresponds with the thinking of Kahn and Langlieb (2003), as mentioned in 2.3.2 under the discussion of the mood and anxiety disorders. Furthermore, according to the joint WHO/ ILO monograph on mental health and work, 15 to 30% of workers will experience some form of mental health problem during their working lives and 20% of the adult working population has

some type of mental condition at any given time (Harnois & Gabriel, 2000, p. 1). Again, local statistics are not known but it is possible given our complex society and rapidly changing work environment, that these figures will be locally duplicated if not exceeded.

Mental disorders are not only highly prevalent but are also amongst the most important causes of **worldwide burden and disability**, as determined by an international study comparing different health conditions. The Global Burden of Disease (GBD) study was a joint project of Harvard Business School, the WHO and the World Bank and set out to determine sex, age, and region determinants of disease and burden across the globe. This study employed a standardised measure referred to as Disability-Adjusted Life Years (DALY's) to ascertain the sum of years of life lost due to premature mortality (death) and years of life lived with disability (adjusted for the severity of the disability) (Murray & Lopez, 1997). This is a particularly useful measure to determine the societal burden of mental disorders, as many do not result in death but are of a chronic nature with high levels of morbidity (sickliness). It was found that neuropsychiatric conditions contributed 10.5% of the worldwide burden of disease in both developed and developing countries (Murray & Lopez, 1997, p. 1441). Unipolar major depression (major depressive disorder), although found to be the 4th leading cause of morbidity worldwide in 1990, is projected to be the most important contributor to the global burden of disease in 2020. Also, six of the top 20 leading causes of DALY's in the age group 15 to 44 are neuropsychiatric conditions, namely depression, alcohol use disorders, self-inflicted injuries, schizophrenia, bipolar disorder and panic disorder (WHO, 2001b, p. 27).

The GBD study employed a second measure of disease burden which looked at morbidity alone, namely the years lived with disability (YLD's). The YLD, often referred to as the disability component of disease burden, includes dimensions such as pain, discomfort, physical dysfunction, emotional distress, inability to carry out usual activities and loss of dignity. With this measure it was found that mental illnesses as a group totalled 30.8% of all YLD's and depression caused the largest amount of YLD's for all health conditions (WHO, 2001b, p. 26). HIV/AIDS ranked 18th and accounted for 1.5% of all YLD's, which is dwarfed by the 11.9% attributed to depression alone. However, it needs to be remembered that HIV/AIDS has a high mortality rate, therefore less years actually lived with disease. The mental disorders have lower mortality, but account for more burden and disability as longer years are generally lived.

Many countries across the globe have initiated or completed burden of disease (BOD) studies since the GBD study. The results of these country-specific studies are not always comparable as each study has been designed to meet the needs of that specific population with adjustments made to accommodate individual data restraints. However, it is interesting to note that Mexico

was the first country to employ DALY's in a national BOD study. This groundbreaking study highlighted regional differences and inequalities and contributed towards the national policy debate and new national health plan for Mexico (Lozano, Murray, Frenk & Bobadilla, 1995). The Australian BOD study reported on the considerable burden due to mental disorders, including drug abuse, in that country (Mathers, Vos & Stevenson, 1999). Closer to home, a study investigating national burden of disease in Zimbabwe found that AIDS accrued an extensive impact, but that the burden of depression and anxiety disorders was also substantial. Furthermore, that rural versus urban differences were significant and should be included in policy decisions (Zimbabwe Burden of Disease Committee, 2001).

The Burden of Disease Research Unit of the Medical Research Council (MRC) of ***South Africa*** released initial South African BOD estimates for the year 2000 in March 2003 (Bradshaw, Groenewald, Laubscher, Nannan, Nojilana, Norman, Pieterse & Schneider, 2003). This landmark document is the first attempt at a national burden of disease study in South Africa incorporating estimates for morbidity and mortality using different sources of data. Mortality figures, for example, were collated from the 1996 Statistics South Africa databank of causes of death, the Department of Home Affairs registered deaths and the UNISA/MRC National Injury Mortality Surveillance System. Statistical models were used to estimate figures for 2000 and to project the impact of AIDS in 2010. As described above though, DALY's comprise both a mortality and morbidity measure (the YLD). The MRC acknowledges in this report that insufficient or incomplete data is available in South Africa to give an accurate estimate of morbidity burden. Because crucial elements of determining YLD's such as the age of onset, duration of disability and incidence of disability is not available for many diseases or conditions, the South African BOD study estimated YLD's by making use of ratios based on the GBD. Therefore, South African DALY's are preliminary figures. Bradshaw et al. (2003) warn that looking only at mortality misrepresents the total disease burden as this would under-estimate the considerable contributions of conditions such as mental disorders, nervous system disorders and intentional injuries. They therefore conclude that while their estimates cannot be regarded as definitive, they do illustrate the importance of non-fatal outcomes when ranking disease and conditions.

On closer inspection of the initial South African **mortality** figures, it comes as no surprise that AIDS and cardiovascular disease rate respectively first and second as causes of death categories for 2000 (Bradshaw et al., 2003, p. 31). Nervous system disorders and mental disorders come in at 13th and 18th respectively, while intentional injuries (including suicide) ranks fifth. Looking at specific conditions, AIDS and ischaemic heart disease rank first and second, with suicide coming in at 16th (Bradshaw et al., 2003, p. 32). However, if one were to look at the years of

life lost (i.e., the YLL measure which determines the amount of years lost that could have been lived due to premature death), nervous system disorders and mental disorders are ranked 12th and 19th respectively and intentional injuries third (Bradshaw et al., 2003, p. 34). If mental and nervous system disorders estimates were combined (as with the GBD study which determines the burden of neuropsychiatric conditions), and if the deaths due to suicide were added to this, one may wonder where mental illness would be ranked for the South African population? It is interesting that the South African study ranks these diseases and conditions separately, especially given the relation of suicide and mental illness. Stahl (2000, p. 141), for example, reports that untreated depression accounts for 30 000 to 35 000 suicides a year in the United States of America. This excludes the deaths from fatal accidents due to impaired concentration and attention or those due to other consequential illnesses (e.g., alcohol abuse). Also, that one out of every seven persons with recurrent depression commits suicide and that 70% of all persons who commit suicide have a depressive illness.

Looking at initial South African **morbidity** figures, it is important to note that the South African BOD study provides estimates for disease categories only (e.g., mental disorders), and not for single diseases or conditions (e.g., depression). Again, this is due to the paucity of reliable disability information. Also, one needs to keep in mind that these are preliminary figures included for illustrative purposes only. This is because the MRC recognises the significant role of non-fatal conditions as well as the considerable burden of conditions such as depression and anxiety disorders that need to be included in burden estimates in order for these conditions to receive adequate policy attention, even though the detail required to accurately determine YLD's are fragmented or unavailable (Bradshaw et al., 2003, p. 24). AIDS is estimated at the highest DALY's ranking, while nervous system disorders (10th) and mental disorders (13th) rank behind intentional injuries (fourth) (Bradshaw et al., 2003, p. 39). However, if nervous system and mental disorders are grouped together, as with the Harvard/WHO/World Bank GBD rankings, these conditions are estimated to rank second on the South African DALY's ranking (Bradshaw et al., 2003, p. 39). This corresponds with global rankings as reported by the Global Burden of Disease Study. Again, one could ask whether adding the burden due to suicide attempts to this combined neuropsychiatric category would affect the overall DALY's ranking of mental illness in South Africa.

Although specific YLD figures for South Africa are not made known in the MRC report, it would appear from graphical representation (Bradshaw et al., 2003, p. 40, Figure 3.6) that nervous system and mental disorders contribute significantly (if not the most extensive contribution) towards disability burden. One can only assume then that a combined neuropsychiatric category (including estimates for suicide) would far out-rate all other health

conditions. This would then correspond with worldwide estimates as provided by the GBD as well as estimates from other African countries. The Zimbabwean BOD study, for example, reports that depression and anxiety are the most common reasons for YLD's in that country (Zimbabwe Burden of Disease Committee, 2001).

2.3.4 Workplace implications

Mental illness is not only costly to society, but also places a burden on the corporate world in the form of direct and indirect costs. ***Direct costs*** of mental illness include the costs of treatment and rehabilitation as covered by medical aid and other managed health care schemes (US Department of Health & Human Services, 1999). ***Indirect costs*** include loss in productivity, decreased motivation, increased absenteeism, increased staff turnover, early retirement, safety risks, accidents, interpersonal conflict, suicide and the cost of inadequate or inappropriate treatment (Conti & Burton, 1994; Kahn & Langlieb, 2003). Depression costs the United States an estimated $43 billion a year in treatment, lost earnings and productivity. Furthermore, this condition leads to 200 million lost working days a year (Greenberg et al., 1993, p. 405). Depression costs 4% of the European Union's Gross National Product and contributes towards 7% of premature retirements in Germany (Medscape, 2000, p.1). Anxiety disorders are estimated to cost an annual $42.3 billion in the Unites States (Greenberg et al., 1999, p. 427). In Finland, mental illnesses are reported to be the leading cause of disability pensions (Medscape, 2000).

With reference to the above, it would be meaningful to re-visit Miner's (1985) understanding of the aspects of work performance as listed under 2.2.4 of this chapter. It was mentioned that work performance is a complex product of internal employee and external environmental factors. The challenge to HR practitioners is to maximise the productive contribution of employees towards the organisation, while at the same time minimising employee-related costs. The four aspects of work performance related to organisational goals and profits are quality, quantity, time on the job, and cooperation. Mental illnesses are not only highly prevalent and generally costly, but also impact on all four aspects of work performance. Given the purpose and objectives of HRM, it is imperative that the HR practitioner be knowledgeable of these potential causes of workplace problems in order to take corrective actions. Relating this to Miner's aspects of work performance, mental illness causes absenteeism, disability, poor work productivity and effects relations at work, impacting on the employee, co-workers, and supervisors.

2.3.4.1 Mental illness and absenteeism

Several studies document the impact of mental illness on absenteeism. One study found that 14% of all work absences were due to mental illness (Jenkins, 1993, p. 65). This estimate does not include absence due to emotional symptoms of physical illnesses such as headaches or flu. Furthermore, mental illness, including anxiety disorders and depression, costs industry an average of 16 days sick leave per year per worker with a psychiatric diagnosis (Dauer, 1989, p. 49).

Depression, for example, is a major cause of absenteeism. Depressed employees are significantly more likely to be absent from work than non-depressed workers (Druss, Schlesinger & Allen, 2001). Workers with depression miss an average of 1.5 to 3.2 days of work per month more than other workers, costing employers in the United States $182 to $395 per month in salary (Kessler, Barber, Birnbaum, Greenberg, Rose, Simon & Wang, 1999, p. 164). A prospective study of depression and days not on the job reported that depression accounted for more than one-fifth (22%) of all days lost from work (Broadhead, Blazer, George, & Tsee, 1990, p. 2525). In 1990, for example, it was found absenteeism secondary to depression cost industry $11.7 billion representing 27% of the total societal costs of depression (Greenberg et al., 1993, p. 411).

2.3.4.2 Mental illness and disability

Mental illnesses also account for longer periods of absenteeism and disability. A study looking at short-term disability, including absence durations of greater than five days up to six months, found that depression contributed significantly to illness absences within a large corporation in the United States (Conti & Burton, 1994). Mental disorders accounted for 11% of all medical plan costs, and depression accounted for 52% of all medical claims for mental disorders (Conti & Burton, 1994, p. 985). Of all the disability absences secondary to mental illness, it was found that depression was responsible for 52% of the diagnoses and 62% of the total days lost from work. Disability absences due to depression averaged 40 days, which was greater than disability absences due to lower back pain (37 days), heart disease (37 days), all other mental disorders combined (32 days), high blood pressure (27 days), and diabetes (26 days). Upon returning to work from disability absence for depression, 26% of workers experienced another episode of disability for depression in the following 12 months. This disability relapse rate was significantly greater than the relapse rates for high blood pressure (11%), lower back pain (10%), heart disease (8%), and all other mental disorders combined (8%). Only diabetes had a similar relapse rate (26%). Thus, it was concluded that depression is associated with both longer and more frequent absences from work. Coetzer (2002) reports that in South Africa, disability applications on the grounds of psychiatric diagnosis accounted for 28.5% of all

disability claims during 2001. This made mental disorders the leading cause of disability, followed by backache (21%) and cardiovascular disease (9%). Previous figures rated backache (at 37% of all claims) as the leading cause for disability in 1998, with claims based on psychiatric causes then rated second at 23%, and cardiovascular disease claims third (roughly 10%). According to Coetzer, the increase in claims based on psychiatric causes is significant, adding that within some individual companies these conditions make up 34% of all causes for disability claims. It would therefore appear that mental disorders are also the leading cause of disability payments in South Africa, as is the case in Finland (Medscape, 2000)

2.3.4.3 Mental illness and productivity

Decreased job performance is often due to mental illnesses. Druss et al. (2001) report that depressed workers were significantly more likely to report decreased effectiveness at work that non-depressed workers. Lost productivity due to depression cost American corporations $12.1 billion in 1990, representing 28% of the total societal costs of depression (Greenberg et al., 1993, p. 411). Anxiety disorders cost American industries $4.1 billion the same year in indirect workplace costs, 88% of this attributed to decreased productivity (Greenberg et al., 1999, p. 431).

Despite this research, the tremendous costs of mental illnesses is not well recognised by industry. Any effort to reduce absenteeism, workplace accidents, interpersonal conflict and job dissatisfaction, needs to understand the central role that these mental illnesses play in causing these problems. If these common work problems, which are so costly to the employee, co-worker, supervisor, and organisation can be identified early, referred for evaluation and adequately treated, many costs can be avoided. This will benefit the overall wellbeing of the organisation, in terms of both employee morale and productivity. Also, these costs need not be so exorbitant, as effective treatments are available (Brundtland, 2001). Given the HR practitioner's role of containing employee-related costs (Wiley, 1992), it should be a priority to identify employees with inefficient work performance possibly due to mental illness and appropriately refer them for treatment. Simon, Barber, Birnbaum, Frank, Greenberg, Rose, Wang & Kessler (2001) note that productivity gains following effective treatment of depression, for example, far exceed direct treatment costs. This is also supported by work of the WHO and APA which show that 80 to 90% of persons with a mental illness who receive adequate treatment can get better (APA, 1996, p.2; WHO, 2001a, p.2; WHO, 2001b, p.4).

2.3.4.4 Effects on the employee and organisational relations

In addition to the enormous indirect costs as mentioned above, mental illness also impacts on employee relations. The effects of absenteeism, accidents, poor job performance, interpersonal

conflict, and job dissatisfaction are difficult to overestimate. Although these problems may start with one employee, the impact could spread to reach other co-workers, management, and perhaps the entire organisation (Pflanz & Heidel, 2003).

Employees with a mental disorder may exhibit a variety of emotional, behavioural, cognitive, and physical problems. Emotional problems include anger, sadness, and irritability. Poor sleep, inappropriate grooming, and missing work are common behavioural problems. Cognitive problems include poor concentration, making mistakes, and poor judgements while physical problems include fatigue, palpitations, and excessive sweating (Kaplan & Sadock, 1997). Employees with a combination of these symptoms may be unsure where to turn for help and hesitant to involve their supervisor for fear of jeopardising their career. This can be incredibly stressful and may exacerbate the mental illness that caused the initial problem. This can potentially lead to increased problematic behaviour, creating a downward spiral of increasing tension between the employee and the organisation (Pflanz & Heidel, 2003). Employee health and wellness programmes should therefore include psychoeducation and HR practitioners should be seen as having a positive attitude towards mental illness in order to facilitate appropriate help-seeking behaviour. This can ultimately contribute towards addressing the high costs and burden of mental illness, as mentioned above. Furthermore, addressing the stigma associated with mental illness or with receiving treatment for a mental disorder should be tackled on all human resource levels (i.e., individual, group, management and organisational culture).

Co-workers may have to increase their workload to make up for the absent or inefficient colleague. This could lead to feeling overwhelmed by the additional workload, which in turn may affect overall morale. Eventually, if not attended to, these problems could spread to other employees in the work group. When injuries are involved co-workers may become overly concerned about safety matters in the workplace. Anxiety about the possibility of future accidents and the resulting fears may actually increase the risk of future accidents (Pflanz & Heidel, 2003). If a problem employee jeopardises the safety of co-workers or causes significant injuries, the work group will likely become angry with both the problem employee and management for not addressing the problem in a timely manner.

Employees with mental illness may become a major preoccupation with **supervisors**, taking up much of their time and interfering with their primary duties (Pflanz & Heidel, 2003). Each problem needs to be thoroughly investigated, carefully documented, discussed with several people, and monitored closely. If supervisors are too tolerant or ignore the issue, co-workers may interpret this to mean that the behaviour is acceptable and behave in similar ways

themselves. Alternatively, those who are upset by the problems may feel hopeless when they see the problem is not being addressed. This may increase their stress levels, leading them to consider resigning their position or transferring to a more satisfying work environment. If supervisors adopt the opposite extreme and aggressively pursue the problem employee, those co-workers who feel burdened by the problem behaviour and having to take on extra work, may greet this with enthusiasm. However, aggressive action by the supervisor may also be viewed as harsh and intolerant, creating an oppressive environment where employees are afraid to get sick or have an off day. Clearly these problems require sensitivity and tact on the part of supervisors, as well as a great deal of time and patience.

These are all challenging problems for employers and particularly HR practitioners who are ultimately responsible for the effective utilisation and management of employees. Given the high workplace prevalence of mental illness it may be assumed that they frequently contribute towards disruption in the work environment, leading to poor morale and decreased productivity amongst entire workgroups. Addressing these behaviours with employees may, however, be difficult and awkward. Supervisors may, for example, be concerned that discussing these issues will embarrass or hurt the concerned employee's feelings and exacerbate an already difficult situation. HR practitioners should therefore have an understanding of the causes of these common work problems as well as their negative impact on both the employee and the organisation. A careful assessment process should include the identification of the workplace problem, referral to professional mental health care, and interventions to correct the problem. Thoughtful planning can minimise or even prevent some of these problems from occurring in the future. This is the challenge to HR practitioners. However, to do so effectively requires competency, which according to Swanepoel (1998) comprises not only knowledge and skills, but also being able to apply what has been learnt and to having a positive attitude.

2.4 The importance of mental health/illness education in the training and development of HR practitioners

The well-established reality of mental illness in the workplace together with the accepted roles and responsibilities of HR practitioners places certain demands on the competencies of HR practitioners. The following section looks at what may arguably be expected of HR practitioners, as well as of the training institutions responsible for their education and development.

2.4.1 Mental health literacy

Mental health literacy is **defined** as the "knowledge and beliefs about mental illness that aid their recognition, management or prevention" (Jorm, Korten, Jacomb, Christensen, Rodgers &

Pollitt, 1997a, p. 182). This term was first coined by the social psychiatrist Anthony Jorm and his colleagues following extensive research into public and professional knowledge of and beliefs about mental illness (Jorm et al., 1997a; Jorm, Korten, Jacomb, Rodgers & Pollitt, 1997b; Jorm, Korten, Rodgers, Pollitt, Jacomb, Christensen & Jiao, 1997c). Jorm (2000, p. 396) states that mental health literacy consists of several **components**:

a) the ability to recognise specific disorders or different types of psychological distress
b) knowledge and beliefs about the risk factors and causes
c) knowledge and beliefs about self-help interventions
d) knowledge and beliefs about professional help available
e) attitudes which facilitate recognition and appropriate help-seeking
f) knowledge of how to seek mental health information.

Given the discussion above on the role of HR practitioners, as well as the extent and impact of mental illness in the workplace, this study argues that HR practitioners need to be mental health literate. Although there appears to be no literature on the mental health literacy of HR practitioners (or the business world, for that matter), from what is reported it is clear that raising mental health literacy levels amongst the general public helps to facilitate early recognition and appropriate help-seeking behaviour (Goldney, Fisher & Wilson, 2001; Jorm et al., 1997a, 1997c; Jorm, 2000). This could, in turn, contribute towards alleviating the considerable direct and indirect costs of mental illness, as already outlined.

A survey amongst the Australian general population using a national random sample of 2031 adults showed that very few could identify depression or schizophrenia by name when presented with a case study of someone clearly suffering from these conditions (39% and 27% respectively) (Jorm et al., 1997a, pp. 183-184). Also, that most respondents believed standard psychiatric treatments such as psychotropic medication, electro-convulsive therapy and admission to a psychiatric ward, are harmful. These beliefs influence help-seeking behaviour, and hold serious implications for adherence to treatment (Jorm et al., 1997a, 1997c). This finding has been duplicated by Goldney and colleagues (2001) who found a community wide lack of recognition of the symptoms of depression and a limited understanding of the availability and effectiveness of standard psychiatric treatments. They report that only 29.8% of the general population and 40% of persons with a diagnosed depression, who took part in a random national sample in Australia, believed that medication would be helpful (Goldney et al., 2001, p. 279). However, numerous research trials and clinical experience provide sound evidence that these treatments are effective and should indeed be considered first-line treatment (Emsley & Pienaar, 2002; Kaplan & Sadock, 1997; Stahl, 2000; Stein et al., 2002).

Most respondents in both the abovementioned studies favoured lifestyle changes (e.g., talking and relaxation techniques) and psychological approaches (e.g., seeing a counsellor) above medication. Angermeyer and Matschinger (1994, p. 40) found similar results with a general population survey in Germany where the majority of the 3098 randomly sampled adults believed that mental illnesses were most often caused by stress. Most respondents therefore believed that private support systems and therapy are the most appropriate treatment modalities. A community survey in the United States showed that 71% believed that mental illness was due to a weak character, 65% said it was caused by bad parenting, 43% were of the opinion that these conditions are untreatable and only 10% believed in a biological basis or that it involved the brain (Stahl, 2000, p. 137). This finding has been duplicated by a community survey in South Africa which found that most respondents believed mental illnesses are stress-related or due to a lack of willpower and therefore advocate talking about problems or going for therapy as best treatment strategies (Hugo, Boshoff, Traut, Zungu-Dirwayi & Stein, in press). Another South African study, looking specifically at Xhosa families of schizophrenia patients, found that the majority believed schizophrenia to be caused by witchcraft or possession by evil spirits and brain disease (Mbanga, Niehaus, Mzamo, Wessels, Allen, Emsley & Stein, 2002). Treatment with psychotropic medications and traditional healers or rituals was most commonly advocated, while psychotherapy was least often recommended It is well accepted, however, that mental illness is caused by a combination of factors, including biological, psychological, genetic and environmental and that the best treatment plan is a combination of medication, therapy and psychoeducation (Charney, Nestler & Bunney, 1999; Emsley & Pienaar, 2002; Kaplan & Sadock, 1997; Stahl, 2000). Indeed, studies surveying mental health professionals' beliefs about mental illness show clear discrepancies between lay and professional views of the causes and most appropriate treatments for mental illness (Jorm et al., 1997b, 1997c; Chen, Parker, Kua, Jorm & Loh, 2000).

It is thought that the reason most lay persons view medication with suspicion and distrust is because they believe them to cause unwanted side-effects, have only a limited action, and are ineffective (Angermeyer, Däumer & Matschinger, 1993; Priest, Vize, Roberts, Roberts & Tylee, 1996). Hugo et al. (in press) report that most lay persons surveyed in South Africa held psychotropic medications in a negative light as they were believed to be habit-forming, not reliable at preventing relapse and could only calm patients down, not treat the actual cause of mental illness. Numerous national and international clinical drug trials have proven that medications used in psychiatry are effective and safe. Anti-depressants are, contrary to popular opinion, not habit-forming (Kaplan & Sadock, 1997; Stahl, 2000; Stein et al., 2002; WHO,

2001b). These discrepancies in professional knowledge and lay beliefs hinder early recognition and appropriate help-seeking behaviour (Jorm et al., 1997c; Goldney et al., 2001).

A multinational study surveying advocacy group members in ten countries suffering from mood and anxiety disorders found that the majority (60%) had a median delay of 8 years before seeking treatment (Seedat, Stein, Berk, Wilson, 2002, pp. 483-484). The South African respondents cited not knowing where to go, wanting to handle the problem on their own, fear of embarrassment, and fear of medication as some of the reasons for this delay. Furthermore, in the multinational group of respondents, those who dropped out of treatment did so most often because they thought they could handle their problem on their own and were afraid of what others' might say. The South African respondents dropped out of treatment most often due to thinking they could manage their condition on their own, were afraid of depending on medication, and believed that seeking treatment indicated personal failure. Unrecognised and untreated mental illnesses hold considerable costs for society and industry. This is compounded by negative attitudes and stigma, which is a component of mental health literacy that deserves special attention amongst lay groups as found in the workplace.

2.4.2 Attitudes towards mental illness

Attitudes are hypothetical constructs about the nature of human behaviour and are not directly observable (Cascio, 1991, p. 106). The concept of attitude refers to a large number of related acts or responses which may be regarded as a tendency to evaluate and respond to social objects in a consistently positive or negative way (Cascio, 1991, p. 107). Attitudes therefore refer to general evaluations that people make about other people, objects or issues. Petty (1995) adds that attitudes are based on feelings, such as like or dislike of psychotropic medications (affect), beliefs or knowledge, such as evaluating medication treatments based on their perceived effects (cognitions), actions, such as avoiding professional mental health care (behaviours), or a combination of these elements. Conversely, attitudes may also impact on feelings, beliefs and knowledge, or actions. For example, a positive attitude towards mental health care may result in pleasant feelings about consulting professional treatment (affective influence), thinking of mostly positive attributes when talking about treatment (cognitive influence), and adhering to treatment regimes (behavioural influence).

Even though beliefs, emotions and behaviours all contribute separately towards attitudes, a particular attitude may be based on just one or two of these components (Millar & Tesser, 1986). Some attitudes may be based on how we feel about a certain social object (e.g., fear the mentally ill), while others may be based on what the social object makes us think (e.g., the mentally ill are to blame for their condition). The most important function of attitudes is to

provide a knowledge basis, that is, to help people to understand and make sense of the world (knowledge function). Previously formed attitudes are believed to help make value judgements on a daily basis, for example, if an object is good or bad, safe or dangerous. This supposedly helps to reduce the stress and anxieties of decision-making and everyday living (Bargh, Chaiken, Govender & Pratto, 1992; Fazio, Blascovich & Driscoll, 1992). Attitudes also serve to protect and enhance self-image (ego-defensive function), like when negative attitudes towards a certain group (e.g., the mentally ill) make one feel superior. Furthermore, attitudes may have purpose in being perceived as leading to reward or punishment (utilitarian function) or in facilitating the expression of important values (value-expressive function).

The link between attitudes and behaviour is a complex interplay of various factors. Behaviour is a function of not only personal factors (e.g., attitudes, motives, and habits) but also environmental factors (e.g., social norms, laws, rewards, and punishments) (Cascio, 1991). The attitude-behaviour relationship is therefore an imperfect one as many forces, attitudes being just one, determine actual behaviour. Furthermore, a reciprocal cause and effect relationship exists between attitudes and behaviours. This is graphically represented in Figure 2.2, where it is shown that attitudes develop from an interaction of a person's past and/or present environmental conditions. The cognitive, emotional and behavioural predispositional components of attitudes form following the cognitive processes of integration and consistency, that is, comparing with existing beliefs and knowledge. Once formed, attitudes may influence behaviour directly, although many other personal and environmental variables also play a role in determining behaviour. Behaviour may, in turn, influence the existing environment, which may then lead to changes in the held attitudes.

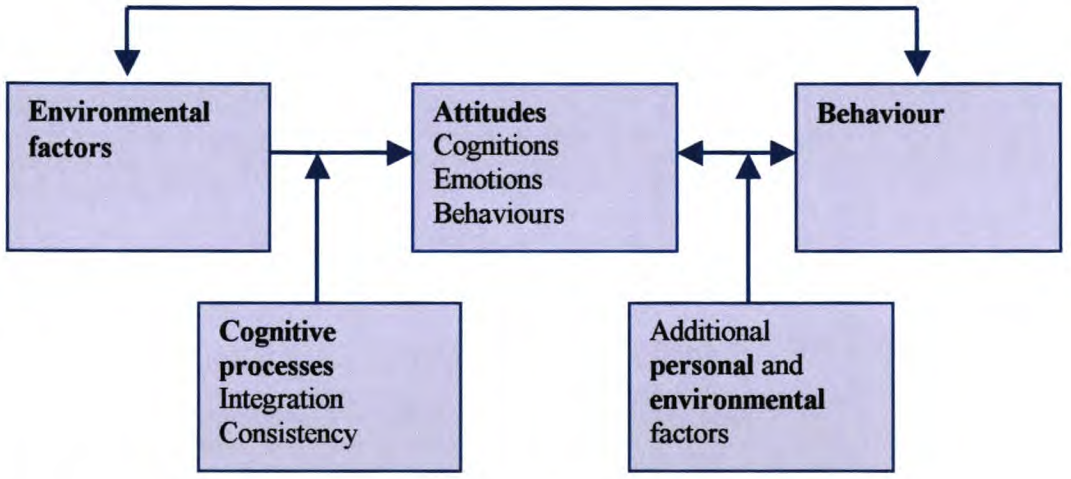

Figure 2.2 The attitude-behaviour relationship

(Adapted from Cascio, 1991, p. 109)

Although this study is not interested in attitudes to be able to predict behaviour, it is interested in their effect on the mentally ill. Several studies have shown that community attitudes impact on the mentally ill and negatively influence their help-seeking behaviour (Angermeyer & Matschinger, 1994; Dear & Taylor, 1982; de Jong, 1987; Jorm, Korten, Jacomb, Christensen & Henderson, 1999; Taylor & Dear, 1981; von Sydow & Reimer, 1998; Wolff, Pathare, Craig & Leff, 1996a). Public attitudes towards mental health, the mentally ill, available treatments, as well as the fear of stigmatisation, may delay or even prevent the mentally ill from seeking professional help. This has been described above in the section on mental health literacy, where studies have shown the significant impact of publicly held beliefs, views and feelings on patient help-seeking behaviour.

Community attitudes may also deter patients from complying with prescribed treatments. Angermeyer and Matschinger (1994, pp. 39-40) explain this in terms of Fishbein and Ajzen's theory of reasoned action. According to this theory, both attitudes (i.e., one's own assessment of best treatments) and subjective norms (i.e., one's own perceived ideas of what other's advocate as best treatments) determine behavioural intention (i.e., to comply or not with prescribed treatments). However, individual attitudes are in turn determined by personal salient health beliefs and evaluation of the outcome of a particular behaviour. Individual beliefs about the risk factors, causes and most effective treatment strategies therefore play a role in compliance behaviour. Moreover, an individual's perceptions of the normative expectations of significant others (e.g., family), as well as the individual's motivation to comply with the expectations of significant others, determines his/her own subjective norms (see Figure 2.3).

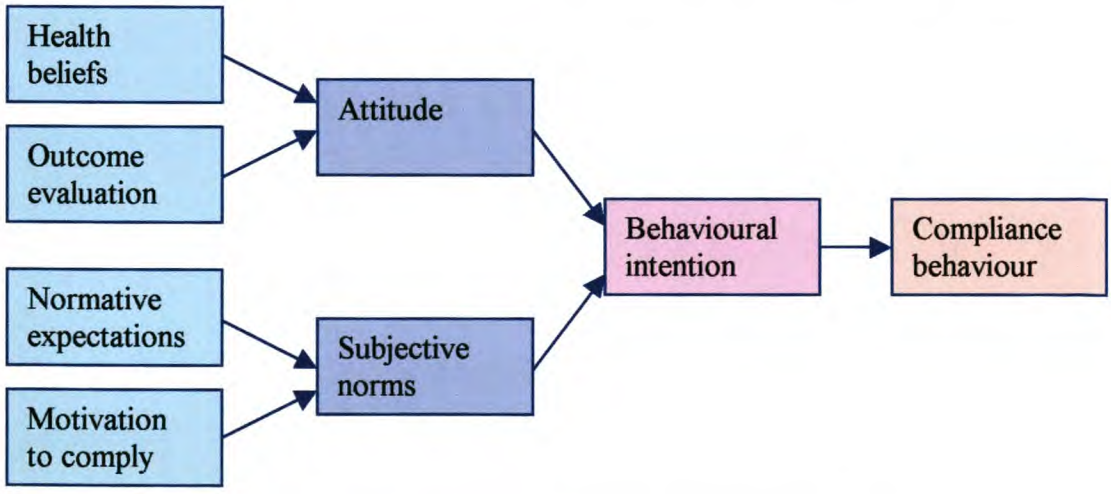

Figure 2.3 Theory of reasoned action applied to compliance with treatment

(Adapted from Angermeyer & Matschinger, 1994, p. 40)

Angermeyer and Matschinger (1994) go on to argue that the normative expectations of patient significant others are based on the ideas about most appropriate treatments in current favour in society. If prescribed treatments are positively viewed by society, as opposed to being considered ineffective or dubious in action, more pressure will be exerted on patients to comply. Conversely, noncompliance may even be encouraged by society and thus by patient significant others if treatments are commonly perceived as more damaging than gainful. It is perhaps here where the interplay between mental health literacy and attitudes towards mental illness is particularly crucial, as the evaluation by the general population of a particular method of treatment will most likely be determined in part by the prevailing beliefs about the causes of the illness in question. Where, for example, a condition is seen as being caused by stress or other psychosocial factors, attitudes toward psychotherapy treatment will be more favourable, while attitudes toward medication treatments will be negatively affected (Angermeyer & Matschinger, 1994; Goldney et al., 2001; Hugo et al., in press; Jorm et al., 1997a, 1997c; Priest et al., 1996). Within the theory of reasoned action, this plays a significant role in determining behavioural intention and compliance behaviour of persons suffering from mental illness.

Another important issue in the recovery and reintegration of the mentally ill is the general attitudes of the public towards those with a mental condition. A random nationwide telephone survey conducted in the United States amongst substance abuse sufferers and families taking part in a recovery project, found that most listed discrimination, embarrassment, and fear of being fired from work or otherwise discriminated against as barriers to recovery (Alliance Project, 2001). Numerous surveys of community attitudes towards the mentally ill in various countries and population settings have reported general negative attitudes, which appear to be consistent over time (Green, McCormick, Walkey & Taylor, 1987; Jorm et al., 1999; Mbanga et al., 2002; Taylor & Dear, 1981; Wessels, Boshoff, Traut, Zungu-Dirwayi, Mbanga & Stein, 1998; Wolff et al., 1996a). Compared to an average person, those with a mental condition (including ex-mental patients) are often viewed as being unpredictable, tense and dangerous, worthless, delicate, slow, weak, dirty, and foolish (Green et al., 1987; Mbanga et al., 2002). Taylor and Dear (1981) suggest **four dimensions** of community attitudes towards the mentally ill, namely: authoritarianism, benevolence, social restrictiveness, and community mental health ideology.

Authoritarianism refers to beliefs that the mentally ill need to be controlled and disciplined like children; that they should be hospitalised at the first sign of illness; that their condition is caused by a lack of self-discipline and willpower; and that it is possible to recognise mental illness by simply looking at an individual for they clearly stand out from normal people. ***Benevolence***

includes feelings of goodwill towards the mental ill, like believing that more tax money should be spent on mental health care and treatment; the mentally ill have been ridiculed for too long; society should be more tolerant towards the mentally ill; the best possible care should be provided; and that mental hospitals are more like prisons than places of care. ***Social restrictiveness*** includes beliefs that the mentally ill should not be given any responsibility; they should be isolated from the rest of the community; it would be foolish to marry an ex-patient; not wanting to live next door to an ex-patient; and not allowing anyone with a history of mental illness in a public office position. A ***community mental health ideology*** includes believing that the best treatment for mental illness is to be part of a normal community; residents should therefore accept the location of mental health facilities in their neighbourhoods; mental health services should be community-based; and the mentally ill hold no danger to local residents and should not be feared.

These four dimensions have been found to be stable over time and place, although it is important to note that they are not mutually exclusive (Taylor & Dear, 1981; Wolff et al., 1996a). A person may hold a conflicting range of attitudes towards the mentally ill, being socially controlling, fearful and benevolent all at the same time.

Findings on the relationship between attitudes towards the mentally ill and sociodemographic variables are not consistent. Some studies report that the young are more sympathetic towards the mentally ill than the old (Taylor & Dear, 1981; Wessels, Zungu-Dirwayi & Stein, 2000; Wolff et al., 1996a) while others find them to be less tolerant (Yamey, 1999) or that age is unrelated to community attitudes (Green et al., 1987; Jorm et al., 1999). Even though most studies suggest that gender is not a determinant of community attitudes (Green et al., 1987; Jorm et al., 1999; Wolff et al., 1996a), some studies have found support for females being more positively orientated towards the mentally ill than males (Taylor & Dear, 1981; Wessels et al., 2000). The majority of literature on socio-economic status and attitudes shows that level of education, social class, and occupation are related to community attitudes towards the mentally ill (Taylor & Dear, 1981; Wessels et al., 2000; Wolff et al., 1996a), although Green et al. (1987) found no support for attitudes being related to education. Studies that have found support for this relationship show that those with a higher education, occupational level and social class are less socially controlling and more benevolent towards the mentally ill. However, it is interesting to note that Jorm et al. (1999) found higher educational level to be associated with a more negative view of the long-term outcomes expected for those with a mental illness. Particularly schizophrenia patients were rated as having poorer outcomes in terms of being violent, drinking too much, taking illegal drugs, having poor relationships and attempting suicide, than depressed patients. The authors interpret this negative rating by more educated

respondents as indicating a more realistic view of schizophrenia, which may be regarded as a chronic, severe, and debilitating medical condition. However, as mentioned above in 2.3.2, many myths and mistruths about schizophrenia are commonly adhered to by the general public which need addressing in psychoeducational programmes. Nonetheless, Wolff et al. (1996a) suggest that the link between negative attitudes and socio-economic variables is mediated by ignorance. They found strong evidence for a lack of knowledge fuelling fear and social controlling sentiments, particularly amongst older persons (i.e., over 50 years of age) and those in lower socio-economic classes (Wolff, Pathare, Craig & Leff, 1996b). This brings one to the important issues of stereotyping, prejudice and discrimination (i.e. stigmatisation), which are often based on mistruths, myths and ignorance.

2.4.3 The role of stigma

Mental health literacy programmes should give extensive attention to understanding and addressing the stigma of mental illness. It has already been emphasised that mental disorders are common amongst the general population and the working world, that left untreated they can be severely disabling, and that they pose a significant burden to society. However, this need not be the case as research has lead to new understanding of these conditions. Advances in neuroscience, neuroimaging, genetics and the behavioural sciences have greatly improved current understanding, knowledge and management of these conditions so that most mental and behavioural disorders can be successfully treated (Brundtland, 2001). Even though some mental disorders are chronic and require long-term treatment, the majority of people with mental disorders can lead productive lives and make significant contributions towards their communities. It is now known that, for example, 60% of those with depression can recover with a proper treatment combination of medication and therapy and 80% of those with schizophrenia can be free of relapse after one year of appropriate treatment with medication and family intervention (WHO, 2001a, p.1). However, nearly ***two thirds of those with a known mental disorder never seek help*** from a health professional, and less than a quarter of those affected actually receive professional treatment (WHO, 2001b, p.2). This quite obviously exacerbates the already enormous costs and burden of mental illness.

One may readily ask why this is so, that is, why do the mentally ill not receive the treatment they need, especially given that we now have the means and knowledge to do so? Various reasons come to mind, such as a lack of resources, facilities and funding. However, ***stigma*** is said to be ***the single most significant barrier to psychiatric patients receiving the care they need*** (US Department of Health & Human Services, 1999).

Stigma is a private, public and inter-personal phenomenon that affects every aspect of health care giving and receiving. The mentally ill are perceived to be dangerous or unpredictable; mental illnesses are viewed as incurable; psychiatric treatments are seen as ineffective or dangerous; treatment centres are thought of as places of horror and abandonment; and mental health professionals are regarded as being mentally abnormal, incompetent, corrupt or evil (Angermeyer et al., 1993; Angermeyer & Matschinger, 1994; Sartorius, 2001; Taylor & Dear 1981; von Sydow & Reimer, 1998). The result is that help-seeking behaviour is impeded, psychotropic drugs are viewed with extreme suspicion and rehabilitation is hampered (Angermeyer et al., 1993; Sartorius, 2001). Stigma impacts negatively on the priority given to mental health, the development and geographical placement of mental health services, the funding made available for research and the attractiveness of the discipline to medical graduates in search of a career (Taylor & Dear 1981; Sartorius, 2001; von Sydow & Reimer, 1998). Clearly, then, stigma needs to be understood and addressed in order to effectively and holistically manage mental illness, both amongst the general population and in the workplace.

The following section therefore explains the term, stigma, and presents possible reasons for the occurrence of this social phenomenon. The impact and consequences of stigma are explored, and anti-stigma strategies are discussed.

2.4.3.1 Conceptualising stigma

Stigma is derived from a Greek word meaning "mark" which is similar to one meaning "to tattoo, prick or puncture" (López-Ibor, 2002). The original term referred to a sign that was cut or burnt into the body of a slave, traitor or criminal to publicise that there was something unusual or bad about the moral status of the bearer. It signified a "blemished" person who needed to be avoided, especially in public places (Goffman, 1963).

Much of current understanding and use of the concept stigma in the social sciences is based on the work of Erving Goffman (Goffman, 1963). Goffman differentiated between three types of stigma: (a) that associated with physical deformity, (b) flawed individual character (including mental disorder), and (c) membership of an objectionable social group. Common to all three types was the possession of a trait that marked the bearer as being culturally unacceptable, inferior and undesirably different. This spoilt identity had widespread negative implications for the person it identified. Discrimination, based on the assumption of lowered status, often resulted in reduced life chances or quality of life and a generalisation of imperfections based on the single original trait. Stigmatisation, the projection onto a group or individual of what is inferior or disgraceful, is therefore believed to cause feelings of shame, guilt and disgrace.

2.4.3.2 Why do we stigmatise?

Goffman (1963) described stigma as a process of social labelling which creates as end result a spoilt identity. Those who are different are singled out, marked, viewed as inferior and then blamed for their otherness. It has been suggested that the deep-seated, unconscious human need to construct "us-and-them" schemas is responsible for this negative labelling process (Gilman, 1985). The human tendency to order the world by separating self from others is believed to reinforce a fragile sense of self-identity. Within these schemas illness acts as a potent classification tool, setting the sick "them" apart to retain the feeling of wholeness (or wellness) of the "us" (Porter, 2001).

Evolutionary explanations have also been given for the origin of stigma as a social process that divides and segregates groups (Gilbert, 2001). Genetic self-interest and learning from what has worked in the past are said to drive the evolution of mental acts and social behaviour. To reject, exclude or avoid some members of a group may be related to protecting reproductive interests. The survival of primates has depended on (a) avoiding various natural dangers in the environment; (b) selecting, attracting and maintaining access to sexual partners; (c) caring for off-spring and relatives; (d) selecting, attracting and developing alliances with co-operative others; (e) competing with potential rivals for resources (Gilbert, 2001). Stigmatising practices such as fear and avoidance based on perceived threat, or viewing individuals as unreliable and uncooperative based on their group membership, possibly relate to these primal survival tactics.

2.4.3.3 The impact and consequences of stigma

Corrigan and Watson (2002) describe the impact of stigma as being two-fold, differentiating between public and self-stigma. The former is said to be the reaction of the general public towards the mentally ill, the latter entails the prejudice which the mentally ill internalise and thus apply towards themselves. Both public and self-stigma constitute three components: stereotype, prejudice, and discrimination. Negative beliefs about an individual, group or self (stereotype) may lead to a negative emotional reaction if endorsed (prejudice). This cognitive and affective response leads in turn to a behavioural reaction (discrimination). The mentally ill are therefore challenged not only by the symptoms - and some would add the treatment (Sartorius, 2001) - of their illness, but also the emotional and behavioural responses to being mentally ill. Based on misconceptions and mistruths their quality of life is often significantly impaired. Life opportunities such as employment, suitable accommodation and satisfactory health care may be negatively affected. Furthermore, internalising these negative reactions may lead to diminished self-esteem and confidence, fear of pursuing life goals, and loss of social and economic opportunities (Corrigan, 1998; Lai, Hong & Chee, 2001). Being aware of the disapproval and negative responses of others may lead to the internalised feelings of shame or

even humiliation, that is, a sense of injustice and desire for revenge for being treated with discrimination or contempt (Gilbert, 2001). See Appendix A for a graphical representation of the consequences and impact of the stigmatisation of mental illness.

It may be worthwhile to note though that membership in a stigmatised group does ***not*** necessarily imply a diminished self-concept. As Corrigan and Watson (2002) point out, one may be aware of society's unfavourable view of mental illness but not agree with this. It may be possible that the stigmatised do not accept these negative evaluations as valid and therefore reject them, that is, do not apply to themselves (Camp, Finlay & Lyons, 2002). Or, that group membership may protect self-concept in that negative feedback is attributed to prejudice against the group and therefore not applied to the individual self (Crocker & Major, 1989).

Nonetheless, stigma does hold numerous ***negative consequences*** for the mentally ill as well as for society as a whole. Fear of stigma may impede help-seeking behaviour (WHO, 2001b; Brundtland, 2001; US Department of Health & Human Services, 1999), perceived stigma may interfere with adherence to treatment (Sirey, Bruce, Alexopoulos, Perlick, Friedman & Meyers, 2001) and endorsed stigma may limit the availability of resources and services (WHO, 2001b; US Department of Health & Human Services, 1999; Sartorius, 2001). Given that mental illnesses are currently responsible for 12% of the global burden of disease, and this is expected to reach 15% by the year 2020 (Murray & Lopez, 1997, p. 1441), society can sorely afford to ignore the cost implications of stigma. Businesses, too, cannot afford to ignore addressing stigma given the direct costs of treatment and disability and the indirect costs of productivity and the like as described in 2.3.4. Moreover, Lyons (1992) and Hayes (1989) observe that where community attitudes toward disabled persons are generally negative, the greatest stigma is attached to those conditions in which the person's behaviour is perceived as unpredictable or potentially dangerous, as is often the case with beliefs about the mentally ill. The widespread social rejection, isolation and abuse of the mentally ill is often fuelled by a lack of resources aimed at educating and addressing mistruths, suspicions and fear (WHO, 2001b; Devenson, 1991; Torrey, 1988; Schneider & Anderson, 1980).

2.4.3.4 Strategies for tackling stigma

The three approaches proposed to act as change strategies in confronting public stigma are protest, education and contact (Corrigan & Penn, 1999; Corrigan & Watson, 2002). **Protest** can be used to dissuade the media from inaccurately representing mental illness and perpetuating negative stereotypes. This is, however, a reactive strategy and does not promote more positive attitudes. It may even be counterproductive by suppressing stereotypes and stigmatising behaviours that can result in a rebound effect. Applied to the HR practitioner, it may be useful

to start by reviewing all company policies, communications and practices for possible stigma or discrimination and to bring this to the attention of top management. Active steps should be taken to eradicate all stigmatising behaviours and stereotypes, including informal or subtle discriminatory practices such as disparaging jokes and the use of labels or unscientific diagnosis being attached to current employees with mental disorders.

Education programmes involve providing accurate facts and information about mental illness to facilitate informed decision-making. A better understanding of mental illness has been shown to reduce fear as well as decrease the likelihood of endorsing stigma and discrimination (Corrigan & Penn, 1999; Corrigan & Watson, 2002). However, the message and the method of informing should to be tailored for different diagnoses and target groups. For example, people with schizophrenia are often stigmatised based on the perception that they are dangerous and unpredictable, whereas those who abuse substances are often perceived as being weak of character and to blame for their condition (Angermeyer & Matschinger, 1994; Gelder, 2001; Wessels et al., 1998). Conversely, Peterson (1986) adds that educating patients with chronic mental illness to resume everyday activities helps to address negative community attitudes and to ease reintegration into normal community and work life. The HR practitioner, in this example, can play a meaningful role by correcting the myth of mental illness and violence and by explaining the psychobiological underpinnings of substance abuse. This implies that the HR practitioner be sufficiently knowledgeable regarding mental illness (i.e., be mental health literate) to be able to present accurate facts in casual conversation or during formal presentations as in training and educational programmes. It also goes without saying that the HR practitioner should have a positive view of mental illness and towards the mentally ill and not perpetuate myths and stigma by his or her demeanour.

Contact with psychiatric patients who lead responsible and productive lives can help to redress stereotypes and reduce negative attitudes (Corrigan & Watson, 2002; Peterson, 1986). This is particularly true if the contact is regular and takes place in a natural (as opposed to experimental) environment. However, the quality of the contact is important as bad experiences can increase stigma. By actively securing the employment, reasonable accommodation and return-to-work after treatment of the mentally ill, the HR practitioner can play a valuable role in tackling stigma in the workplace.

Before embarking on a campaign to combat stigma it may be worthwhile to first examine the various domains and elements of stigma, each of which deserves special attention. According to Corrigan and Watson (2002), stereotyping, prejudice, and discrimination may be applied to others or to self. Hugo, Metelo-Liquito & Stein (2002) propose a third domain in addition to the

already mentioned public and self-stigma; namely *structural stigma*. The mentally ill are often confronted with prejudice and discrimination brought about by strategic policies and practices. These include disparities in medical aid coverage, employment opportunities, and limited health care resources due to the low priority and funding that psychiatry receives worldwide on a national and policy level (Sartorius, 2001; Brundtland, 2001; WHO, 2001b). It is perhaps here that the HR practitioner can play a protest, educational and contact role in tackling stigma by making management aware of subtle and overt discriminatory policies and practices, by helping to create a company culture that accommodates mental illness and by educating the workforce in mental health and illness issues.

Finally, Sartorius (2001) urges *mental health professionals* to be aware of their own role in the stigmatisation of mental illness and to be actively involved in fighting stigma and discrimination. The HR practitioner, although not a mental health specialist, should take note that his or her actions may possibly also play a role in producing or perpetuating stigma. A diagnosis of mental illness is in itself stigmatising, and may be a harmful label when used inappropriately. Side effects of psychotropic medications, such as extrapyramidal signs, may be more potent markers of mental illness than the symptoms of the original diagnosis. Improved treatment and care of the mentally ill are central to the fight against stigma and discrimination. Mental health literacy can contribute to this by facilitating early diagnosis and appropriate treatment referral.

Challenges to the world of work include being proactive in addressing mental illness stigma in the workplace and hereby contributing towards alleviating the burden of these conditions. However, to do this effectively, those responsible for anti-stigma programmes, and this will most probably fall to the HR practitioner/department, will need to be knowledgeable about mental illness and stigma. Furthermore, for such programmes to be credible and have maximum effect they will need to be supported by not only top management but also by the very persons that implement and run them. The HR practitioner should therefore have a positive attitude towards mental illness and to addressing stigma.

2.4.4 Mental health/illness training in HR curricula at SA tertiary education institutions

As mentioned above, an important component of tackling stigma is education. Furthermore, knowledge and understanding of a concept or phenomenon is essential to effectively managing it. Or, in the words of Miner (1963), to take corrective action, comprehensive knowledge of contributory factors is required. It cannot be expected of the HR practitioner to manage that which he/she has no knowledge of or has not been trained in. For this reason, a mini-survey of HR courses in South Africa was conducted. This was not the focus of the study, and only freely

available course information was reviewed. Nonetheless, 28 of the 36 recognised universities and technikons (Pretorius, 2001) in South Africa were approached by telephone, mail, or e-mail for an outline of the subjects covered in their HRM courses. Of the 14 universities approached, 13 responded and all of the 14 technikons approached forwarded their course details (see Table 2.6).

Table 2.6 South African universities and technikons included in the mini-survey

University	Technikon
Cape Town	Border
Free State	Cape Town
Natal	Eastern Cape
Port Elizabeth	Free State
Potchefstroom	Mangosuthu
Pretoria	ML Sultan
Rand Afrikaans	Natal
Rhodes	Northern Gauteng
South Africa	North West
Stellenbosch	Peninsula
Vista	Port Elizabeth
Western Cape	Pretoria
Witwatersrand	South Africa
Zululand*	Vaal Triangle

Note. * *Did not respond.*

Table 2.7 summarise the extent to which tertiary education institutions in South Africa cover mental health or illness in their curriculum. The terms mental health, mental illness, emotional health or emotional wellness were used in the search. Topics such as stress and anger management, self-esteem, emotional wellbeing and counselling were rated as qualifying for covering mental health in the curricula. To qualify as an institution teaching in mental illness as part of a HR course, mental disorders as described above in 2.3.1 needed to be included in course material. Thus, topics such the mood, anxiety, psychotic, substance abuse, personality or cognitive disorders needed to be specifically addressed (with recognition that any such subject would be work-related and applied to HRM). Terms searched included mental illness, mental disorder, psychiatric/ psychological diagnoses, and psychopathology. Both undergraduate and

honours courses were included in the survey. Therefore, if an institution included mental health (MH) or mental illness (MI) at either level it would qualify as teaching in that field.

Including "personality" in a syllabus was not regarded as qualifying for covering mental illness, as this does not necessarily imply that a mental illness (disorder) point of view is taken. Although the broad term "personality" or "aspects of personality" was often mentioned in the syllabi received from the surveyed institutions, from anecdotal experience it is possible that only a description of personality, various personality theories, and measuring personality are covered, with very little attention given to the various personality disorders (thus mental illness) or to managing these in the workplace.

Table 2.7 South African tertiary education institutions that include mental health and mental illness in HR training curricula

	Universities (n = 13)	**Technikons (n = 14)**
Mental health (MH)	10 (77%)	3 (21%)
Mental illness (MI)	6 (46%)	2 (14%)
MI (excluding alcohol/drugs)	5 (38%)	0 (0%)

The mini-survey found that 10 universities (77%) and 3 technikons (21%) covered mental health in their HR curricula. Topics most often addressed were stress, self-esteem, anger and counselling. Only 6 universities (46%) and 2 technikons (14%) included formal training in mental illness. Topics addressed in this category included psychopathology (or abnormal psychology), alcohol and drug abuse, anxiety disorders and severe mental illnesses such as the psychotic disorders. Interestingly, the majority were rated as addressing mental illness solely on the basis of their giving attention to alcohol and drug abuse. Very few universities and technikons actually looked at the mood, anxiety or other categories of mental illness (38% and 0% respectively).

It is important to note that tertiary education in South Africa has undergone major transformation and restructuring due to government intervention (Badat, 2002). Some of the technikons listed in Table 2.6 have joined forces with each other or with neighbouring universities (Louw, 2003) since this survey was conducted. Tertiary institutions were approached for this study during late 2001 and early to mid 2002, whereas cabinet only accepted a national plan for higher education in December 2002 (Louw, 2003). Most institutions

forwarded prospectus or faculty brochures dated the year approached, although some sent information dated as old as 2000. It is possible then that of these academic institutions have in the interim changed or restructured curricula and syllabi. Rhodes University, for example, indicated that the entire psychology module was being restructured and that specific postgraduate study in industrial psychology would fall away. Undergraduate and honours students at this university graduate with a general psychology degree. However, students have the choice of running a few selected industrial/organisational psychology subjects (J. Seymour, personal communication, 07 August 2001). Also, it may be possible that individual lecturers include mental health or illness within their syllabus and that this is not reflected in official summaries of curricula. Nonetheless, from this retrospective survey it would appear that mental health and particularly mental illness is neglected in the formal training of HR practitioners in South Africa.

The following section describes the three mental disorders selected for use with the survey stage of this study. Information is given on the presentation, aetiology, treatments and workplace considerations of each condition.

2.5 Mental disorders selected for use in this study

This study surveyed HR practitioner mental health literacy and attitudes regarding three common mental disorders, namely depression (a mood disorder), panic disorder (an anxiety disorder) and alcohol abuse (a substance-related disorder). All three are prevalent within the business world and have been noted as significant contributors to employee-related costs and inefficiency (see 2.3.3 and 2.3.4).

2.5.1 Depression

Depression is often referred to as the illness of our times (Emsley, 2002a). It is important to differentiate depression as an illness requiring medical attention (major depressive disorder), from the normal occasional feelings of being sad or down. Although everyone will at some stage feel what is commonly referred to as "low" or "blue", if these feelings last for longer than two weeks and affect general functioning and behaviour, it is possible that the person suffers from a depressive disorder. Although depression is defined as a disorder of mood, it affects more that just one's mood and includes somatic symptoms (e.g., aches and pains), cognitive features (e.g., difficulty concentrating, indecisiveness), affective symptoms (e.g., depression, irritability), vegetative features (e.g., troubles with sleep, appetite, sex drive) and behavioural symptoms (e.g., lack of motivation, loss of interest, fatigability) (Stahl, 2000). Depression is a legitimate medical illness and is not due to a weak character or character defect. It cannot be wished away and sufferers cannot simply "pull themselves together". However, with

appropriate medication treatment (i.e., adequate dose, duration, augmentation where necessary and maintenance), psychotherapy or a combination of both, 80 to 90% of sufferers will improve (APA, 1996, p. 4).

2.5.1.1 Demographics and help-seeking

Depressive disorders are common and approximately 17.1% of the population will suffer an episode of depression at some point in their lives (Kessler et al., 1994, p. 12). Twice as many women as men are affected, with estimates showing that as many as one in every five women (i.e., 21.3%) will experience an episode of depression some time in their lives (Kessler et al., 1994, p. 12). All races, socio-economic classes and cultural groups are affected equally. Although one half of all persons with major depression experience their first onset between the ages of 20 to 50, the mean age of onset is 40 (Kaplan & Sadock, 1997, p. 539). Depressive disorders are also more likely in those individuals who are socially isolated and have no close interpersonal relationships or who are divorced or separated.

The majority (up to 66%) of persons who suffer from depression do not seek professional medical treatment (APA, 1996, p.4; Jain & Russ, 2003, p. 4). Of those who do, most seek help in a primary care setting (Docherty, 1997; Montano, 1994) where only about half are accurately diagnosed (Docherty, 1997; Jain & Russ, 2003; Wells, 1999). Furthermore, it is estimated that only 10% of those who suffer from depression receive appropriate treatment (Andersen & Harthorn, 1989, p. 869; Montano, 1994, p. 18). The resulting negative outcomes in terms of quality of life issues, cost implications, disability, impact on the workplace and suicide, have already been highlighted in discussions above (see 2.3.3 and 2.3.4). Reasons for this underdiagnosis or misdiagnosis of depression (and ultimately undertreatment or inappropriate treatment) include the fear of stigmatisation and patient resistance to being diagnosed with a mental illness, lack of awareness or knowledge, and the somatic nature of depression where bodily aches and complaints often mask the actual mood disorder (Emsley, 2002a; Greist & Korn, 2001; Montano & Montano, 2002). Indeed, a cross-cultural WHO-study conducted in 14 countries found that 24% of all patients in primary care settings actually suffer from a mental disorder (WHO, 2001b, p. 23). The most common disorders in these settings were found to be depression, anxiety and substance abuse disorders. Corroborating data has been found in South Africa where it is estimated that as many as 20% of persons seeking general health care have a diagnosable psychiatric disorder, with 92% of these being mood, anxiety and substance use disorders (Thom, 1990, p. 75).

Depressed persons are often not aware they suffer from depression or that effective treatment is available. Some may believe they suffer from "burnout" and that all that is required is a

vacation or some time off (Kahn & Langlieb, 2003). Colleagues, supervisors and even physicians may dismiss the symptoms of depression as normal reactions to stress, evidence of a weak will, or even attempts at obtaining some type of secondary gain (Kaplan & Sadock, 1997). However, the significant problem of non-detection (and thus inappropriate treatment) in primary care settings is most often due to a mixed presentation of syndromes and that patients most often complain of the physical symptoms of their condition (Thom, 1990). This stigma and misinformation must be addressed. Psychoeducation and a positive, non-stigmatising attitude of management and colleagues towards mental illness are therefore vital components of addressing depression and its impact in the workplace. HR practitioners should be well acquainted with the relevant, professional mental health resources in the near environment in order to make appropriate referrals. The referral process should be understood, particularly regarding primary versus secondary or tertiary health care resources. The HR practitioner should also be familiar with more difficult referrals, such as the certification process. It is extremely important to note that untreated depression is associated with high utilisation of general medical care, increased medical costs, increased disability and poor adherence to treatment (Greist & Korn, 2001; WHO, 2001b). Finally, it cannot be ignored that almost 66% of depressed persons contemplate suicide (Kaplan & Sadock, 1997, p. 553) and 15% end their lives by successfully committing suicide (Stahl, 2000, p. 141). This is a particularly tragic outcome of depression as suicide is avoidable. Withdrawal, loss of interest, isolating behaviour, and talk of death should be taken seriously and immediate steps taken for professional care. Again, it should be stated that depression is a serious, legitimate medical condition.

2.5.1.2 Causes of depression

A number of different factors may contribute towards the onset of depression. Vulnerability to depression is likely to be at least partially genetically inherited (Charney, Nestler & Bunney, 1999; Emsley, 2002a). Most depressed patients will report a family history of one or another type of depression. Psychological make-up and environmental factors, such as increased stress or personal losses, may play an important role (Charney et al., 1999; Kaplan & Sadock, 1997). Medical conditions such as thyroid problems, strokes, cancers, and Cushing's disease may result in depression (Kaplan & Sadock, 1997). Certain medications, such as steroids, birth control agents and high blood pressure tablets, may also play a role (Kaplan & Sadock, 1997). While a number of factors (or a combination of factors) may contribute towards the onset of depression, the symptoms are mediated by brain systems and chemicals (Stahl, 2000). A large body of evidence exists showing that the neurotransmitters (i.e., brain chemicals), particularly serotonin and noradrenaline, are involved in depression (Charney et al., 1999; Emsley, 2002a; Kaplan & Sadock, 1997; Stahl, 2000; Stein et al., 2002). Like other medical illnesses though,

depression can be effectively treated. The recent rapid advances in the neurosciences have led to a better understanding of depression and facilitated the development of more specific, safer, effective ad cost-effective treatment regimes (Kahn & Langlieb, 2003; WHO, 2001b).

2.5.1.3 Types of depression

This study looks at major depressive disorder (MDD), commonly known as major, clinical, endogenous or biochemical depression (Kahn & Langlieb, 2003; Stein et al., 2002). Major depression is the best-known form of depression and is popularly referred to in lay terms as "nervous breakdown" or "chemical imbalance". Whereas a manic episode of bipolar mood disorder is characterised by an elevated and expansive mood, major depression is characterised by a depressed mood and loss of interest or pleasure (Kaplan & Sadock, 1997). Different subtypes for major depression include mild, moderate or severe depression. Other specifiers for major depression include depression with psychotic (e.g., delusions or hallucinations), melancholic (e.g., loss of pleasure, feeling worse in the mornings), catatonic (e.g., retarded movements, negativism), or atypical (mood improves in reaction to positive events, weight gain) features. Depression may have a postpartum onset (i.e., within four weeks of giving birth to a child). Depression can also be chronic (i.e., be continuously depressed for at least the past two years), in remission (i.e., no symptoms for at least 2 months), or have a seasonal pattern (APA, 1994). The latter is more of a concern in countries with long, dark winters and is referred to as seasonal affective disorder (SAD) (Kaplan & Sadock, 1997).

2.5.1.4 Recognising and diagnosing depression

The various subtypes and features of major depression mean that different people experience depression differently. This may be one explanation for the underrecognition and associated high costs of this condition. In some people depression is characterised by a sad mood and feeling "down in the dumps", while in others it presents as increased irritability, unexplained pain, or even overeating and oversleeping (APA, 1994; Montano & Montano, 2002). The first sign of depression is often a change in the person's usual behaviour accompanied by interference in social and occupational functioning. Common symptoms of depression include (Emsley, 2002a; Kahn & Langlieb, 2003; Kaplan & Sadock, 1997):

- Persistent sad, anxious, or "empty" mood
- Loss of interest or pleasure in hobbies and activities that were once enjoyed, including sex
- Feelings of hopelessness and pessimism
- Feelings of guilt, worthlessness, helplessness, self reproach
- Insomnia, early-morning awakening, or oversleeping

- Appetite and/or weight loss or overeating and weight gain
- Decreased energy, fatigue and feeling run down
- Thoughts of death or suicide; suicide attempts
- Restlessness, irritability, hostility
- Difficulty concentrating, remembering, making decisions
- Persistent physical symptoms such as headaches, digestive disorders, and chronic pain

Diagnosing major depressive disorder is standardised by using the specific criteria of classification systems such as the DSM-IV and ICD-10, as already discussed in this chapter. According to the DSM-IV (APA, 1994), major depressive disorder can either be diagnosed as a single episode or as recurrent. The full criteria required to accurately diagnose a major depressive episode are listed below in Table 2.8. A diagnosis of recurrent major depression requires that at least a second depressive episode be experienced, with an interval of at least two months separating the two episodes (Kaplan & Sadock, 1997, p. 546).

Table 2.8 DSM-IV diagnostic criteria for a Major Depressive Episode

A. Five (or more) of the following symptoms have been present during the same *two-week period* and represent a change from previous functioning. At least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful).
2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated either by subjective account or observation made by others).
3) significant weight loss or weight gain when not dieting (e.g., more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.
4) insomnia (difficulty sleeping) or hypersomnia (oversleeping) nearly every day.
5) psychomotor agitation (excessive motor and cognitive overactivity) or retardation nearly every day. This should be observable by others and not merely subjective feelings of restlessness or of being slowed down.
6) fatigue (tiredness) or loss of energy nearly every day.
7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day. These should not merely be self-reproach or guilt about being sick.
8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or specific plan for committing suicide.

B. The symptoms do not meet criteria for a mixed episode (i.e., co-occurring manic episode and major depressive episode).

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Table 2.8 continued

D. The symptoms are not due to the direct psychological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

E. The symptoms are not better accounted for by bereavement. That is, after the loss of a loved one, the symptoms *persist for longer than 2 months* or are characterised by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

(Adapted from APA, 1994, p. 327)

Although a depressed mood is a key diagnostic criterion, it is worthy to note that about half of all depressed patients deny feeling depressed or do not objectively look depressed. Montano and Montano (2002, p. 6) report that between 69 and 80% of all primary care patients with depression present exclusively with complaints of a physical nature. Most complain about non-specific musculo-skeletal or lower back pain. It has therefore been suggested that sleep disturbances, fatigue and physical symptoms (particularly pain) should be regarded as highly predictive of depression (Jain & Russ, 2003; Montano & Montano, 2002). Kaplan and Sadock (1997) add that family and employers often refer patients for treatment based solely on withdrawal and decreased activity symptoms. HR practitioners should therefore have a sound knowledge of all subtypes and diagnostic features of depression to be able to accurately identify and appropriately refer possibly depressed employees.

Another important consideration for early recognition and appropriate referral is that anxiety is an extremely common symptom of this condition, present in up to 90% of all depressed patients (Kaplan & Sadock, 1997, p. 553). Furthermore, depression has high comorbidity rates with other psychiatric illnesses, especially the anxiety disorders (Wittchen, Holsboer & Jacobi, 2001). Greist & Korn (2001, p. 3) add that up to 58% of all depressed patients suffer from comorbid anxiety disorders. Compared with non-depressed persons, those with depression are four times more likely to suffer from panic disorder or posttraumatic stress disorder and three times more likely to have social anxiety disorder. This comorbidity with other mental illnesses is often associated with a more difficult course of depression, an increased risk for relapse (i.e., worsening of illness before it completing clears up), a more chronic illness, and suicide (Greist & Korn, 2001; Wittchen et al., 2001).

2.5.1.5 Course and outcome

Depression is generally a recurrent illness (Jain & Russ, 2003). Even though some persons may only experience a single depressive episode during their lifetime, between 50 to 60% of those who have experienced a single episode will suffer a second, 70% of those who have had

two episodes will have a third, and up to 90% of those who have had three episodes stand the chance of a fourth depressive episode (APA, 1994, pp. 341-342). While each episode usually responds to treatment, depression tends to be a chronic disorder and patients tend to relapse. The likelihood of relapse is less for those who continue to use prophylactic medication treatment and for those who have only experienced one or two episodes (Kaplan & Sadock, 1997). Generally, the time between recurrent episodes decreases and the severity of each episode increases when there is an increase in the number of depressive episodes. The aim of treatment is therefore to get each depressed patient into remission (all symptoms have cleared and the patient is well) so that recovery (remission lasts for 6 to 12 months) may be achieved and relapse (ill again before remission achieved) or recurrence (ill again after complete recovery) avoided (Stahl, 2000, p. 142).

2.5.1.6 Treating depression

In most cases the best treatment for depression is a combination of medication and psychotherapy (Emsley, 2002a; Kaplan & Sadock, 1997; Stein et al., 2002). A large number of effective **antidepressants** are available including the tricyclic antidepressants (TCA's), the monoamine oxidase inhibitors (MAOI's), the selective serotonin reuptake inhibitors (SSRI's) and other newer agents (Stein et al., 2002). These are all similarly effective in treating depressive symptoms but have different side-effects and some are therefore better tolerated by certain patients than others (Kaplan & Sadock, 1997). Antidepressants are not addictive or habit-forming as is often misconceived. It is quite safe to use them over extended periods of time (Stein et al., 2002).

The TCA's have been available since the 1950's and include drugs such as amitriptyline (Tryptanol), imipramine (Tofranil) and clomipramine (Anafranil) (Stein et al., 2002). They effectively address symptoms of major depression, particularly sleep problems, but take about two to three weeks to achieve significant improvement (Jordaan & Stein, 2002). Side-effects of the TCA's include blurred vision, dry mouth, difficulty urinating, constipation and memory disturbances (Stahl, 2000). The MAOI's have also been around since the 1950's and include agents such as tranylcypromine (Parnate) and phenelzine (Nardil) (Stein et al., 2002). These older MAOI's have an irreversible action and it is important that people who use them avoid dietary tyramine (found in e.g., matured cheese and meat extracts) as this could lead to a dangerous rise in blood pressure (Stahl, 2000). Certain medications (e.g., some painkillers and cold tablets) should not be taken with MAOI's as they may lead to fatal drug interactions. A newer group of MOAI's is now available that has a reversible action and is therefore safer to take. The only reversible inhibitor of monoamine oxidase A (RIMA's) currently available in South Africa is moclobemide (Aurorix) (Stein et al., 2002). Side-effects of MAOI's, other than

the already mentioned danger of interaction with certain foods and drugs, are insomnia, irritability, restlessness and nausea (Jordaan & Stein, 2002).

The SSRI's are a relatively newer class of antidepressants and are currently considered first-line treatment for major depression (Stein et al., 2002). The five SSRI's available in South Africa are fluoxetine (Prozac), citalopram (Cipramil), sertraline (Zoloft), paroxetine (Aropax) and fluvoxamine (Luvox) (Jordaan & Stein, 2002). These drugs are safer than the TCA's (which may be dangerous in overdose) and also have less severe side-effects due to their very specific working in the brain (Stahl, 2000). The SSRI's usually need to be taken for three to eight weeks before a response is seen. Once symptoms improve, it is recommended that patients continue taking these drugs for at least 12 months to prevent relapse (Stein et al., 2002). Side-effects include insomnia, nausea, vomiting, weight gain or loss, headache and sexual dysfunction (Jordaan & Stein, 2002). Many of these side-effects are usually transient (short-term) and may be dose-related in that adjusting the dose may bring about relief.

Anxiolytics (anti-anxiety agents) such as benzodiazepines (tranquillisers) may sometimes be prescribed for the short-term control of anxiety symptoms that frequently accompany depression. Although benzodiazepines reduce anxiety and have a rapid onset, they are also associated with sedation, cognitive slowing (e.g., impaired memory and attention) and muscle relaxation (Jordaan & Stein, 2002). These drugs run the risk of being abused as they have the potential to form both physical and psychological dependence. Examples of benzodiazepines available in South Africa include diazepam (Valium), lorazepam (Ativan) and oxazepam (Serepax) (Stein et al., 2002). The so-called "date-rape drug", flunitrazepam (Rohypnol), is also a type of benzodiazepine. It is therefore important that they only be taken as needed and for short periods of time. Furthermore, patients should be warned against driving motor vehicles or using heavy machinery while taking benzodiazepines.

Certain types of **psychotherapy** have empirically been proven as effective treatment for mild to moderate depression, and effective in combination with medication for more severe or chronic depression (Emsley, 2002a; Rosenbaum & Fredman, 2002). Psychotherapy is useful to help gain self-insight, change negative thoughts and feelings, and learn new behaviours and coping strategies. The different therapy approaches most often used in depression are cognitive behavioural therapy (CBT), interpersonal psychotherapy (IPT) and psychodynamic psychotherapy (Kaplan & Sadock, 1997).

CBT follows a short-term, structured approach that helps to identify distorted or illogical thought processes and maladaptive patterns of behaviour. These are then replaced with more

reality-based thinking and adaptive behaviours (Rosenbaum & Fredman, 2002). Not only has CBT been shown to be effective treatment for less severe forms of depression, but it has also been proven to reduce relapse and recurrent episodes over the medium-term, that is, up to six years (Fava, Rafanelli, Grandi, Canestrari & Morphy, 1998). Interpersonal psychotherapy follows a short-term, active therapeutic approach. It presupposes that depression is a medical illness that is triggered or worsened by interpersonal difficulties (Rosenbaum & Fredman, 2002). This form of therapy therefore sets out to identify and modify interpersonal problems resulting from grief, role disputes, roles transitions, or interpersonal deficits. This may be the most effective therapy for more acute or severe forms of depression, although more research is needed to verify this preliminary finding (Kaplan & Sadock, 1997; Rosenbaum & Fredman, 2002). Psychodynamic psychotherapy is based on the idea that current behaviour and life experience is influenced by earlier experiences, hereditary traits and present reality. It takes into account the effects that emotions and unconscious material can have on human behaviour. This is usually a long-term open-ended therapy which may continue for years and is often less interactive (Kaplan & Sadock, 1997).

Electro-convulsive therapy (ECT) is a medical treatment that is extremely effective for treating severely depressed persons when other treatments (i.e., medication and psychotherapy) have not been effective or cannot be tolerated (APA, 1990). It is safe for use in the frail and elderly, as well as with pregnant women (Kaplan & Sadock, 1997). ECT shows almost an immediate response and is therefore particularly useful in life-threatening cases where medications do not work fast enough. A course of treatment with ECT usually consists of six to twelve treatments given three times a week for about one month. Treatment takes place under a general anaesthesia and a muscle relaxant is also always given (APA, 1990; Emsley, 2002a). The brain is then stimulated by a series of brief controlled electrical pulses by means of electrodes that are placed at precise positions on the person's head. Many fear ECT based on misinformation which is fuelled by misrepresentations by the popular media and the film industry (Kaplan & Sadock, 1997). Because of the anaesthesia and muscle relaxant, the person receiving ECT feels no pain and his/her body certainly does not convulse. What the electrical stimulus does do is cause a brief seizure within the brain. This alters some of the complex electrochemical processes impaired by mental illness. After about five to ten minutes following treatment the patient will awake, much as one would after minor surgery. Numerous studies since the 1940's have proven that ECT is safe and effective (APA, 1990). Furthermore, it does not cause changes to or damage brain anatomy or tissues (Coffey, Weiner, Djang, Figiel, Soady, Patterson, Holt, Spritzer & Wilkinson, 1991; Hoyle, Pratt & Thomas, 1984). As with any other treatment, ECT does have side-effects (Kaplan & Sadock, 1997). These include headaches, muscle aches, nausea and confusion following immediately after treatment.

Memory may be impaired, especially partial loss of memory of events preceding the period of treatment. For many patients these memories will return after a few weeks or months, while others may report a longer-term problem with recall (Emsley, 2002a).

Psychoeducation is also an important component to holistically managing depression in that it may facilitate appropriate help-seeking behaviour and improve adherence to treatment regimes (Angermeyer et al., 1993; Jorm et al., 1997c). Patients who know more about their condition and the various treatments available are better able to make informed decisions about the management of their condition. Also, knowing that antidepressants are not habit-forming, that side-effects are usually of short duration and that time is needed before symptom relief will come about, could aid compliance and hereby ultimately help prevent relapse. Furthermore, it is important for patients to know that an array of medications are available, therefore if one particular agent does not work for them, others may be tried that could be more suitable (Stein et al., 2002).

2.5.1.7 Workplace considerations

It is crucial that depression be detected early and the concerned employee referred for appropriate professional treatment. It is not expected of the HR practitioner to be a psychiatrist or clinical psychologist. However, much can be done to create a work environment and culture that is accommodating and where signs of possible depression (such as irritability, anger outbursts, poor decision-making, isolation, impaired judgement and inefficiency) are immediately recognised and the employee appropriately referred. Those with depression should feel free to consult professional care without fear of being stigmatised or discriminated against. Community or company-based mental health resources should be identified and be readily accessible. Although depression cannot necessarily be prevented, much can be done to limit the impact and costs. Regular depression screening has been suggested as a means to identifying and addressing depression in a timely fashion amongst general, primary care patients given the high rates of non-detection in these settings (Reuters Medical News, 2002). This may be a suitable method of early detection within employee groups and could facilitate referral to professional diagnosis, treatment and follow-up, where necessary. Just as health screening and safety auditing are accepted as proactive measures to combating general employee health problems (Swanepoel, 1998), so too should depression screening be included in general health and safety practises.

Although a combination of factors lead to the development of major depression, stressful life events and stressful environments may precede a first depressive episode (Kaplan & Sadock, 1997). Preventative steps therefore may include addressing stressful work environments and

job demands, as well as promoting general good mental health amongst all employees. An appropriate venue for this may be existing employee wellness programmes such as employee assistance programmes (EAP's).

Liu and Liew (2003) warn that consequences of depression such as tardiness, absenteeism and accidents could affect the morale of colleagues or the entire workgroup. It is therefore essential that the HR practitioner not only be literate in mental health matters, but that he/she educate supervisors and line management about these conditions. Attention should also be given to substance abuse, both as an issue in recognising depression and in addressing the consequences of untreated depression. Alcohol and drug abuse may lead to depression (APA, 1994), however, it is well known that depressives often abuse these substances as a form of self-medication (Kaplan & Sadock, 1997). Management and co-workers should also be informed on how to deal with depression in the workplace. Flexible work time and practices, clearly defined work objectives and regular feedback processes while recovering could aid successful readjustment to the workplace (Liu & Liew, 2003). Furthermore, return-to-work programmes could be run within EAP's or other already established employee wellness programmes where counselling and training (e.g., life skills training and stress management techniques) are provided (Grobler et al., 2002; Miner, 1992). Mentorship programmes may also be particularly useful in facilitating readjustment to the workplace.

Colleagues and supervisors should be instructed to speak openly to the depressed employee without being patronising, but rather to show concern and support. Asking directly about depression symptoms, treatment, and possible work implications are all useful strategies to doing this. Co-workers should also be provided with accurate facts about depression and its treatment so that myths and mistruths can be addressed before they lead to prejudice or stigma. The attitudes of supervisors, management and the "people persons" in the organisation, (i.e., HR practitioners), towards mental illness could play a valuable role in facilitating appropriate help-seeking behaviour and adherence to treatment. Ultimately then, the goal of managing depression in the workplace is psychoeducation, a positive attitude towards the mental ill and psychiatric treatment, early identification of possible illness, timely referral to appropriate treatment, a supportive environment and culture encouraging adherence to treatment, and a workplace that facilitates rehabilitation and return to work. Indeed, Follmann (1978) contends that employers have a responsibility toward employees who wish to return to work after a period of treatment, as this is an important component of rehabilitation. It helps to re-establish contact with reality by increasing control over own behaviour and increases self-esteem (Harnois & Gabriel, 2000; WHO, 2001b).

2.5.2 Panic disorder

The second mental disorder used to survey the mental health literacy and attitudes of HR practitioners in this study is panic disorder. Panic disorder is an anxiety disorder and is characterised by the occurrence of recurrent, spontaneous panic attacks (Kaplan & Sadock, 1997; Oosthuizen et al., 2002; Stein & Calitz, 2001). **Panic attacks** are discrete periods of intense anxiety and fear which can last anything from five minutes to about half an hour (Stahl, 2000). The first panic attack typically occurs out of the blue, usually while the person is busy with a routine, everyday task such as driving a car, shopping or waiting in a cue. During a panic attack, people may fear they are having a heart attack, a stroke or are going crazy. They report experiencing bodily symptoms such as a racing or pounding heartbeat, chest pains, dizziness, and breathlessness. This is accompanied by a fear of losing control and a sense of impending doom (APA, 1994; Oosthuizen et al., 2002). People with panic attacks often consult various doctors and medical specialists, such as cardiologists, physicians, or neurologists, fearing that they suffer from a life threatening disease. It is not unusual for many years to go by before an accurate diagnosis is made. Indeed, a multinational study surveying anxiety and mood disorder sufferers found that the median South African respondent (where most were panic disorder sufferers) waited one year before seeking treatment while the corresponding figure for American respondents was four years, although international figures show an average of eight years (Seedat et al., 2002, pp. 483-484). Furthermore, more than 40% of the South African cohort saw up to four doctors before a correct diagnosis (as reported by the patient) was made (Seedat et al., 2002, p. 485). Unfortunately, without treatment panic disorder is a chronic disorder and may lead to sufferers avoiding situations or places where the initial attack(s) took place, fearing another attack. This phobic avoidance is referred to as **agoraphobia**, which can be very debilitating and unnecessarily limit the lives of sufferers (Stahl, 2000). However, with appropriate treatment, most persons suffering from panic disorder will experience complete remission or a significant improvement in symptoms (Stein & Calitz, 2001).

2.5.2.1 Demographics and help-seeking

Any person may possibly suffer from panic disorder, irrespective of gender, race, culture, or socio-economic status. Kessler et al. (1994, p. 12) report that 3.5% of the general population may suffer from panic disorder at some time in their lives, while 2.3% may do so during any given year. At least 33 to 50% of those diagnosed with panic disorder also have agoraphobia (APA, 1994, p. 399). Women are two to three times more likely than men to suffer from panic disorder, although underdiagnosis in men may play a role in this finding (Kaplan & Sadock, 1997). Panic disorder usually starts between late adolescence and mid-thirties, although children may also suffer from this disorder. Onset after the age of 45 is rare (APA, 1994, p.

399; Stahl, 2000, p. 347). Although usually spontaneous, the first attack may follow a stressful life event such as the death of a close family member or friend, a loss of a close interpersonal relationship or after a separation (Kaplan & Sadock, 1997).

As with depression, many who suffer from panic disorder are not aware that they have a diagnosable psychiatric illness for which effective treatment exists. More than 80% of panic disorder sufferers complain of physical symptoms such as chest pain, racing heartbeat and indigestion (Roy-Byrne, Russo, Dugdale, Lessler, Cowley & Katon, 2002, p. 443). This leads the majority to look for help in primary health care settings where many are misdiagnosed with a serious medical condition such as a heart or respiratory illness (Kaplan & Sadock, 1997). Unnecessary referrals are often made to specialists for evaluation, for example, to cardiologists and gastro-enterologists. However, on primary care or specialist further evaluation, panic disorder sufferers are announced healthy and fit, as no physical illness can be found. This leads many to believe it is all "in the mind" or that they are suffering from an undetected life-threatening illness (APA, 1994; Stein & Hollander, 2003). This could lead to chronic debilitating anxiety or excessive and repeated visits to health care facilities. Such behaviour is costly both in terms of time off work and medical expenses. Others may change their behaviour or develop avoidance behaviour (agoraphobia) due to the fear of another panic attack, but deny experiencing fear of another attack or the consequences of such attacks (APA, 1994). This can be severely disabling and limit social, work and other important areas of functioning.

Less than one-third of panic sufferers actually receive appropriate treatment (Stahl, 2000, p. 347). Furthermore, of those who are accurately diagnosed and given treatment, up to 40% do not take their medication (Roy-Byrne et al., 2002, p. 445). This may be due to patients not being informed about the possible initial adverse effects of medication, or because they do not believe the medication will be effective. Coupled with this, Roy-Byrne et al. (2002) report that many panic disorder sufferers who receive treatment in primary care settings are undertreated in that medication is prescribed at either too low a dose or for too short a duration. It is therefore essential that patients be informed about the various treatments available and what to expect while on medication. Although HR practitioners are not medical specialists or pharmacists, numerous reliable organisations have informative brochures available that can freely be distributed at company-based employee wellbeing points. The Mental Health Information Centre of South Africa, the Depression and Anxiety Support Group of South, and the South African Federation for Mental Health are examples of organisations which may be helpful in this respect (see Appendix B). Furthermore, workplace psychoeducation sessions could include presentations by expert speakers (again, the above mentioned organisations may be consulted) so that both panic sufferers and fellow workers/supervisors may know what to expect and can

monitor progress or the lack thereof. Underdiagnosed and undertreated panic disorder should not be taken lightly as patients suffering from this condition have a suicide rate comparable to that of patients with depression. About one half of panic disorder patients report having thought about suicide and 20 to 40% have reportedly attempted suicide (Stahl, 2000, p. 347).

2.5.2.2 Causes of panic disorder

As with depression, a combination of factors plays a role in the aetiology of panic disorder. Research in psychiatry has shown that biological abnormalities in both the structure and function of the brain mediate the symptoms of panic disorder. Laboratory experiments provide evidence of a general fear circuit in the brain, which involves the limbic system, the brainstem, and the prefrontal cortex (Kaplan & Sadock, 1997; Stein & Hollander, 2003). Neurotransmitter (brain chemical) systems have also been implicated, including those of serotonin, norepinephrine and γ-amino butyric acid (Kaplan & Sadock, 1997). Panic disorder with or without agoraphobia also has a definite genetic component. According to Stahl (2000, p. 347), there is a 15 to 20% risk for panic disorder in first-degree relatives of patients and a 40% concordance rate in monozygotic twins. A connection has also been suggested between separation issues and the development of panic disorder. Many with panic disorder also suffered from childhood separation anxiety or report a history of parental separation or loss (Kaplan & Sadock, 1997; Stein & Calitz, 2001). Furthermore, the initial panic attack is often preceded by the threat of or actual separation or loss of a significant other. Finally, conditioning and the learning theory may possibly explain the anticipatory anxiety characteristic of panic disorder and agoraphobia (Kaplan & Sadock, 1997; Stein & Hollander, 2003). Experiencing a panic attack is extremely anxiety-provoking and uncomfortable, repeated attacks may lead to general anxiety and fear of further such unpleasant experiences (anticipatory anxiety), which in turn leads to phobic avoidance of situations that are associated with previous attacks.

The HR practitioner should be aware of workplace events that could involve separation issues and therefore trigger a panic attack. These could include job transfers, promotion or demotion, layoffs or employing new recruits (Stein & Hollander, 2003). It is also possible that over time, certain workplace situations may be associated with panic attacks and be experienced as extremely fearful or uncomfortable, leading to avoidance behaviour. Utilising public transport, driving to work, or even attending meetings where the patient may feel physically or emotionally trapped, are possible situations that could be feared by panic disorder sufferers.

2.5.2.3 Recognising and diagnosing panic disorder

The key feature of panic disorder is the presence of recurrent, unexpected **panic attacks** (APA, 1994). A panic attack is a short-lived period of unexpected terror which is accompanied by a

variety of neurological, gastrointestinal, cardiac or pulmonary symptoms (see Table 2.9). At least four of the thirteen listed symptoms must be present to qualify as a panic attack (APA, 1994; Kaplan & Sadock, 1997). Because of these physical symptoms, persons experiencing panic attacks often think they have a serious medical illness, leading to numerous visits to health care facilities. Indeed, panic disorder sufferers are noted as having the highest use of emergency rooms of all psychiatric patients (Stahl, 2000). Panic attacks are associated with extreme anxiety and fear, as well as catastrophic thinking with a sense of impending doom, an urge to escape, and the belief that loss of control, death, or insanity is imminent.

Table 2.9 DSM-IV diagnostic criteria for a Panic Attack

A discrete period of intense fear or discomfort, in which *at least four* of the following symptoms developed abruptly and reached a peak within 10 minutes:

1) palpitations, pounding heart, or accelerated heart rate
2) sweating
3) trembling or shaking
4) sensations of shortness of breath or smothering
5) feeling of choking
6) chest pain or discomfort
7) nausea or abdominal distress
8) feeling dizzy, unsteady, lightheaded, or faint
9) derealization (feelings of unreality) or depersonalization (being detached from oneself)
10) fear of losing control or going crazy
11) fear of dying
12) paresthesias (numbness or tingling sensations)
13) chills or hot flushes

(Adapted from APA, 1994, p. 395)

The first panic attack is usually spontaneous, although it may occur after exercise, excitement, sexual activity or moderate emotional trauma (Kaplan & Sadock, 1997). Panic attacks are also known to begin with the use of mind-altering drugs such as marijuana, LSD, sedatives, cocaine, and amphetamines (Stein & Hollander, 2003). These life events or chemical stressors may trigger the onset of panic disorder in predisposed persons. A panic attack usually lasts between 5 and 30 minutes, with the symptoms peaking at about 10 minutes (Stahl, 2000, p. 346). Panic attacks may also occur during sleep, which is referred to as nocturnal panic attacks. These attacks may wake the person from sleep, but are otherwise similar in symptoms to daytime panic attacks.

It is important to note that panic attacks are experienced with other anxiety disorders, particularly with specific phobias, social phobia, and posttraumatic stress disorder (Kaplan & Sadock, 1997). However, with panic disorder, the attacks usually occur at any time and are not associated with any identifiable situational stimulus, whereas with the phobias and posttraumatic stress disorder they are usually expected or triggered by a recognised or specific stimulus or situation. A diagnosis of panic disorder cannot be made if the panic attacks are secondary to physical problems, such as certain tumours which induce panic attacks or thyroid problems, or substance abuse problems (Stein & Hollander, 2003).

The essential feature to diagnosing **panic disorder** is therefore the experiencing of at least two *unexpected* panic attacks (although most sufferers have considerably more) followed by at least one month of persistent anxiety or concerns about having more attacks or about the consequences of attacks, or by significant behavioural changes related to the attacks (APA, 1994). The presence of persistent anxiety or behavioural changes is important to diagnosing panic disorder as up to 10% of the normal population may experience a panic attack at some time during their lives, but they do not develop persistent anxiety or modify their behaviour and therefore do not develop panic disorder (Stahl, 2000, p. 347). See Table 2.10 for the standardised diagnostic criteria for panic disorder as provided by the DSM-IV.

Table 2.10 DSM-IV diagnostic criteria for Panic Disorder

A. Both (1) and (2):

(1) recurrent unexpected *panic attacks* (see Table 2.9)
(2) at least one of the attacks has been followed by *1 month* (or more) of one (or more) of the following:

(a) persistent concern about having additional attacks
(b) worry about the implications of the attack or its consequences (e.g., losing control, having a heart attack, "going crazy")
(c) a significant change in behaviour related to the attacks

B. The panic attacks are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism).

C. The panic attacks are not better accounted for by another mental disorder, such as social phobia (e.g., occurring on exposure to feared social situations), specific phobia (e.g., on exposure to a specific feared situation), obsessive-compulsive disorder (e.g., on exposure to dirt in someone with an obsession about contamination), posttraumatic stress disorder (e.g., in response to stimuli associated with a severe stressor), or separation anxiety disorder (e.g., in response to being away from home or from close relatives).

(Adapted from APA, 1994, p. 402)

According to the DSM-IV, panic disorder may be diagnosed as with or without **agoraphobia**. Agoraphobia may literally be translated to mean "fear of the market place" (Stein & Calitz, 2001). Sufferers of agoraphobia anticipate the possibility that they may have another panic attack, and therefore avoid situations where it is difficult to escape or to get help (Oosthuizen et al., 2002). When not avoiding, they prefer to be accompanied by family and friends when they visit public places like the church, restaurants, and shopping centres or confined places like lifts, aeroplanes, and cinemas. Some avoid, or endure with great anxiety, travelling in a motorcar or on a freeway, while others may become totally housebound.

Panic disorder often co-occurs with other mental disorders. Kaplan and Sadock (1997, p. 594) report that 91% of persons with panic disorder and 84% of those with agoraphobia have at least one other psychiatric disorder. The most common comorbidity is with depression, other anxiety disorders, personality and substance-related disorders. Major depressive disorder occurs in 50 to 65% of individuals with panic disorder, while social phobia (15 to 30%), generalised anxiety disorder (25%), specific phobia (10 to 20%), and obsessive-compulsive disorder (8 to 10%) are also common comorbid conditions (APA, 1994, p. 398). Many panic disorder sufferers self-treat their anxiety with alcohol or medications, often leading to substance-related disorders (APA, 1994; Kaplan & Sadock, 1997; Oosthuizen et al., 2002). As with depression then, and indeed any psychiatric disorder, early identification and referral for professional diagnosis and mental health care is essential. The HR practitioner should therefore be aware of the typical signs and symptoms of panic disorder, as well as the commonly associated conditions such as depression and substance abuse and the danger of suicide. Furthermore, as already noted, panic disorder sufferers often present with concerns of cardiac or respiratory problems and fears that they are about to die of a heart attack or stroke. Repeated visits to emergency rooms or for specialist evaluation, which come back clear, should not be lightly regarded as hypochondriasis but should be considered as possible signs of this anxiety disorder. Timely, appropriate intervention can contribute towards an overall better prognosis and ultimate better functioning of persons who suffer from this condition.

2.5.2.4 Course and outcome

Without treatment, panic disorder is usually a chronic condition, although the course is variable between patients and even within the same person (Kaplan & Sadock, 1997; Oosthuizen et al., 2002). Some panic disorder sufferers experience a waxing and waning course, with periods of remission and relapse (Stein & Calitz, 2001). Longitudinal studies show that about 30% are symptom free at long-term follow-up; about 40 to 50% have mild symptoms that do not significantly interfere with their lives; and about 20 to 30% continue to experience significant symptoms (APA, 1994, p. 399). Furthermore, the presence of comorbidity has a negative

impact on the course of panic disorder, including higher rates of suicidality, greater severity of panic disorder symptoms, more impairment in social and work functioning, and poorer response to treatment (Roy-Byrne, Stang, Wittchen, Ustun, Walters & Kessler, 2000; Simon & Rosenbaum, 2003). In cases with comorbid agoraphobia and those who self-medicate with alcohol or other substances, the course is even more complicated (Oosthuizen et al., 2002).

Panic disorder and agoraphobia have far-reaching psychosocial consequences for sufferers, including marital discord, time lost from work, financial difficulties due to work loss and alcohol or other substance abuse (Kaplan & Sadock, 1997). Panic disorder sufferers often report subjective feelings of poor physical and emotional health, impaired social functioning, and financial dependency. Indeed, a review of papers published between 1984 and 1999 on the quality of life of anxiety disorder patients found that 35% felt they were in poor physical health and 38% felt they were in poor emotional health. Moreover, 27% were on welfare or receiving some type of disability compensation (Mendlowicz & Stein, 2000, p. 672). Not counting the frequent absences for medical visits, the average length of work disability for panic disorder sufferers is more than two and a half years. Due to their condition, about 70% lose or quit their jobs and 50% are unable to drive more than 3 miles (4.828 km) from home (Stahl, 2000, p. 348). Demoralisation is therefore a common consequence, often leading to discouragement, shame, and unhappiness about the difficulties in carrying out their normal daily routine (APA, 1994). Many believe their problems are due to a weak character or lack of strength, and the demoralisation may become generalised to areas beyond specific panic-related problems. The risk of suicide, as already mentioned, is also significant with these individuals. However, with appropriate treatment, significant improvement in panic disorder patients, including those with agoraphobia, can be achieved. This includes areas such as emotional role limitations, social functioning, energy, avoidance and fear, and general mental health (Mendlowicz & Stein, 2000).

2.5.2.5 Treating panic disorder

The most important first step to effectively managing panic disorder is to consult a professional for an accurate diagnosis. Physical conditions and substances which may present with or exacerbate panic disorder symptoms need to be excluded. Excessive use of caffeine, nicotine or marijuana may also trigger panic attacks and need to be excluded (Stein & Calitz, 2001). With appropriate treatment, most patients with panic disorder and agoraphobia will experience a dramatic improvement in symptoms (Kaplan & Sadock, 1997). Both medication and psychotherapy are useful, although a combination of the two is most often recommended. Family and group therapy is also useful to help patients and their families deal with the psychosocial problems brought about by having the condition.

The first-line **medications** for treating panic disorder are the antidepressants (Kaplan & Sadock, 1997; Stein et al., 2002). The term "antidepressant" may be misleading as these are excellent anti-anxiety treatments and do not require the presence of a depressed mood to be prescribed (Stein & Hollander, 2003). Antidepressants used in panic disorder include the selective serotonin reuptake inhibitors (SSRI's), tricyclic antidepressants (TCA's), and monoamine oxidase inhibitors (MAOI's), as discussed above in 2.5.1.6 (Stein & Calitz, 2001). These drugs take a while (up to a few weeks) before symptom relief is experienced, but they can readily be discontinued and are not habit-forming. The SSRI's are most widely used in panic disorder due to their effectiveness and good side-effect profiles (Stahl, 2000; Stein et al., 2002). Although the high-potency benzodiazepines also block panic symptoms and have a rapid onset (often within a week), they run the risk of dependency. They have the potential for causing cognitive impairment, may lead to abuse if taken over long periods, and patients need to be advised against driving or operating heavy machinery while taking benzodiazepines. Discontinuation may lead to rebound anxiety or a withdrawal syndrome, sometimes requiring comprehensive detoxification programmes (Kaplan & Sadock, 1997). In general, it is therefore recommended that the slower-acting antidepressants be taken as standard treatment and that benzodiazepines only be used for short periods, particularly for acute panic attacks or for anticipatory anxiety (Stein & Calitz, 2001).

Panic disorder patients are usually extremely sensitive to normal antidepressant doses, and may experience initial anxiety and jitteriness or even short-term worsening of their panic (Stahl, 2000; Stein & Hollander, 2003). They are therefore prescribed very low doses to start with, which are gradually increased to an optimal dosage. Once symptom relief is achieved, patients need to continue taking their medication for at least another year, after which time they will gradually be tapered off (Stein et al., 2002). Although antidepressant treatment will block panic and decrease anxiety, psychotherapy may be needed to address phobic avoidance (Stein & Hollander, 2003).

Cognitive behavioural therapy (CBT) is accepted as an effective therapy for panic disorder, and is most often recommended in combination with medication treatment (Kaplan & Sadock, 1997; Stein & Calitz, 2001; Stein & Hollander, 2003). The focus of CBT is to instruct patients about their false beliefs (i.e., their tendency to interpret mild bodily sensations as indicative of impending panic attacks or danger) and to provide information about attacks so that patients may understand they are of short duration and are not life-threatening. Interventions include relaxation techniques to instil a sense of control over anxiety, breathing retraining to help control hyperventilation, and systematic desensitisation (Kaplan & Sadock, 1997).

Desensitisation involves sequential gradual exposure to the feared stimulus to the point where patients become desensitised to the experience. This is a particularly useful intervention for avoidance behaviours (Stein & Calitz, 2001).

Another important element of effectively managing panic disorder is **psychoeducation,** so that patients may understand the causes, development, course and treatment of their condition. This may help to address the demoralisation, shame and discouragement so often felt by sufferers. It may also help to reduce prejudice, overcome misunderstandings and empower patients to take control of their condition and to participate in its treatment (Oosthuizen et al., 2002). Belonging to a support group may also be helpful, such as the Depression and Anxiety Support Group of South Africa which has groups in every province. The value of support groups lies in their being able to provide information about the condition, allowing patients to share experiences in a non-judgemental environment and learn that they are not alone in their suffering, and to be encouraged by other fellow sufferers who can provide coping methods from a personal point of view (Stein, 2003).

Important aspects of psychoeducation regarding antidepressant treatment include knowing that these drugs are not addictive and that they are highly effective in treating panic disorder, even though they are referred to as "antidepressants". Furthermore, that it will take a few weeks before relief of symptoms is achieved, and that when this happens they should continue taking their medication for at least a year. Patients should be informed that an initial worsening of anxiety may be experienced, but that this and other side effects of the antidepressants are typically temporary (Oosthuizen et al., 2002; Stein et al, 2002).

2.5.2.6 Workplace considerations

The foundation of effectively managing panic disorder in the workplace is timely recognition, referral to appropriate treatment, and support of adherence to prescribed treatment regimes. This requires that the HR practitioner be knowledgeable about the signs and symptoms of panic attacks, the different presentations and changes in behaviour indicating possible panic disorder, and understand the basics of appropriate treatment strategies. Experiencing a panic attack is not only extremely uncomfortable and fearful, but also effects efficiency at work (Kaplan & Sadock, 1997). Anticipatory anxiety may lead to phobic avoidance of certain required work situations, impacting negatively on productivity and employee relations. Projects or promotions may be turned down due to fear of travel or group environments. Frequent visits to health care facilities or for specialist evaluations inevitably mean absence from work and high medical expenses. The psychosocial consequences of having panic disorder (i.e., substance abuse,

personal distress, demoralisation and increased suicide risk) may also negatively affect work performance and impact on the workgroup.

Typical avoidance or change in behaviour of panic disorder sufferers may concern co-workers, particularly if patients try to keep their panic attacks secret. A supportive, non-stigmatising work environment may assist patients in seeking appropriate treatment and adhering to prescribed treatments. Education of supervisors and colleagues, particularly regarding the causes, course and treatment of panic disorder, is therefore essential. It should be understood that time may be needed off work for an initial evaluation and possibly to initiate treatment. However, treatment is effective and usually produces rapid results and a speedy return to work should be expected and indeed encouraged (Stein & Hollander, 2003). Supervisors and co-workers should also be reassured that an excellent prognosis may be achieved with appropriate treatment, and that they should encourage patients in complying with this. Phobic avoidance may make treatment and return to work and previous levels of productivity more complex. However, even though agoraphobia may interfere with certain work functions (e.g., travelling), part of the treatment involves exposure to feared situations. Supervisors and colleagues can help decrease avoidance behaviours once treatment has commenced by encouraging patients to gradually return to feared situations and by helping with travel arrangements.

2.5.3 Alcohol abuse

The third mental disorder covered in the survey stage of this study is alcohol abuse. This is possibly the one psychiatric condition which has received considerable attention by the HR field. Almost every textbook on personnel/ human resource management, industrial/ organisational psychology provides information on alcohol abuse, usually within the chapter covering health and safety issues and/or employee wellness programmes (see for example Carrell et al., 1998; Follmann, 1978; Gerber, 1998; Grobler et al., 2002; Pieters, 1996; Miner, 1992).

The chemical compound in alcohol, ethyl alcohol (also called ethanol), is a psychoactive substance that depresses the central nervous system (de Miranda & Wilson, 2001; Kaplan & Sadock, 1997). It has been noted as probably the oldest psychoactive substance known to mankind, with fermented beverages containing ethyl alcohol dating as far back as 8000 BC (de Marinda & Wilson, 2001, p. 180). Moreover, it is probably the most frequently used brain depressant in all cultures, causing significant health, interpersonal, occupational, and societal problems (APA, 1994; Kaplan & Sadock, 1997; Schuster, 2003). Alcohol abuse and dependence, commonly referred to as **alcoholism**, are medical illnesses and are classified as substance-related disorders in the DSM-IV (APA, 1994). Alcoholism affects almost every body

system and organ, including the gastrointestinal, endocrine, cardiovascular, and immune systems and particularly the liver, pancreas, and brain. It is also associated with nutritional deficiencies (e.g., malnutrition), certain cancers (e.g., of the oral cavity), infectious diseases (e.g., tuberculosis), birth defects (i.e., foetal alcohol syndrome), neuropsychiatric conditions (e.g., Wernicke-Korsakoff syndrome), and numerous psychosocial problems (e.g., crime, accidents, marital problems) (de Miranda & Wilson, 2001). Untreated alcoholism leads to many health problems, and in some cases may cause convulsions, extremely rapid heartbeat and even death (Schuster, 2003). It is, however, treatable and about one third of persons who abuse alcohol remain sober for at least two years after appropriate treatment (Pienaar, 2002. p. 177).

2.5.3.1 Demographics and help-seeking

Alcohol is freely available in most societies and the consumption therefore is most often lawful and indeed, often associated with socio-cultural customs (de Miranda & Wilson, 2001; Pienaar, 2002). Whereas many people can drink alcohol socially without developing any problems, others develop what Pienaar (2002, p. 174) refers to as the "acquired disease of alcohol dependence". Alcoholism is seen as an acquired condition in that addiction can only come about after consumption and abuse of a substance. It is argued that nobody intentionally sets out to become an abuser of alcohol. However, the danger is that the initial positive effects of socially using alcohol may become a repetitive habit, developing into a pattern, a lifestyle and eventually an unhealthy crutch.

Alcohol abuse and dependence are among the most common mental disorders in the general population across the globe. Kessler et al. (1994, p. 12) report that the lifetime prevalence for alcohol abuse and dependency are 9.4% and 14.1% respectively, being more prevalent in males (12.5%; 20.1%) than in females (6.4%; 8.2%). Alcoholism occurs in all socio-economic classes, not discriminating between ethnicity or race, region or urbanicity, although it is particularly frequent in people with higher academic qualifications and in upper socio-economic classes (Kaplan & Sadock, 1997).

In South Africa, it is estimated over 6 billion litres of beverage alcohol is consumed a year, meaning that close to 10 litres of absolute alcohol is consumed per adult per year, placing South Africa as one of the highest consuming nations of alcohol in the world (Parry, 1997, p. 1). As many as 30% of certain groups (e.g., adult African urban residents) partake in risky drinking, defined as drinking five or more standard drinks per day for men and three or more drinks for women (Parry, 2001, p. 443). Other high-risk groups in South Africa include males, youths (of all races), workers in certain occupations (e.g., mine workers, farm workers), and peri-urban township or informal settlement inhabitants (de Miranda & Wilson, 2001). A study of

community attitudes towards alcohol and drug abuse in a black urban township in the East Coast of South Africa found that the majority sanctioned the use of alcoholic beverages, including beer, wine and spirits (Gatley, 1989). Indeed, not only did more people sanction alcohol use than oppose it, but the majority also listed these beverages as most frequently used in their own drinking patterns. Furthermore, 87% of those surveyed felt that others in their community abused alcohol (Gatley, 1989, p. 76).

Workplace estimates show that between 5 and 10% of employees in any company have a substance abuse problem (alcohol or drugs) severe enough to warrant treatment (Gerber, 1998, pp. 247-248). Some would even say that up to 35% of South African employees abuse alcohol (Grobler et al., 2002, p. 458). It is possible that individuals in certain occupations are prone to alcoholism, for example bartenders (de Miranda & Wilson, 2001). Follmann (1978) contests, however, that alcoholism occurs at all levels of the workforce, and in all professions. Furthermore, employees who abuse alcohol are generally in the 35 to 55 year age bracket, have been in the same organisation for about 10 to 12 years, and are therefore valuable employees (Follmann, 1978, p. 223). These figures correspond with those provided by the Alcohol and Drug Abuse Research Group of the Medical Research Council of South Africa which found in a national project that the average age for persons in specialist treatment centres for alcohol abuse was between 37 and 42 (Myers & Parry, 2002, p. 1).

One possible reason for the older average age of persons who abuse alcohol, as reported above, may be a delay in help-seeking. An American study investigating patterns of help-seeking behaviour found that persons who abuse alcohol tend to recognise their problem drinking many years before seeking treatment (Simpson & Tucker, 2002). This study reports that many experience negative alcohol-related events, which indicated an early appearance of problem drinking practices and adverse psychosocial consequences (i.e., work, financial, legal or relationship problems). Those who sought professional help had greater alcohol-related psychosocial problems and higher dependence levels than those who did not. Even so, contrary to the theory that those who abuse alcohol are in denial, most subjects knew that they had a drinking problem for an average of 10.1 years and experienced negative consequences of alcohol abuse for approximately 9.3 years before seeking treatment (Simpson & Tucker, 2002, p. 659).

Untreated alcoholism poses not only significant health consequences for affected individuals, as already mentioned, but also has a considerable impact on the workplace. Absenteeism, lateness, impaired decision-making, temper tantrums, accidents, carelessness, failure to complete assignments on time, sexual harassment of fellow workers, irritability with clients, and reduced

employee morale are some of the consequences which may be experienced in the workplace (Schuster, 2003). Furthermore, severe alcohol intoxication may lead to feelings of pessimism, hopelessness, depression and even suicide (APA, 1994; Schuster, 2003). It is therefore imperative that HR practitioners be aware of the risk factors and causes of alcoholism in order to take appropriate, timely action.

2.5.3.2 Causes of alcoholism

There are several causes of alcoholism, with psychosocial, behavioural and genetic factors playing a role to a varying degree in any individual case (de Miranda & Wilson, 2001; Kaplan & Sadock, 1997; Pienaar, 2002). Alcohol abuse and dependence are always preceded by the stages of drinking, that is, early experimentation, social drinking, and misuse (de Miranda & Wilson, 2001). However, not everyone who misuses alcohol will go on to abuse or develop dependence. People drink because of the favourable physical and psychological effects of alcohol (Pienaar, 2002). It can help relax, reduce tiredness, stabilise mood, alleviate shyness, anger or frustration, and offer temporary escape from the stressors of everyday life that everyone experiences. Although the exact cause of individual vulnerability to, or protection against, alcoholism is not known, strong evidence exists for a genetic predisposition as it does tend to run in families. Several studies have consistently shown that first-degree relatives of alcohol abusers have high rates of the disorder. Roughly 25% of fathers and brothers of alcohol abusers are themselves alcoholic (de Miranda & Wilson, 2001, p. 186). Compared with normal persons, relatives of alcohol abusers have higher rates of depression, criminal behaviour, and antisocial personality disorder. These have all been associated with alcohol abuse or dependence, and personality disorders, particularly antisocial personality disorder, predisposes a person to alcohol-related disorders (Kaplan & Sadock, 1997).

Persons in whom genetic factors may predispose alcoholism are typically male, have a clear positive family history, start drinking large amounts of alcohol at an early age, and have displayed antisocial tendencies in their adolescent years. They have often experienced problems due to their drinking by the time they reach 25 years of age (Pienaar, 2002, p. 173). These persons are referred to as Type-II alcohol abusers. Type-I alcohol abusers, on the other hand, usually start drinking at a later age, gradually increase their intake of alcohol, do not have a family history or have a modest family history of alcoholism, are equally male or female, and develop alcohol dependence at a much later age (de Miranda & Wilson, 2001; Pienaar, 2002). Type-II alcohol abusers generally have a poorer response to treatment than Type-I alcohol abusers. Type-II alcohol abusers most often have personality characteristics of impulsivity, recklessness and distractibility, while Type-I alcohol abusers often have personality characteristics of guilt, worry, dependency and introversion.

A heritable biological brain function may predispose children of alcohol abusers to an alcohol-related disorder (Kaplan & Sadock, 1997). A range of deficits with neuro-cognitive testing and a variety of abnormalities on electroencephalogram (EEG) recording have been found in high-risk children (i.e., where one or both parents have an alcohol-related disorder). Furthermore, up to 60% of children with a positive family history of alcoholism have a blunted effect of alcohol compared to 10% in those with no family history (Pienaar, 2002, p. 173). This "low response" to alcohol may result in greater intake to achieve a desired effect. This corresponds with the drinking patterns of Type-II alcohol abusers.

Social and environmental factors may play a role in the development of alcoholism. Some social settings commonly lead to excessive drinking, for example tertiary education dormitories and military bases. Learning and gender socialisation may also play a role. Children may follow their parent's drinking habits, and boys are generally more encouraged to drink than girls (i.e., binge-drinking rituals to prove masculinity). Repeated experience of withdrawal may lead to alcohol dependency, as drinking to relieve withdrawal symptoms may reinforce further drinking (de Miranda & Wilson, 2001). Conversely, some cultural and ethnic groups, for example Asians and conservative Protestants, use alcohol less frequently than other groups (Kaplan & Sadock, 1997). The so-called oriental flush (i.e., the genetically-based facial flushing in oriental persons after consuming small amounts of alcohol) may protect these ethnic groups from alcoholism (de Miranda & Wilson, 2001).

There is also a potential reciprocal relationship between the workplace and alcoholism. Employees who abuser alcohol may demoralise or annoy co-workers, who often have to take on extra workload or deal with the personal conflict and physical risk that may accompany alcoholism (Schuster, 2003). On the other hand, insecure or unpleasant work environments, such as during growth, mergers, or layoffs may trigger anxiety and depression, which could lead to susceptible workers increasing alcohol intake or developing problem drinking behaviour. Overly critical or irritable supervisors or co-workers may produce workplace tension, and workplace change, work relationships or individual traits may lead to anger, frustration or depression. This could potentially exacerbate problem drinking or contribute towards alcoholism. Furthermore, workplace situations which promote drinking with colleagues and clients, such as business meals, office parties, and business conventions, can permit the development of alcoholism in susceptible workers. Staff or colleagues may cover for an intoxicated supervisor or co-worker by making excuses on behalf of the inebriated person or ensuring that the work gets done, further enabling problem drinking behaviour. Often, such a tense, demoralising and unproductive situation is ignored until a crisis happens (Schuster,

2003). Timely recognition and intervention may therefore not only improve the prognosis for alcohol abusers, but also address workplace consequences of alcohol-related problems before they significantly disrupt work and relations.

2.5.3.3 Recognising and diagnosing alcoholism

Arguably the most important step to addressing alcoholism is recognising that a problem exists so that professional help may be sought, especially given the characteristic long delay in help-seeking behaviour by alcohol abusers. The DSM-IV makes a distinction between alcohol abuse and dependency, although both fall within the category alcohol-related disorders, which in turn are classified as substance-related disorders (APA, 1994). Although the difference between alcohol abuse and dependence is important for research and public health strategies, in the context of the workplace it may be of less importance as the two conditions often overlap and have the same workplace consequences (de Miranda & Wilson, 2001; Schuster, 2003). The term alcoholism, although not used by the DSM-IV as it lacks a precise definition, is commonly used with reference to these two conditions and is used in this study.

Alcoholism may be indicated by the need for the daily use of large amounts of alcohol for adequate functioning, a regular pattern of heavy weekend drinking and periods of sobriety interspersed with binge-drinking (Kaplan & Sadock, 1997). Alcoholic drinking patterns are often associated with certain behaviours, including the inability to cut down or stop drinking, repeated efforts to control or reduce drinking, binges (i.e., heavy alcohol intake and remaining intoxicated for at least two days), blackouts (i.e., not remembering events that occurred while intoxicated), and continuing to drink despite knowing that it worsens a serious physical disorder. Moreover, social and work functioning is impaired due to alcohol use, such as absences from work, job loss, violence while intoxicated, legal problems, traffic accidents, and relationship problems with family, colleagues or friends stemming from the excessive consumption of alcohol. Alcohol dependence is also sub-typed as occurring with or without physiological dependence, that is, manifestation of tolerance or withdrawal (see Table 2.12). This maladaptive pattern of drinking behaviour should be present for at least 12 months for the diagnosis to be made. See Tables 2.11 and 2.12 for the full diagnostic criteria for alcohol abuse and dependence as provided by the DSM-IV (APA, 1994).

Table 2.11 DSM-IV diagnostic criteria for Alcohol Abuse

A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a *12-month* period:

(1) recurrent substance use resulting in a failure to fulfil major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household)
(2) recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile when impaired by substance use)
(3) recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct)
(4) continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights)

B. The symptoms have never met the criteria for Substance Dependence for this class of substance (i.e., alcohol).

(Adapted from APA, 1994, p. 182-183)

Table 2.12 DSM-IV diagnostic criteria for Alcohol Dependence

A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by at least three of the following, occurring at any time within the same *12-month* period:

(1) tolerance, as defined by either of the following:
    (a) a need for markedly increased amounts of the substance to achieve intoxication or desired effect
    (b) markedly diminished effect with continued use of the same amount of substance
(2) withdrawal, as manifested by either of the following:
    (a) the characteristic withdrawal syndrome for the substance
    (b) the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms
(3) the substance is often taken in larger amounts or over a longer period than was intended
(4) there is a persistent desire or unsuccessful efforts to cut down or control substance use
(5) a great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects
(6) important social, occupational, or recreational activities are given up or reduced because of substance use
(7) the substance use is continued despite the knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

(Adapted from APA, 1994, p. 181)

Diagnosing alcoholism may be made difficult because of denial by patients, family or other's close to the person who often minimise the problem, rationalise, or are afraid of the stigma attached to the condition (de Miranda & Wilson, 2001). However, family and colleagues are often in the best position to identify early the symptoms of alcoholism, such as change in work habits or productivity, lateness or unexplained absences, and minor personality changes like irritability or moodiness. Characteristics of alcohol intoxication, such as an odour of alcohol on the breath, slurred speech, unsteady gait, and a red face, may, in addition to impaired work performance, be suggestive of alcoholism (Schuster, 2003).

A further confounding factor in the diagnosis and ultimate referral for treatment of persons who abuse alcohol is that alcoholism often co-occurs with other mental disorders, also referred to as dual diagnosis. The most frequent comorbidity is with other substance-related disorders, anxiety or mood disorders, or antisocial personality disorder (de Miranda & Wilson, 2001; Kaplan & Sadock, 1997; Pienaar, 2002). It is estimated that 45% of alcohol abusers have at least one coexisting psychiatric disorder, while 78% of alcohol-dependent men and 86% of alcohol-dependent women will meet criteria for another psychiatric disorder sometime in their lives (Myrick & Brady, 2003, p. 261). Alcohol abusers are often dependent on addictive sleeping pills or tranquillisers, barbiturates or uppers like cocaine or Ecstasy (Schuster, 2003). Dependence on more than one substance is referred to as polydrug dependency. Furthermore, roughly 30 to 40% of alcohol abusers will meet the criteria for major depressive disorder sometime in their lives (Kaplan & Sadock, 1997, p. 393). These persons have a high risk of attempting suicide and often have other substance-related disorders as well. Many people with anxiety disorders use alcohol to self-medicate their anxiety. An estimated 25 to 50% of alcohol abusers meet the diagnostic criteria of an anxiety disorder, particularly panic disorder or one of the phobias (Kaplan & Sadock, 1997, p. 393).

Dual diagnosis is of particular importance as the co-occurrence of another disorder impacts negatively on the course, treatment outcome and prognosis of both disorders. However, abstinence is needed before an accurate diagnosis can be made, as the symptoms of mood or anxiety disorders may overlap with that of alcoholism (Pienaar, 2002). Conversely, alcohol intoxication or alcohol withdrawal may mimic certain psychiatric disorders such as the mood and anxiety disorders (Schuster, 2003). The general rule is to treat the alcoholism first, although comorbidity requires specialist attention and should be referred to a psychiatrist (Pienaar, 2002). It also needs to be acknowledged that between 10 and 15% of people with an alcohol-related disorder commit suicide, although alcohol is involved in a much higher percentage of suicides (Kaplan & Sadock, 1997, p. 393). Timely intervention is therefore essential, based on early identification and appropriate referral.

2.5.3.4 Course and outcome

The first episode of alcohol intoxication, that is, significant maladaptive behaviour or psychological changes following recent ingestion of alcohol, usually occurs in the mid-teens, with the majority of persons who develop an alcohol-related disorder doing so by their late 30's (APA, 1994, p. 202). The course of alcoholism differs from one individual to another, although it is often characterised by periods of remission and relapse. A review of ten follow-up studies showed that 2 to 3% of alcohol abusers become abstinent each year, with 1% returning to controlled (i.e., non-symptomatic) drinking (de Miranda & Wilson, 2001; p. 194). At follow-up, 46 to 87% of the subjects remained alcoholic, 8 to 39% had achieved abstinence, and 0 to 33% were controlled drinkers. Kaplan and Sadock (1997) note that although some professionals and groups support the concept of controlled drinking, complete abstinence should be regarded as a key component of a successful treatment strategy for alcoholism. Moreover, according to the American Psychiatric Association, follow-up studies of higher functioning individuals show at least a 65% one-year abstinence rate following treatment (APA, 1994, p. 202). A minority of those with alcohol dependence (roughly 20%) may even achieve long-term sobriety without active treatment (APA, 1994, p. 203).

As already mentioned, comorbidity plays an important role in the course and outcome of alcoholism. Those with a co-occurring other substance-related, mood, anxiety, or personality disorders, have a poorer outcome (Kaplan & Sadock, 1997; Myrick & Brady, 2003; Schuster, 2003). A study investigating the role of psychiatric disorders in predicting treatment outcomes found that men, in particular, had a worse outcome when another psychiatric disorder was present (Compton, Cottler, Jacobs, Ben-Abdallah & Spitznagel, 2003). The presence of major depression predicted using a larger number of substances, and having more drug dependence diagnoses and symptoms. Interestingly, women with phobias had a better substance dependent treatment outcome than other groups of subjects observed. The risk for suicide should also not be taken lightly in these individuals. Factors which have been shown to be associated with suicide among alcohol abusers include a co-occurring major depressive episode or a serious medical condition, lack of social support, unemployment and living alone (Kaplan & Sadock, 1997).

Alcohol abusers most often go for treatment because of pressure from a spouse or employer, or because they fear that their continued drinking may be fatal. Those who are persuaded, encouraged and even forced into treatment by a significant other are more likely to remain in treatment and to have a better outcome than those who are not pressured. However, persons

who realise that they abuse alcohol and voluntarily consult professional help have the best prognosis (Kaplan & Sadock, 1997).

2.5.3.5 Treating alcoholism

Various treatments are available for alcoholism, depending on the progress of the condition and whether any complications exist. Inpatient treatment at a hospital or specialised alcohol treatment centre may be required for severe intoxication, withdrawal symptoms, coexisting medical complications or other psychiatric disorders, or where a pathological home or work environment exists (Schuster, 2003). Outpatient treatment, ranging from brief counselling to comprehensive medical, psychiatric and psychotherapeutic interventions, may be indicated where there is no risk for withdrawal symptoms, the person is medically stable, not suicidal or psychotic, and has a supportive environment.

Components of treatment include psychoeducation, behaviour modification, individual or group therapy, occupational therapy, medication, and long-term support (de Miranda & Wilson, 2001). **Psychoeducation** should give attention to informing alcohol abusers of all aspects of alcohol use, abuse, its effect on health, the body, psychological and social functioning. Pienaar (2002) adds that it is important to highlight that nobody intentionally sets out to become an abuser of alcohol. Patients should therefore be taught about dependence on alcohol, the dangers of continuing drinking and the advantages of sobriety. Information should also be provided about the available programmes and treatment facilities. Recovering alcohol abusers may be used in this education process to reinforce the message and offer encouragement. Family and close colleagues of alcohol abusers should also be included in psychoeducation. It is particularly important to inform significant others of the underlying factors that could possibly perpetuate alcoholic behaviour. Enabling acts such as covering for the person who abuses alcohol, taking on extra work, or giving in to the intense emotional games that they play, may maintain pathological drinking and do not aid the recovery process.

Individual **psychotherapy** usually focuses on the reasons for drinking, exploring the situations in which the person drinks, the motivating forces behind drinking, the results expected from drinking, and on alternate ways of dealing with these situations (Kaplan & Sadock, 1997). Often a spouse, companion, friend or other family member is involved in some of the sessions. Indeed, because of the impact of alcoholism on the family and the possible resistance in the family to changing ingrained dysfunctional relationships, family therapy is considered an integral part of treatment (de Miranda & Wilson, 2001). Behaviour therapy teaches alcohol abusers other ways to reducing anxiety, including relaxation techniques, self-control skills, assertiveness training, and strategies to master the environment (Kaplan & Sadock, 1997).

Various forms of group therapy can help alcohol abusers achieve proper self-management. Self-help support groups like Alcoholics Anonymous (AA) emphasise the importance of abstinence and provide social group support to maintain self-identification as a recovering person. In addition to self-monitoring, groups may help to teach coping skills and relapse prevention training. The 12-step programme of the AA is regarded as effective in recovery and an integral part of any multi-treatment approach. It is not within the scope of this study to provide further information on the 12-steps, but the interested reader is referred to http://alcoholicsanonymous.cape.org.za/howitworks.htm for an outline and explanation of this approach. Support groups are also available to help spouses (e.g., Al-Anon) and children (e.g., Alateen) of alcohol abusers. Their value lies in assisting family members to regain self-esteem, not feel responsible for the abuser's drinking, and rebuild a meaningful family life. Occupational therapy may be necessary in the rehabilitation phase, given the loss of concentration and general skills in those with longstanding alcohol dependence. The focus is generally on retraining social skills, the constructive use of leisure time, relaxation exercises, and coping mechanisms (de Miranda & Wilson, 2001).

Medication may be required to treat the anxiety or depression commonly experienced by alcohol abusers. Both antidepressants and anti-anxiety agents are used, although benzodiazepines are generally not recommended except for withdrawal states or in extremely anxious patients (de Miranda & Wilson, 2001; Pienaar, 2002). Medications for anxiety and depression is usually only given after detoxification, as these disorders may be related to alcoholism itself (de Miranda & Wilson, 2001). Disulfiram (Antabuse) may be used in the initial stages of sobriety as an external motivator to behaviour change (Pienaar, 2002). Patients take this medication first thing in the morning while they are still motivated to abstain. Any temptation later in the day to drink is countered by the knowledge that alcohol will now cause severe physical discomfort, such as nausea, abdominal cramps, palpitations, headaches, dizziness, and flushing. Patients should be thoroughly instructed on how disulfiram works, that it will make them very ill should they drink any alcohol, and should only be used voluntarily by person who abuses alcohol.

Considerable advances in the medication treatment of alcoholism have been made recently. Naltrexone (Revia), a drug which blocks opiate receptors in the brain, has been found to decrease craving in alcohol dependent persons, thereby increasing abstinence rates (Pienaar, 2002; Stahl, 2000). If alcohol is drunk after taking this medication, the opiates released do not lead to pleasure, and alcohol therefore looses its positive effects. Naltrexone is usually given during the first 90 days of abstinence when the risk for relapse is highest, although it may be

taken for up to a year (Stahl, 2000, p. 524). Acamprosate (Sobrial), which interacts with certain brain receptors, has been shown to reduce withdrawal distress and craving for alcohol (Pienaar, 2002; Stahl, 2000). It can therefore help to ensure longer sober periods. Topiramate (Topamax), an anti-epileptic agent, has recently been shown to help reduce alcohol intake and craving (Johnson, Ait-Daoud, Bowden, Di Clemente, Roache, Lawson, Javors & Ma, 2003). It may therefore be useful in initiating abstinence, with the added reported benefits of improving general wellbeing and psychosocial functioning. Medication, although not replacing psychotherapy and rehabilitation strategies, is therefore useful in combination with these methods in treating alcoholism (Pienaar, 2002). Long-term support and positive reinforcement are crucial to maintaining abstinence. Periodic follow-up sessions with a psychiatrist or mental health professional are therefore highly recommended as part of a comprehensive treatment programme (de Miranda & Wilson, 2001).

2.5.3.6 Workplace considerations

Grobler et al. (2002) note that managers have two responsibilities given the reality and impact of alcoholism in the workplace, namely (1) to create programmes for employees who abuse alcohol and (2) to create a work climate that minimises the conditions and circumstances that may lead susceptible employees to seek relief in excessive drinking. Because both personal and work factors may contribute towards alcoholism, active steps should be taken to combat stress and anxiety in the workplace. Even though stress, challenges and conflict may be inevitable in the work of managers and indeed any level of employee, much can be done educate top and middle management about the potentially harmful effects of excessive job stress and anxiety. HR practitioners could utilise training and development activities to make executives aware of the significant impact that management style and job design have on employee mental and physical health.

Efforts to reduce alcoholism in the workplace have been around since the 1930's, but it is only since the late 1970's that comprehensive programmes have seen a significant rise in existence and been seriously implemented in companies (Cook, 1987, p. 350). These have most often been through EAP's, and indeed, as already noted in this chapter, the history of EAP's is closely linked to combating alcoholism at work. In a survey of EAP services in the United States it was found that all had alcohol programmes, and the majority of companies (70%) reported these programmes to be the most frequently used EAP service (Miner, 1992, p. 586). Since their inception, EAP's have become recognised as effective tools to dealing with troubled employees, including alcohol abusers. A survey of Fortune 500 companies in the United States found that 90% had EAP's, while the corresponding figure for large companies in the United Kingdom was 78% (Bennet, 2001, p. 1). In South Africa, 45% of large companies surveyed were found

to have established such programmes, although it is expected that this figure will increase as more companies realise the benefits of implementing structured interventions to deal with employee's troubles (Sithole, 2001, p. 80).

Even though EAP's and alcohol programmes require substantial amounts of money to establish and run, this should be seen as an investment with longer-term returns (Swanepoel, 1998). A study of companies employing more than 500 people in the United Kingdom found that for every £1 invested in an EAP there was a saving of £13.50 in terms of absenteeism, paid sick leave, staff attraction and retention (Bennet, 2001, p. 1). The value of EAP's in providing constructive assistance to alcohol abusers is strongly confirmed by the survey mentioned above of EAP services in the United States, where it was found that 85% of HR managers felt that the service was effective (Miner, 1992, p. 586). Furthermore, the majority of employees who abuse alcohol recover fully following rehabilitation programmes, with business and industry success rates ranging from 65 to 80% (Grobler et al., 2002, p. 461). A retrospective12-month study of 480 EAP's in the United States found that 70% of the employee-alcohol cases returned to adequate job performance, 10% returned with marginal performance, and 5% were dismissed, with the remainder of cases still in treatment during the time of the survey (Cook, 1987, p. 350).

Alcoholism can therefore be successfully and cost effectively managed in the workplace. Successful early intervention **alcohol programmes** should consist of the following five **components** (Gerber, 1998; Sithole, 2001):

1) ***Policy document***: a written policy should declare top management's and the company's commitment to an alcohol programme. The document should state the willingness of the company to help affected employees and recognition that alcoholism is a medical condition. Employees who seek treatment will therefore not be penalised but assisted. The allocation of responsibilities to relevant personnel, as well as the procedures for identifying and confronting employees who have a drinking problem, should be specified.
2) ***Channels of intervention***: specific channels within the organisation should be clearly identified whereby problem-drinking employees may receive counselling or be referred to appropriate community resources for professional help with their problem.
3) ***Cooperation with trade unions***: involving trade unions and other employee organisations in the early stages may help to gain support for the programme and in obtaining appropriate assistance from the abuser's colleagues.

4) ***Education***: the entire workforce should be provided with education and training regarding all aspects of alcoholism, including the company policy, procedures, and the principle of seeking help without being penalised.
5) ***Training***: supervisors and all level of management should be trained regarding their responsibilities in implementing the programme and on handling employees who abuse alcohol.

Supervisors are primarily responsible for identifying problem drinking behaviour and for dealing with employees who abuse alcohol within their workgroup (Gerber, 1998). A crucial aspect of effective intervention is timing. Schuster (2003) warns that confronting an employee based solely on the odour of alcohol on the breath may be premature. A clear pattern of impaired job performance must be documented before action can be taken, although in the case of obvious intoxication at work or where the employee's behaviour may endanger others (e.g., pilots, train drivers, heavy machine operators) immediate referral for treatment is justified. The supervisor should therefore keep an exact record of the employee's behaviour, with particular emphasis on productivity levels, absenteeism, lateness and excuses to leave the workstation (Pieters, 1996). The focus should initially be on low or unsatisfactory work performance resulting from the suspected problem drinking. The first confrontation should be by the immediate supervisor, and should be a private verbal warning about work behaviour. If the employee's behaviour does not improve, a written warning may be issued, which should be filed in the employee's confidential folder. The procedure to follow before the next step is taken will differ according to the company's alcohol policy, although it is generally accepted that three written warnings justify referral to the HR department, EAP, or consulting mental health professional (Schuster, 2003). During this counselling session the problem situation is empathetically discussed. If the employee then admits that his/her underachievement is due to alcoholism, the employee should be supported in seeking treatment and joining a rehabilitation programme. If the employee is uncooperative, it should be clearly stated that he/she may loose his/her job unless treatment is sought. The employee should also understand though that the job will be kept available until treatment is completed.

Return to work after treatment and rehabilitation may initially require constant support and consideration from the supervisor and the HR practitioner. It is strongly advised that newly recovering alcohol abusers not be sent on out-of town business trips (Schuster, 2003). A solid support network is needed during this stage and those closest to the employee will know best which subtle changes in attitude may lead to relapse. Also, in-flight drinks or hotel room drink cabinets may prove too much of a temptation, where craving could give in to rationalisation. For example, thinking that no one will know or that the stress of travelling and out-of-town

work permits drinking. Furthermore, it is not easy for newly sober alcohol abusers to be alone in a strange place.

Workplace factors that may trigger a craving for alcohol should also be taken into consideration, for example troublesome interpersonal tensions at work, organisational change and stress. A lateral job transfer may help where difficult relations with peers or a supervisor exist, particularly given the potential disruptive effect of alcoholism on work relationships prior to treatment. The HR practitioner should always keep in mind the employee's highest level of past performance, although a promotion too early in recovery with all its accompanying stress could trigger a relapse. Another important aspect is to respect the returning employee's confidentiality. Although honesty is needed for recovery, it is not necessary to share details of treatment or rehabilitation with colleagues that are not directly and closely involved with the employee. This could lead to excuses and lies on the part of the recovering alcohol abuser, creating mistrust and an atmosphere of deception, potentially encouraging rationalisation and even relapse (Schuster, 2003). Finally, it is necessary for recovering alcohol abusers to consult a mental health professional periodically for follow-up sessions, particularly if comorbidity existed before alcohol treatment. Anxiety and mood disorders may recur, and follow-up assessments could contribute towards preventing relapse and ultimately preserving optimal job performance from the returned employee.

2.6 Summary

This chapter reviewed the HR function and outlined the roles and required competencies of HR practitioners. Mental health and illness were described, and the prevalence and impact of mental illnesses in the workplace was highlighted. The training of HR practitioners in mental health and illness was briefly explored, showing an apparent lack of recognition of the reality of mental illness in the workplace. The concept mental health literacy was described and brought into context of the HR domain. Attitudes towards mental illness, as well as the social phenomenon of stigma, were explained and workplace implications detailed. Mental disorders and problems commonly found in the workplace were described and particular attention was given to describing the three conditions used in the survey stage of this study, namely depression, panic disorder and alcohol abuse. Available treatments and workplace considerations in addressing these three conditions were also outlined.

It was emphasised that even though the HR practitioner is not a psychiatrist or clinical psychologist, a basic knowledge and understanding of the risk factors, causes (including workplace factors), course and outcome, as well as available treatments for mental illnesses is required to effectively manage these conditions in the workplace. This includes being able to

recognise possibly mental illness, make an appropriate referral, and hold a positive view of the mentally ill, that is, be mental health literate.

The following chapter provides information on the research methodology of the study. The research design, study population, sampling method, measuring instrument and coding of data are described. The accepted level of significance is set, and the analysis of data is explained.

Chapter 3

"Everything should be made as simple as possible, but not simpler."
(Albert Einstein, 1879–1955)

RESEARCH STRATEGY AND METHODOLOGY

3.1 Introduction

Chapter 2 discussed the field of human resource management and examined the roles, activities and required competencies of the HR practitioner. This was followed by a discussion on mental health and illness, and related these to the HR function. A review of both the HR literature and training curricula revealed an apparent lack of recognition of the importance of mental illness, even though these conditions clearly impact on the workplace. This chapter describes the methods and instrument used to survey the mental health literacy and attitudes of HR practitioners, as well as the statistical methodology employed. The research problem, objectives and assumptions are stated, followed by a discussion of the research design, population and sampling method. A description of the research instrument is provided, giving attention to the measurement of attitudes towards mental illness, mental health literacy, and the use of vignettes in survey research. Information is provided on the methods used to capture and analyse data, the statistical analysis of data, as well as the accepted levels of significance.

3.2 Research problem and objectives of the study

Mental illness is a reality in the modern business world. Not only are these conditions highly prevalent within this population group, but they also pose a significant burden in terms of their direct and indirect impact on employee costs, productivity and relations. An extensive theoretical review of HR literature as well as an investigation of the content of current HR training programmes, reveals an apparent lack of cognisance or attention given to mental illness.

Ignorance and misinformation are known to compound the costs of mental illnesses to society and industry in that effective diagnostic, treatment, rehabilitative and preventative mechanisms are available. However, many sufferers of mental illness are unaware that they have a diagnosable and treatable condition. Furthermore, due to stigma and the fear of the consequences of stigma (such as prejudice and discrimination), many do not seek treatment even when aware that it is available. This reality is exacerbated by the many myths and mistruths surrounding the causes and treatment of mental illness, which impact negatively on appropriate help-seeking behaviour. For example, because many believe that stress or a weak

character cause conditions such as depression and the anxiety disorders, they do not consult professional mental health care. Or, beliefs that anti-depressants are habit-forming lead many to avoid such treatment modalities, even though evidence-based research clearly shows that these treatments are effective and safe. Undiagnosed and untreated, or inappropriately treated, mental illnesses contribute significantly towards the burden of these conditions. Furthermore, mental disorders continue to increase in prevalence and impact negatively on society, starkly contrasted by the rapid advances in the fields of psychiatry and psychology which offer much hope and relief. In South African industry too, the direct and indirect costs of mental illnesses continue to escalate in an environment where employee costs and a lack of productivity are common and well-documented concerns. However, little evidence can be found that the "people specialists" in business (i.e., HR practitioners) have given attention to, or even taken note of, the reality of mental illness.

The term mental health literacy was coined following an extensive series of community studies investigating knowledge and beliefs about mental illness and the impact of these on help-seeking behaviour. Mental health literacy refers to the knowledge and beliefs about mental illness that aid their recognition, management or prevention. It incorporates having sufficient knowledge to be able to recognise possible mental illness and identify different disorders, understanding what the causes and risk factors are, being able to seek appropriate help or know what appropriate help entails and where to find it, and having a positive attitude towards mental illness.

Given the prevalence and impact of mental illness in the workplace, and that HR practitioners are the persons in business concerned with the optimal utilisation of human resources, it may be deduced that HR practitioners should be knowledgeable about mental illness and hold a positive attitude towards the mentally ill, that is, be mental health literate and not stigmatise. This is further supported by the notion that the HR function is that business function concerned with people issues, as opposed to financial, marketing, sales and the like, matters. HR practitioners are the persons in business supposedly knowledgeable about the behavioural sciences and, as such, should take the lead in addressing mental illness matters in the workplace. However, the apparent lack of recognition and attention given to mental illness in the workplace raises questions about the mental health literacy and attitudes of HR practitioners.

The ***research questions*** to be investigated in this study were therefore formulated as:

1) Can HR practitioners in South Africa *recognise* possible mental illness?
2) Can HR practitioners in South Africa *identify* different mental illnesses?

3) What do HR practitioners in South Africa believe are the *risk factors and causes* of mental illness?
4) What do HR practitioners in South Africa believe to be appropriate *treatments* for mental illness?
5) What is the *orientation* (i.e., attitudes) of HR practitioners in South Africa towards the mentally ill?

However, from an extensive literature search it would appear that the knowledge and attitudes of HR practitioners regarding mental illness is not known. Indeed, no such specific research appears to have been conducted in South Africa, or in any other country, to date.

The ***research objective*** for this study was therefore formulated as:

To investigate and describe as accurately as possible the mental health literacy and attitudes of HR practitioners in South Africa.

3.3 Research aim

Mental illnesses are real and significant health problems that hold productivity and cost implications to businesses. This calls for efficient and timely management of these conditions within the workplace. However, to do so requires first, a recognition of the problem; second, accurate knowledge about mental illness matters; and third, a positive attitude. This study had a descriptive aim and did not constitute hypothesis-testing research (Barnes, 2003). ***Assumptions*** were therefore investigated in place of hypotheses. The main assumption was that South African HR practitioners are not literate regarding mental illness. This was broken down into the following *specific assumptions*:

1) HR practitioners in South Africa do not *recognise* mental illness when confronted with a specific case study satisfying DSM-IV diagnostic criteria (i.e., either depression, panic disorder, or alcohol abuse).
2) HR practitioners in South Africa cannot *identify* different mental illnesses (i.e., depression, panic disorder, or alcohol abuse).
3) HR practitioners in South Africa lack knowledge regarding *the risk factors and causes* of mental illness (i.e., depression, panic disorder, and alcohol abuse).
4) HR practitioners in South Africa lack knowledge regarding the appropriate *treatments* for mental illness (i.e., depression, panic disorder, and alcohol abuse).

5) HR practitioners in South Africa hold negative *attitudes* towards the mentally ill as measured by the Community Attitudes toward the Mentally Ill scale (i.e., score high on the Authoritarianism and Social Restrictiveness subscales, and score low on the Benevolence and Community Mental Health Ideology subscales).

Investigating these five assumptions will enable answering the first two research questions stated in chapter 1. Data derived from these determinations, in addition to looking at the demographic and work variables of respondents, will also assist with answering research questions three through to five. That is, determining whether mental health literacy levels differ for different mental disorders, and whether any associations exist between HR practitioner characteristics and their mental health literacy and attitudes.

3.4 Research design

The research design of a study refers to the kind of study being planned and the kind of results aimed at (Babbie & Mouton, 2001). Arriving at a suitable research design requires extensive consideration of the why, what, when, and where of the study to be able to adequately address the questions and objectives of the research (van der Merwe, 1996).

3.4.1 Selecting an appropriate research design

The first consideration in furthering this process of conceptualisation and operationalisation is to clearly state the ***purpose*** of the research. Three of the most common goals of social research are exploration, description, and explanation (Babbie & Mouton, 2001). This study had a *descriptive* aim, as the purpose was to describe the mental health literacy and attitudes of HR practitioners as accurately and clearly as possible. The statistical methods employed, as described below in 3.8, therefore entailed descriptive and inferential statistics aimed at describing and determining association, not causality.

The next step in the research process is to outline the ***unit of analysis***, that is, to clearly state who or what will be studied. This study was concerned with *individuals* (i.e., HR practitioners) as opposed to groups, organisations, or social artefacts (van der Merwe, 1996). More specifically, it was interested in individual characteristics and conditions of being (e.g., HR qualifications, registration, experience, job, and mental health literacy) and orientations (i.e., mental health attitudes). The ***time dimension*** is also an important factor in selecting a research design. Studies may either be cross-sectional or longitudinal (Babbie & Mouton, 2001). Due to time and budgetary constraints, this study was limited to observing HR practitioner characteristics and orientations at the time of sampling and was therefore *cross-sectional*. Finally, the ***context*** of the research, or the "where" component, may be either in the natural

environment where the phenomenon occurs, in an artificial laboratory, or independent of a specific context or environment (van der Merwe, 1996). As this study was concerned with the mental health literacy and attitudes of the unit of analysis, the whereabouts of respondents during the survey was of no consequence. It was therefore *independent* of context.

Given the research purpose, unit of analysis, time dimension and context of a study, a suitable research design may be selected to adequately address the research problem. The three basic research designs most often used in social research are surveys, experiments, and fieldwork (van der Merwe, 1996). Babbie & Mouton (2001) mention three other types of research that are fast becoming popular in the social sciences, being participatory action research, evaluation research and unobtrusive research designs. This study, however, employed a ***survey research*** design.

3.4.2 Sample survey research

Survey research studies, also referred to as ***sample surveys***, select samples from the target population to determine the relative incidence, distribution and interrelations of sociological and psychological variables (Kerlinger, 1986). To ensure representativeness, random sampling methods are usually employed so that inferences may be made to the whole population. Surveys are most often descriptive or explanatory, are suitable for any time dimension, and are usually independent of a specific context given that groups are statistically compiled by means of sampling (van der Merwe, 1996).

Sample surveys have the *advantage* of enabling generalisations to be made to an entire population by inferences from relatively small samples (Rea & Parker, 1992). They are generally less costly than other types of research and data collection can take place within a relatively short period of time. Also, they provide reasonably accurate data on individual characteristics at a given time (i.e., at the time of sampling) and are particularly useful for determining values, beliefs and attitudes (Kerlinger, 1986). Data generated by well-structured surveys is standardised, thereby amendable to quantification and consequent computerisation and statistical analysis. Surveys are also flexible in that many questions can be asked about a given topic, increasing the options for statistical analysis (Babbie & Mouton, 2001).

The *disadvantages* of surveys in general do not necessarily imply weaknesses to this study, given the specific research problem and purpose being aimed at. Surveys cannot adequately establish causal relationships between variables (de Vaus, 1996). They are primarily concerned with aspects of people's beliefs and actions without taking into consideration the context in which they occur. Furthermore, surveys cannot measure social action, but can only collect self-reports of remembered or anticipated action. Not all things are measurable by survey methods,

and studying a topic, for example attitudes, may influence it. For this reason, some regard survey data as artificial, in that respondents may form opinions as they answer a question, or they may respond in a prejudiced manner without necessarily being prejudiced in real life. Due to the standardisation of questionnaire items, surveys are often regarded as superficial in their coverage of complex topics. Finally, surveys have been accused of being inflexible in that they strictly adhere to preset study designs, and of being too statistical and sterile in nature.

In summary, sample surveys are generally strong on reliability and weak on validity. Because of the standardisation with survey methods, information gathered is generally consistent over time, thereby limiting unreliable observations and responses (Babbie & Mouton, 2001). However, the artificiality of survey formats may compromise the validity, as responses may merely be approximate indicators of the concepts under study. This study built on the strengths of survey research and aimed to address the relevant weaknesses by utilising sound methods and procedures.

The next step in the scientific research process was to select a specific type of survey method by means of weighing the research needs, the type of population under study and the resources available.

3.4.3 Selecting an appropriate type of survey research

Surveys are classified according to the means of obtaining information, namely personal interviews, mail questionnaires, panel, or telephone surveys (Kerlinger, 1986). Given that this study aimed to describe a national sample within cost and time constraints, that it was assumed all potential respondents were literate, that a complete address list was available, and that the topic being studied could be considered sensitive, the technique of ***mail questionnaires*** was selected as survey method (Babbie & Mouton, 2001; de Vaus, 1996). This choice was further supported by the literature stating that mail questionnaires are particularly suited to obtaining information on beliefs, opinions, attitudes and knowledge (Bourque & Fielder, 1995; de Vaus, 1996; Rea & Parker, 1992).

The *advantages* of mail questionnaires include fewer costs as they save on the expenses of interviews and telephone surveys, and the time saved above personal interviews (Babbie & Mouton, 2001). Fewer personnel and structures are required for the implementation, and large geographical areas can be covered (Bourque & Fielder, 1995). It is also more convenient for respondents as they can respond at a time and rate suitable to them. The improved anonymity makes this method more suitable for sensitive or controversial issues. Furthermore, interviewer

bias is reduced as all respondents receive exactly the same wording of questions. Indeed, this method offers an entirely standardised measuring instrument (Sapsford, 1999).

Disadvantages include poor response rates and the considerable time that may be required for mailing, return mail and follow-ups (Rea & Parker, 1992). Questionnaires are also subject to self-selection and bias, including non-responses due to literacy and language deficiencies. Questionnaire construction needs to be optimal to motivate potential respondents. Questions need to be objective and clear, and care should be taken to guard against order effects, that is, where questions influence or bias each other (Bourque & Fielder, 1995). Furthermore, the population should have recognisable addresses. Further limitations are the lack of interviewer involvement to clarify uncertainties and open-ended questions to provide relevant information not covered by structured questionnaires.

3.5 Population and sampling

As it was logistically impossible to survey the entire population of HR practitioners in South Africa, it was necessary to draw a sample that would nonetheless provide an accurate reflection of South African HR practitioners, that is, be ***representative***. Kerlinger (1986) explains that a representative sample refers to a portion of a population that has approximately the same characteristics of that population relevant to the research in question. Furthermore, the aggregate mental health literacy and attitudes of the sample needed to closely approximate those same aggregate characteristics of HR practitioners in South Africa (Babbie & Mouton, 2001).

3.5.1 Defining the population and sampling frame

A population is a theoretically specified aggregation of study elements, that is, the units about which information is gathered (Babbie & Mouton, 2001). It is therefore that group of, in this case, people, about whom the study would like to make conclusions. The elements (referring to sample selection) and also the units of analysis (referring to data analysis) of interest to this study are ***South African HR practitioners***. The ***study population*** was therefore defined as:

> All human resource practitioners in South Africa who were either active in the field or who were involved with training in academic institutions (universities and technikons) and were members of the South African Board for Personnel Practice (SABPP) and who resided in South Africa during the time of the study survey.

The ***SABPP*** is the professional standards body of HR in South Africa and is recognised by the South African Qualifications Authority (SAQA) as the Education and Training Quality Assurance (ETQA) body for some of the crucial HR qualifications in this country (SABPP, 2003). The mission of the SABPP is to establish, direct and sustain a high level of professional and ethical conduct in personnel practice. To achieve this, the Board performs functions such as registering HR practitioners along specific levels and categories, appointing mentors, conducting assessments or examinations, awarding certificates, and accrediting education or training suitable for registration (Grobler et al., 2002). The Board also audits tertiary institutions, conducts research, publishes papers and research findings, and is concerned with continuing professional education (SABPP, 2003). Professional registration with the SABPP affords a professional status, aids career development and enforces adherence to a Code of Professional Conduct (Grobler, et al., 2002). ***Registration*** is at different *levels*, which at the time of this study, and therefore included as a variable in the measuring instrument, comprised (SABPP, 2001):

1. Personnel Practitioner
2. Associate Practitioner
3. Candidate Practitioner
4. Candidate Associate Practitioner

The level of registration is determined by qualification, experience and proven competence. For example, to register at the level Personnel Practitioner would require a minimum of a four-year post-matriculation, accredited and relevant qualification and four years of appropriate experience (Carrell et al., 1998, p. 42). Registration as a Candidate implies being enrolled in a two-year candidateship to focus and structure development for ultimate registration. Mentors and the Board evaluate the experience gained during this candidateship against criteria set by the Board.

Registration is also within two *categories*, namely Generalist or Specialist. Various specialisations exist and the field in which a practitioner works determines registration as a Specialist. To register as a Generalist requires extensive theoretical and practical exposure to at least two-thirds of the HR spectrum as well as a broad coverage of all other HR areas (SABPP, 2003). A specialist registration can only be applied for if more than one-third of the theoretical and practical exposure has been concentrated in one specialist area. It is possible to register in more than one category, that is, as a generalist and as one or more type of specialist. *Specialisations* at the time of this study, and therefore listed in the measuring instrument as a study variable, comprised (SABPP, 2001):

1. Training & Development
2. Industrial Relations
3. Recruitment & Selection
4. Personnel Service
5. Education & Research
6. Psychologiae
7. Employee Assistance Programmes
8. Assessment Centres

Cognisance is taken that the SABPP approved *new levels and categories* for registration, effective as of 23 July 2002 (SABPP, 2002). However, as these are being phased in, current registrations at previous levels and categories remain valid until May 2004. It was therefore decided to rather provide the old registration levels and categories within the measuring instrument as these were still in use at the time the study survey was conducted. Also, it was assumed that the majority of members had either not yet been informed about the new registrations or had not had sufficient time to register at new registrations, given that the survey was conducted late 2002 and early 2003. It is worthwhile to note that the new levels Master, Chartered, and Technician HR Practitioner are now possible (SABPP, 2002).

Registration with the Board is currently *voluntary* (Carrell et al., 1998). Therefore, not all HR practitioners practicing in South Africa are registered. Nonetheless, current membership totals about 2800 paid-up members, who can be roughly divided into 80% senior practitioners, 15% medium level practitioners and 5% students (H. van Rensburg, personal communication, 25 April 2003). At the time of sampling, roughly 2500 HR practitioners (including candidates) were registered and entered in the membership list. The list of address labels based on the SABPP membership list was used as the sampling frame for this study.

A ***sampling frame*** is the actual list of sampling units from which a sample is selected (Babbie & Mouton, 2001). Each person registered with the SABPP has a membership number. These numbers are unique (i.e., only one number per individual, and only one individual per number) and are printed on the address labels originating from the membership list. Therefore, the sampling frame consisted of all listed, and therefore registered and paid-up, members of the SABPP at the time of sampling. As this complete list of the population was available, random sampling was possible (Sapsford, 1999).

3.5.2 Probability and random sampling

To be able to provide meaningful descriptions of the population, the sample should contain the same variations of interest to the research as found in the population. The best way to achieving approximate sample and population means is through probability sampling.

There are two broad types of samples, namely probability samples and non-probability samples (Kerlinger, 1986). ***Probability sampling*** is where each person in the population has an equal, or at least known, chance (i.e., probability) of being selected. With non-probability sampling however, some may have a greater, but unknown, chance of being selected (de Vaus, 1996). The surest way of obtaining equal probability of selection is to use the principle of random selection. ***Random sampling*** makes it possible to draw unbiased samples, where no one member has a greater chance of selection than any other (Kerlinger, 1986). Random sampling requires a complete list of all population members (i.e., the sampling frame), so that equal probability of selection can take place (Babbie & Mouton, 2001). Most authors define random sampling by way of this unbiased sampling method. Kerlinger (1986), however, adds that a more refined definition of random sampling should acknowledge that when sampling, only one portion of a population is selected and studied. However, it is possible to draw many such portions (samples) from the same population. Random sampling is therefore that method of selecting a portion from a population so that all possible samples with the same fixed size (n) have an equal chance at selection (Kerlinger, 1986, p. 110).

The *advantages* of this method are twofold; firstly that it is more likely to produce representative samples and secondly, that it enables estimates of the accuracy or representativeness of sampling (de Vaus, 1996). Whereas probability theory specifies that, for example, 95% of a factitious large number of samples would produce estimates falling within two standard errors of the parameter, it may be assumed that any single random sample has a 95% chance of falling within that range (Babbie & Mouton, 2001, p. 182). It is therefore possible to say with 95% confidence where the sample statistic will fall. This confidence increases when a larger margin of error is allowed.

3.5.3 Selecting an appropriate probability sampling method

Given the above-mentioned advantages of probability sampling, it was decided to use this method to select the study sample. There are, however, four main types of probability sampling, being simple random sampling, systematic sampling, stratified sampling and multistage cluster sampling (de Vaus, 1996; Rea & Parker, 1992). The choice between employing any of the four probability sampling methods is determined by the nature of the

research problem, the availability of a sampling frame, the accepted level of accuracy, the method of data collection and the research budget (de Vaus, 1996). Since this study was descriptive in nature, comprising a mail questionnaire survey, and had a good sampling frame available for the relatively small population, it was decided to use ***simple random sampling.***

3.5.4 Simple random sampling

Simple random sampling (SRS) is the best-known form of probability sampling and is based on the assignment of a single number to each sampling unit (potential respondent) in the sampling frame (de Vaus, 1996). Numbers are then chosen randomly in a way that does not tend to favour certain numbers or patterns of numbers. A table of random numbers is commonly used in this random process, and the numbers selected become part of the sample itself.

A ***probability sample of 900 respondents*** was therefore drawn from the 2500 existing SABPP members at the time of sampling by means of simple random sampling. The SABPP database of members has membership numbers running beyond the actual number of members, as past and present members are included and new members do not take on old or expired numbers. Thus, membership numbers may be attached to retired, deceased or immigrated persons, or those whose registration has lapsed. These numbers do not have an address label though. The membership numbers run from 1 to 5995, although only 2500 address labels existed at the time of sampling.

Microsoft Excel was used to generate a ***random list of numbers***, with $N = 5995$. Following this list, and starting at a random point, 900 consecutive random numbers were used to select the sample, where address labels having membership numbers corresponding with those arrived at in the random list were included in the sample. In cases where a number in the random list was not in current use (i.e., in cases where no current member with that particular membership number was registered and therefore no corresponding address label existed), the following consecutive number in current use was drawn. If a membership number was arrived at where the printed address label showed the person was not a South African resident (e.g., Namibian), the next consecutive membership number and its corresponding address label, was used.

3.5.5 Determining the sample size

A crucial aspect of being able to generalise findings from a sample to the entire population is the sample size. Generally, the larger the sample size, the greater the level of accuracy and the better the certainty about inferences made from the sample to the population (Kerlinger, 1986; Rea & Parker, 1992; Sapsford, 1999). The two interrelated factors that need to be considered when determining sample size are the level of confidence and the precision.

The *level of confidence* is the risk of error accepted by the research study. This is usually set at either a 95% or a 99% level of confidence (Rea & Parker, 1992, p. 126). This study accepted a ***95% level of confidence***, therefore was prepared to take a 5% risk of error.

The *precision* (C_p), determines the level of sampling accuracy obtained in a given research study (Sapsford, 1999). The selection of the sample size is therefore directly related to the accuracy of the sample mean as an estimate of the true population mean. The *standard error* (i.e., standard deviation of the mean, also referred to as sampling error) is a measure of the dispersion of the distribution of sample means (Kerlinger, 1986). The sample error therefore reflects the error of measurement due to a predictable variation between samples when drawn randomly from the same population. The precision is usually set at 1%, 3% or 5% and represents the margin of error due to the sample drawn (Rea & Parker, 1992; Sapsford, 1999). This study accepted a ***5% precision.***

As this study makes use of Likert-type questions (see 3.6 below) and is therefore mostly concerned with proportions, the formula to determine sample size for variables expressed in terms of ***proportions*** was utilised. This formula expresses the relationship between the precision, the level of confidence and the standard error as follows (Rea & Parker, 1992, p.129):

$$n = \left(\frac{Z_\alpha \sqrt{p(1-p)}}{C_p}\right)^2$$

where n = the required sample size, Z_α = Z-scores for various levels of confidence $(1 - \alpha)$, C_p = precision interval in terms of proportions, and p = the true proportion. For the purposes of this study, $Z_\alpha = 1.96$ as the 95% level of confidence was accepted (Sapsford, 1999, p. 92). When investigating proportions (e.g., the proportion of HR practitioners favouring a particular treatment), the true proportion is not known. However, the most conservative way of handling this uncertainty is to set the value of p at the proportion that would result in the largest sample size. According to Rea and Parker (1992, p. 129), this occurs when $p = 0.5$. As the square root of $0.5(1 - 0.5) = 0.5$ the equation now reads:

$$n = \left(\frac{Z_\alpha (0.5)}{C_p}\right)^2$$

Substituting Z_α with the already mentioned accepted Z-score of 1.96 (95% confidence level) and C_p with a 5% error (precision), the value of n, and thus the required sample size, is ***385***.

As mentioned above though, the SABPP listed 2500 registered members at the time of sampling. According to Rea and Parker (1992, p. 136), any population smaller than 100 000 members may be regarded as a ***small population***. The formula for determining sample size when populations are small differs slightly from the one as described above. This is because the standard error needs to be recomputed to include the finite population correction. The corrected formula thus reads as (Rea & Parker, 1992, p. 131):

$$n = \left(\frac{Z_\alpha \sqrt{p(1-p)}}{C_p} \cdot \sqrt{\frac{N-n}{N-1}} \right)^2$$

Since n is present on both sides of the equation, the following formula may be derived for n:

$$n = \frac{Z_\alpha^2 [p(1-p)]N}{Z_\alpha^2 [p(1-p)] + (N-1)C_p^2}$$

If p is replaced with 0.5 as previously discussed, the equation to determine sample size when the population is small reads:

$$n = \frac{Z_\alpha^2 (0.25)N}{Z_\alpha^2 (0.25) + (N-1)C_p^2}$$

The required sample size for a population of 2500 (i.e., $N = 2500$) using this formula, and accepting a margin of error of 5% and a 95% confidence interval, would be ***334***.

The calculated sample size based on a population of 2500 (i.e., 334) is slightly smaller than that required when variables expressed as proportions are used (i.e., 385). However, data analysis for this study also made use of summated ratings, delivering ***interval scale measures***. When both proportional and interval scale variables are present, Rea and Parker (1992) suggest that the largest sample size requirement be satisfied, in this case, 385.

From the above determinations, a sample size of between 334 and 385 would be necessary to be able to make inferences from the sample to the study population. Budgetary constraints, however, necessitated that the lower estimate be accepted. Indeed, this was rounded down to the lowest 100. Therefore, it was decided that ***300 usable responses*** would be accepted as an

adequate sample size. This needed to be evenly distributed across the three study vignettes, thus an approximate of ***100 respondents per vignette*** was required.

Reassurance was also found for accepting this smaller than optimal sample size in the knowledge that some error cannot be corrected by larger sample sizes alone. Even though sampling error is dependent on the size of the sample, non-sampling error is fault relating to the design and method of data collection (Sapsford, 1999). These include errors of measurement and of coding, mistakes on the part of respondents (often due to poor questionnaire design) and errors following biased sampling. This study therefore set out to minimise non-sampling error and to ensure a well-designed and conducted survey.

A final consideration in the determination of sample size is the ***response rate***. Mail distributed surveys generally yield lower response rates than other survey methods (de Vaus, 1996; Hakim, 2000; Kerlinger, 1986). Although most literature report estimated response rates of between 60 and 80% (de Vaus, 1996, p. 107; Hakim, 2000, p. 93), Kerlinger (1986, p. 380) maintains that the response rate for mail surveys is commonly less that 40 to 50%. However, Alreck and Settle (1995, p. 35) believe that response rates of less than 30% may be expected. Given then that a minimum of 300 respondents was considered useful for this study, and that a conservative response rate of 30% was expected, the ***final sample size*** was determined to be ***900***. Therefore, if only 30% of the sample returned completed and usable questionnaires, 300 cases would be available for data analyses. The final sample size was evenly distributed across the three vignettes to enable meaningful comparison of mental health literacy levels concerning the three disorders surveyed. Therefore, ***300*** respondents each received a questionnaire based on a depression ***vignette***, 300 regarding panic disorder and 300 regarding alcohol abuse.

Finally, if an adequate response rate had not been received by the pre-determined deadline date, it was decided that a further 300 respondents would be drawn from the same sampling frame using the same method of sampling. This would be evenly distributed across the three study vignettes.

3.6 Measuring instrument

This study made use of mail questionnaires. A ***questionnaire*** is by definition a highly structured technique for gathering information whereby each person is asked the same set of questions (de Vaus, 1996, p. 80). Babbie and Mouton (2001) note, however, that the term "questionnaire" is not always accurate as *statements* often equal or even outnumber the amount of questions, as was the case with this instrument. Nonetheless, questionnaires are the most

widely used survey data collection technique and are central to the operationalisation process with this type of research.

In order to address the research problem it was crucial that the questionnaire provide accurate observations of the relevant variables. All steps in the construction and administering of the questionnaire, and indeed the entire research process, were therefore directed at delivering quality measurements. Sample surveys by nature are strong on reliability but weak on validity. Ensuring the questionnaire actually measured HR practitioner mental health literacy and attitudes was therefore a primary concern, although providing results that could be empirically retested was no less important given the original research problem and that this was a descriptive study. Moreover, given the low response rates generally associated with mail questionnaires, efforts were concentrated on motivating respondents and facilitating easy and convenient replies.

3.6.1 Constructing the questionnaire

The study questionnaire comprised ***three sections***, namely questions and statements to gain information on respondent (a) demographic, HR training and work characteristics, (b) attitudes towards the mentally ill, and (c) mental health literacy. One of three vignettes describing the behaviour of a person with a mental disorder (i.e., depression, panic disorder, or alcohol abuse) was included within the questionnaire (see Appendix C).

The ***general format*** of the questionnaire was designed to be neat and professional. The focus was on clarity and simplicity to avoid uncertainties, misinterpretations, and respondents loosing interest or perceiving that responding would be too complicated or too time consuming. Questions and statements were therefore, where possible, short, clear, simple, objective, relevant, not double-barrelled, not stated in the negative, or ambiguous (de Vaus, 1996). Biased items and terms were also avoided, that is, not worded in such a way so as to encourage respondents to answer in a particular manner (Babbie & Mouton, 2001). Clear, basic instructions were provided at the beginning of the questionnaire, which included an example of a completed question. Each section commenced with introductory comments about the purpose and content of that section, as well as further instructions for responding. All instructions, including the vignette, were blocked to contrast with questions and statements.

Close-ended, or forced choice, questions were used as ***response format*** for the majority of the questionnaire. These are questions, or statements, where a number of alternative options are provided from which respondents were instructed to select one, or as indicated, more responses (de Vaus, 1996). This was to ensure uniformity of responses and to ease the processing of data.

Provided response categories were *exhaustive*, that is, included all possible responses that might be expected, and therefore included, where relevant, an "Other" or "None of the above" category (Babbie & Mouton, 2001). Response categories were also *mutually exclusive* within most of the questionnaire. Respondents therefore had to respond to each item by selecting only one of the provided options. However, the provision of *multiple answers* was necessary with some of the questions in the demographic section. See the discussion below on data coding and entry (3.10) for information on how these were managed. Only two *open-ended* questions were included, that is, where respondents could formulate their own answers (de Vaus, 1996). These were a background measure (demographic question) and a knowledge measure (mental health literacy question), and were readily post-coded.

3.6.2 Scaled response format

The ***levels of measurement*** hold important implications for the analysis of data (see discussions under 3.11) and were therefore considerations in the construction of the questionnaire (de Vaus, 1996). Variables whose attributes are only exhaustive and mutually exclusive are *nominal* measures. Variables whose attributes can be logically rank ordered are *ordinal* measures, where the different attributes represent relatively more or less of the variable. *Interval* measures are variables where the actual distance between attributes have meaning and can be expressed in meaningful standard intervals, although no true zero exists. *Ratio* measures are those where the attributes composing a variable have all the characteristics of the three other measures, but are also based on an absolute zero.

The study questionnaire mostly made use of nominal and ordinal measures. Response categories were attached to ***numerical values***, by numbering each category on 3- or 5-point rating scales. The latter may be referred to as a Likert-type scale. A ***Likert scale*** entails a 5-, 7-, or 9-point rating scale in which the opinion of the respondent is measured on a continuum from highly favourable to highly unfavourable, with an equal number of positive and negative response categories and one middle neutral category (Rea & Parker, 1992, p. 74). The wording on a true Likert scale ranges from "strongly agree", "agree", "neutral", "disagree", and "strongly disagree" for a 5-point scale (Babbie & Mouton, 2001). The Likert scale is particularly useful in the context of a series of questions eliciting attitudes about a specific subject matter (Rea & Parker, 1992).

Likert scales are also a type of ***summated rating scale***. This comprises a set of, for example, attitude items, all of which are considered to have an equal "attitude value", and each of which are responded to with degrees of agreement or disagreement (Kerlinger, 1986). The individual

item scores are then summed, or averaged, to obtain an overall attitude score for each respondent.

There are many *advantages* to using multi-item scales in survey research. As the concepts mental health literacy and attitudes are complex and cannot be measured directly, it is necessary to use indirect measures or indicators of these abstract concepts (de Vaus, 1996). An ***indicator*** is something which is known or believed to correlate with the subject of interest, and is derived from previous research (Sapsford, 1999). For example, the mental health literacy and attitudes statements used in this study are valid based on their use in previous research where they have successfully been employed as indicators of these concepts (Angermeyer et al., 1993; Angermeyer & Matschinger, 1994; Jorm et al., 1997a, 1997c; Jorm 2000; Taylor & Dear, 1981).

Combining these statements provides a better measure of what is being studied, and helps to understand the complexity of these concepts (de Vaus, 1996). Using only one statement could be misleading, but using a measure in context with other statements helps to avoid misinterpretations and therefore provides more valid measures. Given the weakness of sample survey research, multi-item scales are preferred methods to avoid some of the distortions and misclassifications that can occur when only a single-item measure of a complex concept is employed. Furthermore, combining responses to multiple indicators increases reliability, as responses may be a function of the wording of a particular statement. The possible effect of a badly worded item can be minimised in this way. Finally, as is the case with the attitude and mental health literacy measures in this study, summarising the information obtained by a number of statements into one variable simplifies analysis.

3.6.3 Measuring mental health attitudes: approaches and scales

Methodological ***approaches*** to measuring attitudes towards persons with health conditions include (a) picture ranking, (b) sociometric methods measuring behavioural responses, and (c) paper-and-pencil survey methods (Lyons & Hayes, 1993, p. 542). Survey methods are most commonly used in attitude studies and were the choice for this study.

Three major ***types*** of attitude scales used in surveys are summated rating scales, equal-appearance interval scales, and cumulative scales (Kerlinger, 1986, p. 453). Likert-type scales are examples of summated rating scales and have already been described above as the type of scale employed in this study. Summated rating scales are commonly used in attitude research, and the majority of mental health attitude studies employ Likert-type scales (Jorm et al., 1999; Taylor & Dear, 1981; Wolff et al., 1996a). These scales allow for measurement on two levels, namely, direction and intensity (Kruger, 1996). Direction refers to indicating whether an

attitude is positive or negative towards the study subject, while intensity refers to the degree of like or dislike for an object or person.

Two of the most comprehensive and best-validated ***mental health attitude scales*** are the *Opinions about Mental Illness* (OMI) and the *Community Mental Health Ideology* (CMHI) scales (Baker & Schulberg, 1967; Cohen & Struening, 1962). The *Community Attitudes toward the Mentally Ill* (CAMI) scale is based on the OMI and CMHI scales, but was designed specifically for use with lay populations (Taylor & Dear, 1981). The authors of the CAMI substantially revised the OMI and CMHI to reduce the total number of items, making it more suitable for surveys. This study employed the CAMI as the instrument to measure HR practitioners' mental health attitudes.

3.6.4 The Community Attitudes toward the Mentally Ill (CAMI) scale

The CAMI acknowledges the multi-dimensionality of attitudes and provides a systematic description of attitudes towards mental illness and the mentally ill. Based on previous research, it focuses on those dimensions that are the most strongly evaluative and therefore best discriminate between people who are positively or negatively disposed towards the mentally ill.

The CAMI comprises ***four subscales***, each measuring a specific dimension of attitudes towards the mentally ill, namely: authoritarianism, benevolence, social restrictiveness, and community mental health ideology (Taylor & Dear, 1981). *Authoritarianism* statements measure sentiments relating to the need for hospitalising the mentally ill, the difference between patients and so-called normal people, and the importance of custodial care. *Benevolence* sentiments include society's responsibility towards the mentally ill, the need for sympathetic and kind attitudes, willingness to become personally involved, and anti-custodial feelings. The *social restrictiveness* statements measure sentiments relating to the perceived dangerousness of the mentally ill, the need to maintain social distance, and patients' lack of responsibility. *Community mental health ideology* (CMHI) items express sentiments about the therapeutic value of the community, the impact of mental health facilities on residential neighbourhoods, and acceptance of the principle of de-institutionalised care.

Each of these four subscales consists of 10 ***items***, therefore totalling 40 items for the complete CAMI. Five of the items within each subscale express a positive sentiment about the underlying concept being measured, while the remaining five statements are negatively worded (Taylor & Dear, 1981, pp. 228-229). The reason for this sequencing is to minimise the possibility of *response set bias*. De Vaus (1996) explains that where respondents are requested to agree or disagree with a statement, the possibility exists that some may simply agree regardless of their

true opinion. These questions may therefore create an *acquiescent* response set. Other questions may produce a *social desirability* response set, where respondents provide answers that will make them look good in the eye of the researcher (de Vaus, 1996, p. 86). Varying the direction of scales in attitude surveys is a common method for reducing the chances of obtaining response sets from subjects (Green et al., 1987; Jorm et al., 1999).

As each subscale consists of 10 items rated on a 5-point Likert scale, the minimum ***aggregate score*** for each subscale is 10 (i.e., all items rated as 1 and indicating strong agreement) and the maximum is 50 (i.e., all items rated as 5 and indicating strong disagreement). A rating of 3 to any item on the CAMI reflects a neutral sentiment, and if a respondent were to respond neutrally to all items on any subscale the aggregate score for that subscale would be 30. A high aggregate score on the Authoritarianism and Social Restrictiveness subscales (i.e., between 31 and 50) suggests a negative attitude, while low scores (i.e., between 10 and 29) may be interpreted as a positive attitude towards the mentally ill with reference to the underlying concepts being assessed. The inverse holds true for the Benevolence and Community Mental Health Ideology (CMHI) subscales, where high aggregate scores suggest a positive attitude and low scores indicate a negative attitude regarding the two concepts assessed by these subscales.

Extensive statistical analysis was preformed in the original CAMI paper to determine the ***reliability and validity*** of the subscales. The alpha coefficients of all four subscales show high to good reliability, being $r = 0.88$ (CMHI subscale); $r = 0.80$ (Social Restrictiveness subscale); $r = 0.76$ (Benevolence subscale); and $r = 0.68$ (Authoritarianism subscale) (Taylor & Dear, 1981, p. 229). Both internal and external validity of the CAMI subscales have also been proven. High levels of internal validity were shown based on item-scale correlations, alpha coefficients, and factor analysis (Taylor & Dear, 1981, p. 238). The external validity was examined looking at both the construct and predictive validity. Within a theoretical framework attitudes toward the mentally ill are a function of a combination of personal characteristics. The construct validity was therefore determined by analysing the relationships between the attitude subscales and a range of personal characteristics, such as socio-economic status, life-cycle status, personal beliefs and values. Parametric and non-parametric correlation coefficients were also employed where appropriate (Taylor & Dear, 1981, pp. 232-234). Although this study is descriptive in purpose, it is worthwhile to note that the CAMI subscales also have proven predictive validity. This was determined by analysing relationships between the subscales and various measures of responses to mental health facilities, using correlation coefficients and analysis of variance (Taylor & Dear, 1981, pp. 235-236).

The CAMI has been employed in various ***community surveys*** determining attitudes towards mental illness and the mentally ill, both locally and abroad (Hugo et al., in press; Wessels et al., 1998; Wolff et al., 1996a). In combination with other knowledge, beliefs, and anticipated behaviour measurements, it has also been used in studies concerned with aspects of mental health literacy (Dirwayi, 2002; Wessels, Boshoff, Traut, Zungu-Dirwayi, Mbanga & Stein, 1999; Wolff et al., 1996b).

3.6.5 Measuring mental health literacy

Mental health literacy is a relatively new concept and was first coined by Jorm et al. in 1997 following their research into public recognition of mental disorders and beliefs about appropriate treatments (Jorm et al., 1997a, 1997c). As defined in the literature chapter of this study, this concept refers to knowledge and beliefs about mental disorders which aid their recognition and management.

The concept mental health literacy may be broken down to comprise several ***components***, each of which needed to be ascertained from the HR practitioner sample in this study. The ability to recognise mental illness and identify specific mental disorders, knowledge and beliefs about the risk factors, causes, self-help and professional help available, as well as attitudes facilitating recognition and appropriate help-seeking, needed to be covered by the measuring instrument (Jorm, 2000). Attitudes towards the mentally ill were assessed with the CAMI, as described above. The remaining components of mental health literacy were assessed by using a combination of Angermeyer and Matschinger's (1994) and Jorm et al.'s (1997a, 1997c) instruments. The former was employed to assess beliefs about the risk factors and causes of mental illness, while the latter measured what Jorm et al. (1997c, p. 472) refer to as ideologies of treatment. These are belief systems, that is, positive or negative views, about available self-help and professional treatments.

3.6.6 Measuring beliefs about risk factors and causes of mental illness

Angermeyer and Matschinger (1994, p. 40) compiled a list of possible risk factors and causes of mental illness, taking into account biological factors, psychosocial stress, socialisation, intrapsychic factors, the state of society, and supernatural powers. Three items were included within each of these ***domains***, resulting in an inventory of 18 ***items*** with a 5-point Likert-type response format. Although Jorm et al. (1997a) also provide a scale of possible risk factors and causes of mental illness, Angermeyer and Matschinger's inventory is more extensive. It may also be considered more suitable for a South African population in that it includes beliefs about the role of supernatural powers in the aetiology of mental illness. Mubbashar and Farooq (2001) advise that mental health literacy studies in developing countries should acknowledge

the locally held superstitions and beliefs about supernatural causes of mental disorders. As this study surveys the knowledge and beliefs of a national population, it is possible that some respondents may adhere to traditional views of these conditions, which should be accommodated in the measuring instrument.

Angermeyer and Matschinger's original item list was designed to serve as an ***inventory*** to assess respondent's beliefs about the causes of mental illness, which are grouped according to the authors' conceptual assumptions based on theoretical considerations (M.C. Angermeyer, personal correspondence, 10 June 2003). The manifest items within each of the six domains are therefore not interchangeable indictors and removing any one of them will change the dimensional concept being assessed (H. Matschinger, personal correspondence, 09 June 2003).

This inventory has been employed in ***international studies*** reported in peer-reviewed journals (Angermeyer & Matschinger, 1994; Angermeyer & Matschinger, 1996). It has also been used in ***local studies***, both with the lay public in general and with Xhosa families of schizophrenia patients in particular (Hugo, et al., in press; Mbanga et al., 2002; Wessels et al., 1998). A more recent and as yet unpublished study compares the original findings of the inventory from the early 1990's with 2001 data, using the same study population in East and West Germany (M.C. Angermeyer, personal correspondence, 10 June 2003).

3.6.7 Measuring beliefs about treatment strategies for mental illness

This study assessed beliefs about the appropriate treatments for mental illness with a questionnaire designed by Jorm et al. (1997a, 1997c). They compiled an initial list of 30 professional and other treatment strategies, which could be rated on a 3-point scale as being useful, harmful, or neither useful nor harmful. Using principle components analysis and rotated factor loadings, the initial list was found to comprise three factors that represented public beliefs about useful treatment strategies. The ***three factors*** entailed a medical treatment ideology (e.g., using antidepressants or tranquillisers), a psychological treatment ideology (e.g., consulting a social worker or a counsellor), and a lifestyle treatment ideology (e.g., utilising close family or physical activity) (Jorm et al., 1997c).

Jorm et al.'s final questionnaire was narrowed down to 21 ***items*** by deleting items with factor loadings of less than 0.40. Alpha coefficients for the three factors were 0.76 for the eight-item Medical scale; 0.72 for the seven-item Psychological scale; and 0.58 for the six-item Lifestyle scale (Jorm et al., 1997c, p. 470).

This inventory has been used by several ***studies conducted abroad*** to assess beliefs about the best treatment strategies for mental illnesses (Chen et al., 2000; Goldney et al., 2001; Jorm et al., 1997b, 1997c). To date no published South Africa studies have employed Jorm et al.'s scale.

3.7 Using vignettes

The use of vignettes in mental health attitude and literacy surveys has become a common practice (Angermeyer & Matschinger, 1994; Dirwayi, 2002; Hugo et al., in press; Jorm et al., 1997a, 1997c; Jorm et al., 1999; Wessels et al., 1998). Vignettes are useful tools to measure variables in a realistic yet unobtrusive manner. They are brief, concrete descriptions of realistic situations that are constructed in such a way that responses to them, often by means of rating scales, yield measures of the variables under study (Kerlinger, 1986). Vignettes are particularly useful for measuring attitudes in surveys as they provide a standardised context for respondents to reply to questions that are often abstract (de Vaus, 1996).

In this study each respondent was presented with a vignette, which described a case study of a fictitious person suffering from either depression, panic disorder, or alcohol abuse. These three diagnoses were selected as representative of the most common and costly mental illnesses confronted in the workplace (see chapter 2). The vignettes were designed to satisfy DSM-IV (APA, 1994) diagnostic criteria for the specific diagnoses. The depression vignette is provided in the box below as an example. See Appendix D for a copy of all three vignettes used in the study.

> **Brenda** started feeling increasingly sad after her sister died in a motorcar accident. Of course, the whole family had been affected by this tragic loss, but Brenda's sadness seemed to last the longest. Some six months after her sister's death, she was still unable to keep thoughts about this loss out of her mind. She continuously questioned the value of life. She found that she had difficulty falling asleep, lost 10kg in weight, had very little energy, and she had trouble concentrating. At work, she found herself crying without reason.

The panic disorder vignette described a "Joe's" situation while the alcohol abuse vignette presented a person called Jeremy. Jorm et al. (1999) randomly assigned gender to a person described in two vignettes portraying either depression or schizophrenia in a mental health attitudes survey. It was found that the gender of the person described in the vignette made no difference to study findings.

Respondents were instructed to read the vignette and respond to the subsequent statements based on the case study. This method was used to measure respondent ability to recognise mental illness and identify different disorders, as well as their beliefs regarding the risk factors, causes and most appropriate treatments of the described behaviour in the vignette. Examples of questions relating to the vignettes and measuring ***recognition*** of mental illness include:

Question 54: "[Name of person in the vignette]'s behaviour is a normal response"
Question 56: "[Name of person in the vignette]'s behaviour is typical of a mental illness"

Responses on the provided 5-point Likert-type scale could be rated as ranging from "definitely yes" (rated as 1) to "definitely no" (rated as 5). An open-ended question was also included (Question 58, Appendix C) to determine whether respondents could correctly ***identify*** (i.e., name) the mental disorder described in the vignette presented with.

To determine respondent beliefs about the ***risk factors and causes*** of mental illness, a list of statements was provided and respondents were instructed to respond to each by marking the number on the 5-point Likert-type scale most closely representing their view. Listed risk factors and causes included:

Question 63: "Heredity/ genetic factors"
Question 65: "Lack of willpower"

To determine respondents' views about the appropriate ***treatments*** of mental illness, a list of various psychological, medical, and lifestyle strategies that could possibly be useful to the person described in the vignette, was provided. Respondents were instructed to respond to each possibility by marking on the provided 3-point numerical rating scale whether they thought these would be helpful, harmful, or neither. Listed treatment strategies included:

Question 77: "Counsellor"
Question 87: "Antidepressants"
Question 92: "Physical activity"

3.8 Maximising response rates and ethical issues

Mail questionnaires are associated with low response rates. It was therefore crucial to employ known strategies to motivate potential respondents to complete and return questionnaires.

3.8.1 Cover letter

One method of maximising response rates is to include a good cover letter with mail questionnaires, as this is the main opportunity to ***motivate*** potential respondents (de Vaus, 1996). A simple yet businesslike cover letter was included with the study questionnaire, written on the official letterhead of the Mental Health Information Centre of South Africa (MHIC). The cover letter was used to introduce the study to potential respondents, to state the organisations conducting the study, to mention the objectives and usefulness of the research, explain how the respondent was chosen, assure confidentiality and anonymity, and that individual participation was valuable to the study (Rea & Parker, 1992). The cover letter accompanied the measuring instrument as the first page of the printed booklet (see Appendix E). Although Bourque and Fielder (1995) recommend that the salutation be personalised and include the name of the respondent, this study addressed the potential respondent as "Dear Human Resource Practitioner". The reason being that the cover letter was an integral part of the total questionnaire and having a personal salutation on the cover would compromise the stated anonymity. The cover letter also provided the name and full contact details of the researcher and offered to answer any questions that may arise or to provide further information if needed.

3.8.2 Returning the questionnaire

Detailed information was provided on how to return completed questionnaires and the deadline date was clearly stated. Questionnaires could be returned by mail and a self-addressed, stamped ***envelope*** was provided to make this more convenient for respondents. Questionnaires could also be returned by ***fax***, or by downloading an electronic version made available on the ***Internet*** and e-mailing completed questionnaires to the researcher. Each cover letter therefore included instructions and a password to gain access to the electronic version.

3.8.3 Incentives and feedback

Incentives are a standard means to encouraging respondent participation (Bourque & Fielder, 1995; de Vaus, 1996). However, due to financial restrictions, material incentives could not be provided by this study. An ***executive summary*** of findings was, however, offered to those who responded and were interested in receiving feedback. Advance letters and follow-up mailings were also not used, although these are recognised means of increasing response rates (Bourque & Fielder, 1995). The SABPP address labels were purchased with the agreement that copies would not be made or entered into a computer address labelling system. Therefore, only one mailed item could be forwarded to each selected potential respondent. A ***feedback*** section was included at the end of the questionnaire to allow respondents the opportunity to make any personal comments about the questionnaire or the study (Bourque & Fielder, 1995). This section also allowed respondents to express any opinions about limitations or usefulness of the

questionnaire, or to provide any information they felt relevant to the study but not covered by any of the questions.

3.8.4 Ethical considerations

Ethical issues in social research refer to the general agreements among researchers about what is proper and improper, usually encapsulated in codes of conduct (Babbie & Mouton, 2001). Ethical obligations to ***subjects*** include the principles of voluntary participation, no harm done to participants, anonymity and confidentiality, and not deceiving subjects. Although voluntary participation is an important norm, and it is the recognised right of any subject not to take part in the survey, it is also important that sufficient numbers of the sample respond to enable generalisations to the population. Potential respondents were not forced to participate (this would have been impossible given the chosen research design), but honest and generally accepted attempts were made to motivate all sampled HR practitioners to complete and return the mailed questionnaire. Ethical obligations to the ***scientific community*** relevant to this study include objectivity and integrity in the conduct and reporting of scientific research (Aguinis & Henle, 2002). Moreover, a detailed study proposal was submitted to the ***ethics committee*** at the University of Stellenbosch, Faculty of Health Sciences. This study, under the title "Mental health literacy and attitudes of human resource practitioners in South Africa" was approved, including all ethical aspects, by Subcommittee C of the Research Committee and accordingly registered (reference number 2001/C103).

3.9 Pre-testing the questionnaire

Babbie & Mouton (2001) note that no matter how carefully a data collection instrument is designed, the possibility for error always exists. It is particularly crucial to pre-test an instrument where more than one cultural or language group is included in the sample, as with this study. A pre-test is therefore a small-scale implementation of the draft questionnaire that assesses it along certain ***critical factors*** (Rea & Parker, 1992). Factors relevant to this study included clarity, comprehensiveness, acceptability and flow of the questionnaire, as well as whether it could maintain respondent interest and attention (de Vaus, 1996). Furthermore, questions that invade privacy or abridge ethical or moral standards could lead to non-responses, and were therefore avoided with this study.

3.9.1 Pre-test with colleagues

Therefore, to maximise the validity and reliability of responses, the completed draft questionnaire was first given to a small group of four colleagues at the MHIC and the MRC Unit on Anxiety and Stress Disorders for general comments and suggestions.

3.9.2 Feedback from colleague pre-test

Based on their feedback the ***wording*** of some of the questions was adapted, ***additional*** questions and response categories were included in the demographic section, and some questions were ***deleted***. However, as mentioned above, the mental health literacy and attitude statements were taken directly from rating scales with proven reliability and validity and the wording or sequence of questions could therefore not be adjusted (Angermeyer et al., 1993; Angermeyer & Matschinger, 1994; Jorm et al., 1997a, 1997c; Jorm 2000; Taylor & Dear, 1981).

The ***order*** of questions was also changed based on the feedback from colleagues. Where the mental health literacy section with its accompanying vignette was originally placed before the attitudes section, it was felt that reading the vignette could bias the answering of the subsequent attitude questions. Therefore, the final sequence of sections was first the demographic section, then the section measuring mental health attitudes, followed by the case study and then the related mental health literacy questions.

Most authors on survey questionnaire construction caution against ***placing demographic*** questions first, as these could be perceived as dull and dissuade potential respondents from completing the questionnaire (Babbie & Mouton, 2001; Bourque & Fielder, 1995; de Vaus, 1996). It is also stated that the first few questions should be interesting, obviously related to the subject of study, relatively easy to answer, and non-threatening. Questions covering sensitive issues should always be placed late in the questionnaire as potential respondents may decide to terminate responding if they react negatively to these initial questions. As the section measuring mental health attitudes had to be placed before the literacy section, as motivated above, and attitudes towards mental illness may be regarded as sensitive, the logical placement of the demographic section was at the beginning of the questionnaire. It could be argued though, that the questions within the demographic section did not cover the usual "boring" items of age, gender, or ethnic group. Instead, it covered topics that were easy to answer, obviously related to the aim of the study, and not threatening or complicated, such as respondent professional affiliation, number of years in the HR field, and health facilities available in the workplace. These could also be perceived as interesting, given that questions eliciting respondent opinion about certain mental health and work characteristics were set within this section. Finally, Babbie & Mouton (2001) report that less educated respondents are more influenced by the order of questionnaire items than those with more education. It was assumed that sample members for this study had at least some tertiary education, and therefore may be less influenced by item order.

3.9.3 Pilot study

Once the draft questionnaire had been duly adjusted, it was pre-tested with a group of 42 undergraduate ***students*** at the University of Stellenbosch, Faculty of Health Sciences. This is well within the recommended pre-test sample size of 20 to 50 respondents (Bourque & Fielder, 1995, p. 87; Rea & Parker, 1992, p. 36). The pre-test sample comprised a mixed group of third- and fourth-year physiotherapy, occupational therapy, oral hygiene and nursing students. While it is not recommended that a pre-test group be a representative sample or precisely selected in any way, it should nonetheless bear a reasonable resemblance to the study's actual working population, particularly regarding age, gender, language, educational background and ethnic group (Babbie & Mouton, 2001; de Vaus, 1996; Rea & Parker, 1992). The aim of the pre-test is not to enable inferential statistics, but to give feedback on the overall quality of the questionnaire's construction. Therefore, as this group were of mixed gender, language, educational background and ethnic group membership, it was deemed reasonably similar to the study population. All fell within the same age group (i.e., 20 to 30 year-old), but based on the other similarities with the study population, this obvious incongruency with expected population characteristics was considered acceptable.

It needs to be noted that the ***different study directions*** the pre-test group were taking meant not all had been exposed to psychiatry or psychology or had any experience in mental health matters. All did have some level of tertiary education though, which may, arguably, be considered to resemble the study population regarding educational level. Moreover, the group was not biased in that they did not volunteer to take part but were requested to do so during one of their course prescribed lecture periods. In keeping with ethical guidelines though, none were coerced and non-participation did not hold any negative consequences or penalty (Aguinis & Henle, 2002).

3.9.4 Results of the pilot study

Feedback from this group was that the measuring instrument was ***interesting and comprehensive***, not too lengthy or boring, and acceptable. It had ***face validity***, that is, it logically measured knowledge and beliefs about mental illness and the mentally ill (Babbie & Mouton, 2001). However, some of the statements in the attitudes section were in the ***negative*** and were therefore more difficult to respond to than other statements. Again, as mentioned above, the statements within this section were taken directly from a psychometrically sound questionnaire and could not be changed without compromising the already established validity and reliability. The general opinion was that these statements were ***clear*** and not ambiguous (although required more attention) and could be included as was. A last comment was that it was not clear whether the questions in the mental health literacy section pertained specifically to

the vignette or to any mental disorder in general. The ***wording*** of the statements measuring whether respondents could recognise and identify mental illness was therefore changed to include the name of the person as described in the vignette (see Questions 54 to 57). Also, all ***instructions*** in this section were revised to include the name of the person as described in the vignette, thereby relating statements that followed to the case study.

3.10 Coding and data entry

Returned questionnaires were first ***reviewed*** for completeness, legibility and therefore suitability for entry into the computer databank. All received questionnaires were serially marked with an ***identifying number***. Those that had not been completed or had complete sections left unanswered were not regarded as suitable for data entry.

3.10.1 Post-coding returned questionnaires

All returned questionnaires judged suitable were then post-coded for entry into and use in a statistical programme. The majority of responses were in the form of ***categorical data***, that is, the data consisted of frequencies of responses that fell into fixed categories (Howell, 1999). These, in turn, were attached to numerical scales as already mentioned. Responses on these numbered scales were entered directly into the computer databank. Therefore, a response of 1 on a numerical scale was entered as 1 within the databank, 2 as 2, and so forth. Recoding of responses to questions which provided an "Other" option was not necessary, as these were entered using the corresponding number as provided on the original questionnaire.

One question (Question 6) provided ***quantitative data***, that is, representing a score along a continuum (Howell, 1999). This question inquired about the year in which respondents had received their most recent HR qualification. The exact year as provided by respondents was entered into the statistical programme in the form of four digits, for example, 1996.

Two ***open-ended*** questions were also included in the measuring instrument. These related to the academic institution where respondents had received their most recent HR qualification (Question 5) and respondents' naming of the diagnosis in the vignette presented with (Question 58). All possible responses to Question 5 (academic institution) were listed separately in the order they were received and then coded 01 to 29, where each number corresponded with a particular institution. For example, all University of the Witwatersrand Business School responses were consistently coded as 01 and Stellenbosch University responses were coded as 04. All responses indicating an international qualification were coded as 29, irrespective of the particular institution named. Responses to Question 58 (diagnosis) were post-coded according to pre-determined categories, where 1 = correct diagnosis given (e.g., depression); 2 = could

identify the correct category of disorder (e.g., mood disorder) or that it was a mental illness; 3 = attributed behaviour in vignette to stress/ burnout/ or overload; and 4 = incorrect diagnosis given or respondent did not know.

Finally, two questions made provision for ***multiple responses*** (i.e., respondents could select as many of the provided options as was relevant to them). These two questions (Question 2 and Question 8) were post-coded by separately assigning a number to each option provided, where 1 = option selected and 2 = option not selected. Therefore each of the response options within these two questions was treated as an item in its own right.

3.10.2 Statistical package

Computer-aided statistical tools have been available to social researchers since the 1960's and have greatly influenced the development of quantitative empirical social science (Scarbrough & Tanenbaum, 1998). The study reported on here was conducted from a quantitative research paradigm in that an emphasis was placed on ***quantitative*** (i.e., numerical representation) measurement and analysis (Babbie & Mouton, 2001). All data received and accordingly coded was therefore entered into a standard statistical package, the ***Statistical Package for the Social Sciences*** (SPSS for Windows, Release 10.0). SPSS was initially designed for mainframe computers but has been adapted for personal computer use. It allows for complex and sophisticated analysis techniques, and is especially efficient and quick in producing cross-tabulations (Hakim, 2000; Rea & Parker, 1992). This programme was selected as it is primarily geared to quantitative analysis in the social sciences and offers a comprehensive, multi-faceted statistical programme (Rea & Parker, 1992). SPSS is menu-driven and highly user-friendly, with a tutorial on using the package and on understanding certain statistical procedures (SPSS Inc., 1999). It also features context-sensitive help screens. This programme is regarded as highly reliable (Howell, 1999) and is available on the University of Stellenbosch's internal computer network to be downloaded for use on personal computers.

3.11 Data analysis

As with all descriptive research, this study set out to determine ***what*** the current state regarding HR practitioner mental health literacy and attitudes is, not why it is so. De Vaus (1996) notes that accurate and thorough ***description*** is the basis of sound theory as it enables attempts to explain. Furthermore, that good description provides a stimulus for further research, for explanation and ultimately theory construction. However, he points out that the key role of descriptive research is to highlight the existence and extent of social problems, which in turn can stimulate social action. Also, that a competent description makes it more difficult to deny the existence of problems. In the context of this study, data analysis needed to present an

accurate and thorough description of mental health literacy levels and attitudes. Only then could the aims of stimulating interest, directing further research and motivating action from industry based on study results, be fulfilled.

The methods employed to analyse study data were therefore mostly descriptive in nature. As generalisations were to be made from the sample to the general HR practitioner population, inferential statistics were also determined. ***Descriptive statistics*** are methods for presenting quantitative descriptions in a more manageable form and help to describe variables or the association between different variables (Babbie & Mouton, 2001). Descriptive statistics were therefore used to summarise patterns in responses of the study sample. ***Inferential statistics***, or tests of significance, enable inferring from the sample to the population (de Vaus, 1996). This study therefore employed inferential statistics to determine whether the patterns described in the sample are likely to apply in the population from which the sample was drawn.

3.11.1 Descriptive statistics: univariate analysis

The most commonly used descriptive statistics are frequency distributions, measures of central tendency and dispersion, and contingency tables (de Vaus, 1996; Rea & Parker, 1992; Sapsford, 1999). The simplest and most interpretable description of data is to present it in table form, and ***frequency distributions*** are the most elementary *tabular* presentation of data (Sapsford, 1999). These are used in univariate analysis (i.e., one variable being studied) and summarise the frequency of responses for each category of the variable (de Vaus, 1996). In order to eliminate any potential distortions due to missing cases (i.e., where a respondent did not respond to a particular question in the measuring instrument), the *adjusted frequencies* as provided by SPSS were used in this study.

Frequency data can also be presented in *graphical* form, for example bar graphs, histograms, frequency polygons and pie charts (de Vaus, 1996; Rea & Parker, 1992). This study mostly made use of nominal or ordinal levels of measurement, therefore bar graphs and pie charts were used to display frequency information. *Bar graphs*, useful for all levels of measurement, plot the categories of a variable along the horizontal axis and the frequency of responses to the variable along the vertical axis. *Pie charts*, or circle graphs, are particularly useful to display percentages or proportions of the whole and are most often used for nominal or ordinal data. With this method the 360 degrees of a circle are proportionally divided among the variable categories. The magnitude of variable categories is therefore visible at a glance.

The mean, mode and median are measures of ***central tendency*** that describe a group in terms of the average, or most typical, response (de Vaus, 1996). The *mode* refers to the single most

common response, or the largest category of responses, and is used with nominal variable (Sapsford, 1999). Ordinal variables use the *median* as the average measure (de Vaus, 1996). After all cases have been ranked from low to high, the category to which the middle person belongs is the median category. The cumulative percentage just past 50%, as provided by SPSS, indicates the median. Interval or ratio variables use the arithmetic *mean* as measure of central tendency (Sapsford, 1999). The mean is calculated by dividing the sum of all values by the number of cases. This is the most common average measure, however, it is influenced by extreme cases.

As this study used mostly ordinal variables, one would expect that the median be the preferred measure of central tendency. However, Rea and Parker (1992) caution against this and advocate the use of the ***mean for scaled frequency distributions***, particularly when using the Likert scale. This is because the mean provides more information than the median on a scale rating from highly positive to highly negative and which also provides a neutral option. Using, for example, a 5-point Likert scale, an arithmetic mean of 2.57 gives more information than a median of 3. The latter would correspond with the neutral category, whereas the former would imply an average response slightly more positive than neutral. Furthermore, in a series of similar responses, an overall mean may be accepted as summary measure of the subject under study. This study therefore used the *arithmetic mean* to indicate averages, unless otherwise stated.

The ***dispersion*** of cases is also an important measure when describing sample responses, and measures most often employed for this purpose are the *variation ratio*, the *decile range*, and the *standard deviation* (de Vaus, 1996). As this study mostly made use of the mean to describe central tendency, the standard deviation was consequently used to describe the dispersion of the observations around the mean.

3.11.2 Bivariate and multivariate analysis

This study was concerned with describing more than one variable, therefore bivariate and multivariate statistics were also employed to simultaneously analyse various variables.

The simplest techniques used were ***contingency tables*** of frequencies. This method provides information on the relationship between two variables derived by, in this case, SPSS-generated cross-tabulations of two variables (Rea & Parker, 1992). The independent variable is placed as the column variable and the dependent variable as the row variable.

De Vaus (1996) advises that although tables provide a wealth of information, they may not always be appropriate. This is especially so when dealing with variables with a large numbers

of categories. Tables multiply the categories of the independent variable with those of the dependent variable to form the table cells. Therefore, excessive categories result in huge numbers of cells, which make the table uninterpretable. Also, with smaller samples, this may result in some cells being "empty", in that no cases fall within a particular intersection of a row with a column. This complicates meaningful interpretation of the table. It is therefore a rule of thumb that tables should only be used when variables have less than seven or eight categories each (de Vaus, 1996, p. 164). This study took cognisance of the rule of thumb and heeded further advice to *combine* some categories for variables with more than seven subgroups.

Various types of ***correlation co-efficient*** are used to give a description of the character of the relationship between two variables, depending on the level of measurement used. The *character* of relationship refers to the strength, direction, and nature of association (de Vaus, 1996). Large differences between subgroups (i.e., categories of the independent variable) imply a *strong* relationship, that is, where belonging to a certain subgroup makes a big difference to their characteristics on the dependent variable. A correlation co-efficient will always be between -1 and +1, where 0 means no association and ±1 means a perfect positive or negative association (de Vaus, 1996). The absolute size therefore reflects the strength of the association. The *direction* of the relationship for ordinal or interval variables may also be described in terms of being either positive or negative. A positive relationship occurs where respondents score high, or low, on both variables. However, if those who score high on the one variable are more likely to score low on the other, a negative relationship exists. The association between ordinal or interval variables may furthermore be described in terms of their *nature*, that is, they can be either linear or curvilinear. A linear relationship refers to a straight relationship, where comparisons across subgroups show that percentages change in a consistent direction. A curvilinear relationship occurs where comparisons across categories of the independent variable show that the change in percentages is not consistent.

It is important to note that an association between two variables does not prove that they are causally related. Other statistics are needed to determine a causal relationship. As this was a descriptive study, it was not concerned with these measures. Moreover, different measures of association are appropriate depending on **the *level of measurement*** of the variables under study.

When both variables are nominal, or where one is nominal and the other is ordinal, chi-square and lambda, Cramer's *V* or theta may be used to determine the association between variables set in cross-tabulations (de Vaus, 1996). When both variables are ordinal, chi-square and lambda, gamma, Kendall's tau or Sommer's *d* may be used (Babbie & Mouton, 2001). Where one variable is ordinal or nominal and the other variable is an interval measure, eta, Kendall's tau or

Spearman's rho may be used. When both variables can be measured on an interval or ratio scale, however, the most appropriate measure of association would be Pearson's correlation co-efficient (r) in a regression analysis.

This study used ***chi-square***, ***Cramer's V*** and ***gamma*** to measure association in tables where only nominal and/or ordinal variables were used. Aggregated or group mean scores were compared using ***eta*** or ***Pearson's r***.

3.11.3 Inferential statistics

This study surveyed a sample of HR practitioners who are members of the SABPP in order to describe their literacy and attitudes regarding mental illness and the mentally ill. However, the aim of the study was to ultimately know more about the mental health literacy and attitudes of HR practitioners in South Africa. The research design and methods employed in this study were therefore selected on the basis of their being able to facilitate the extrapolation of patterns found in the sample to likely patterns in the population from which the sample was drawn. Inferential statistics refer to the statistical measures used for making ***inferences*** about the population based on the interpretation of sample findings (Babbie & Mouton, 2001; de Vaus, 1996; Rea & Parker, 1992).

The measure of sampling error with the associated components of confidence interval and level of confidence, as described in the discussion on selecting the sample size in 3.5.5, act as inferential statistics with ***univariate data*** (de Vaus, 1996). The already stated 95% confidence level and 5% confidence interval for this study allow generalisations to be made from the sample to the population as the sample was drawn from the population about which inferences were made and simple random sampling was employed (Babbie & Mouton, 2001). It is noted, however, that inferential statistics only refer to sampling error, not non-sampling error. Generalisations to the population were therefore made with cognisance of the role that non-sampling error may play.

Inferential statistics for ***bivariate and multivariate data*** entail tests of significance (Babbie & Mouton, 2001). These statistics help to determine whether a given association between two variables is significant and therefore worth reporting.

The most frequently used test of statistical significance when using nominal data is the ***chi-square test*** (Babbie & Mouton, 2001; de Vaus, 1996; Rea & Parker, 1992). Although chi-square is the only significant test available for data measured on the nominal level, it can also be used for ordinal and interval scale data that has been categorised and presented in a contingency

table, as was done in this study. The ***Mann-Whitney U-test*** is more suitable when a dichotomous nominal independent variable is included in the analysis, while ***one-way analysis of variance*** (*F*-test) is used with interval data. The non-parametric ***Kruskall-Wallis test*** for significance may be used for nominal and/or ordinal data where no assumptions are made about symmetry.

The chi-square test is primarily concerned with the differences in ***observed frequencies*** in the sample and those that may be ***expected*** if there was no true difference among the categories of variables (Kerlinger, 1986). It therefore seeks to identify whether the observed differences are real or the result of sampling error. The calculation of the chi-square statistic (χ^2) is expressed as (Rea & Parker, 1992, p. 194):

$$\chi^2 = \sum \frac{(f_o - f_e)^2}{f_e}$$

Under the assumption that there is no difference, f_o = the observed frequency in each cell and f_e = the frequency expected in each cell. A ***table of critical chi-square values*** is needed to interpret the calculated chi-square (see Appendix F). If the calculated chi-square equals or is greater than the critical chi-square from the table, the differences among the cells may be regarded as a real relationship between the variables and not the result of random sampling error (Kerlinger, 1986). The appropriate level of significance and the degrees of freedom are needed to identify the critical chi-square for the contingency table. The significance level is usually accepted as 5% or 1%. This study used the ***5% level***.

Degrees of freedom (*df*) is a statistical concept that, in the context of chi-square, refers to the possibilities for variation within a statistical model. For chi-square, the formula for the degrees of freedom reads (Babbie & Mouton, 2001, p. 483):

$$df = (r - 1)(c - 1)$$

where r = the number of categories of the dependent variable (i.e., rows) and c = the number of categories of the independent variable (i.e., columns). Using the table of critical chi-square values, a calculated chi-square of 14.78 with *df* of 8 at the 5% level of significance, is, for example, less than the critical chi-square value of 15.507 (see Appendix F). This may be interpreted as indicative of sampling error rather than a statistically significant relationship between variables (Sapsford, 1999).

The use of chi-square is restricted in that it is more reliable as the overall sample size increases. Rea and Parker (1992, p. 198) mention a general rule of thumb that each cell in the contingency table should contain an expected frequency of at least 5 cases. If the expected frequency is less than 5 in any one cell, categories should be merged where reasonably possible (Sapsford, 1999). Tables with only two categories of variables (e.g. 2 x 2 tables) do not allow for merging of categories. In such cases, where expected frequencies are less than 5 in any one cell, ***Fisher's Exact Test*** was used in this study (Rea & Parker, 1992, p. 199).

3.12 Summary

This chapter discussed the research and statistical methodologies employed in the study. The research problem, objectives and assumptions were outlined, and the research design was described. A detailed description of the population and sampling method was provided, as well as that for the compilation and use of the research instrument. Particular attention was given to the measurement of mental health literacy and attitudes, and the use of vignettes in survey research. The statistical analyses of research data, including the use of frequency distributions, correlations, and the tests of significance, were described.

In chapter 4, the analyses of the results will be provided, reporting on the demographic, work and HR training characteristics of the study sample. Findings relating to the mental health literacy of the sampled HR practitioners, as well as their attitudes towards mental illness and the mentally ill, will be presented and briefly discussed.

Chapter 4

"The outcome of any serious research can only be to make two questions grow where only one grew before."

Thorstein Bunde Veblen (1857–1929)

RESULTS AND INTERPRETATIONS

4.1 Introduction

The previous chapter described the research strategy and methodology of this study. The research problem and objectives were outlined and the assumptions to be investigated were stated. Information was provided on the research design employed, the sampling method used, as well as the research population. The survey instrument was described, with particular attention given to the measuring of attitudes towards mental health, mental health literacy, and the use of vignettes. The statistical methods of the study were expounded on, including the coding, capturing and statistical analysis of data and the accepted levels of significance.

This chapter provides information on the study findings. Guided by the research questions and assumptions, particular attention is given to fulfilling the research objective of determining the mental health literacy and attitudes of HR practitioners in South Africa. The response rate and respondent demographical information serve as a basis for interpreting and applying the attitude and literacy results, and are therefore discussed in some detail. Following this, the research questions and corresponding assumptions are responded to in the sequence stated in chapter 3. Mental health literacy findings are presented for respondents as a group and for each of the three vignettes used (i.e., depression, panic disorder, and alcohol abuse). The attitudes of the surveyed HR practitioners towards the mentally ill are described in general and in terms of the four attitude subscales of the measuring instrument (i.e., authoritarianism, benevolence, social restrictiveness, and community mental health ideology).

4.2 Response rate

An initial *sample of 900 respondents* was randomly drawn from the membership list of the South African Board for Personnel Practice (SABPP). Of the 289 returned questionnaires, only 271 were complete and usable for data entry, yielding a response rate of 30%. Even though this may be considered an acceptable response rate for a sample survey research design, it did not yield sufficient responses as determined at the onset of the study to be necessary for data analysis. A minimum of 300 questionnaires needed to be returned, roughly 100 for each

vignette, to enable meaningful analysis of data and to be able to make inferences from the sample to the study population (see 3.5.5 in chapter 3).

A *second round of random sampling* was therefore deemed necessary. The same sampling frame was used to draw a further 300 HR practitioners, using the same method as with the first round of sampling. Sampling was started at the exact point within the list of random numbers as where it had ended with the first round. The total sample size was hereby increased from 900 to 1200, and considered as one sample.

With the second round of sampling, 102 questionnaires were returned, of which 97 were suitable for data entry. These were added to the initial set of returned suitable questionnaires, which then totalled 368, bringing the ***total response rate for this study to 31%.*** Whereas the total sample size (i.e., n = 1200) amounted to 49% of the target population, respondents represented 15% of the SABPP membership, given the actual number of members at the time of sampling (N = 2454). The slight improvement in response rate of the second round of sampling could be attributed to the timing, as the first set had been mailed during the last quarter of 2002, whereas the second round went out early in the first quarter of 2003. Mailing survey questionnaires at the end of the year may be influenced by delays in postal systems and absences due to holidays (de Vaus, 1996).

Analysis of data included comparing results from the three vignettes referred to in the mental health literacy section of the measuring instrument. For this reason a minimum of 100 respondents was needed for each of the three vignettes. Sufficient questionnaires were returned regarding the depression and panic disorder vignettes, where 134 (36.4% of responses) and 137 (37.2% of responses) usable questionnaires were received respectively. Only 97 usable questionnaires concerning the alcohol abuse vignette were returned, contributing towards 26.4% of the total responses (see Figure 4.1). Even though this was marginally less than the required minimum of 100, it was deemed sufficient to be included in the analysis of data.

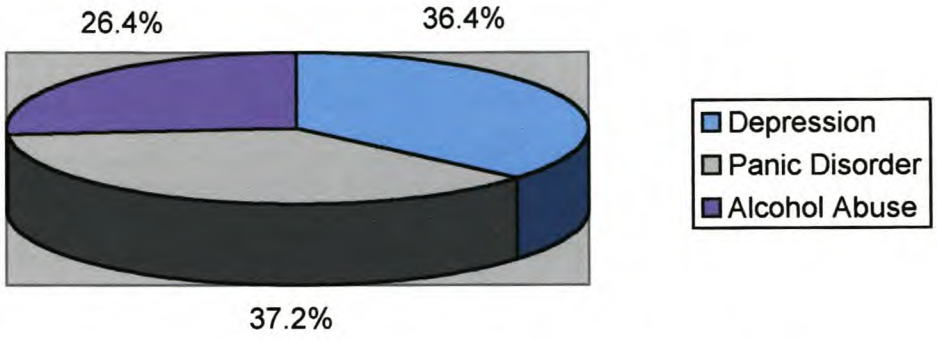

Figure 4.1 Distribution of respondents included in the study across the three vignettes

To test whether the two rounds of sampling could be considered as *one sample*, frequency scores on all the demographic questions, the aggregated attitude subscales, and the mental health literacy recognition and identification questions where compared. Data in the combined datafile was split into two groups using identification numbers, and frequencies were cross-tabulated. No significant differences were found between the two groups after performing chi-square analysis, with significance levels ranging between $p = 0.160$ (for registration level) and $p = 0.889$ (for academic institution where most recent HR qualification had been obtained, using recoded data). The combined responses from the first and second rounds of sampling were therefore considered as one sample for all further analysis and interpretation of findings, as reported below and in chapter 5.

4.3 Demographic and work characteristics of respondents

The demographic and work variables reported here pertain to the randomly selected respondents drawn from the SABPP membership list who returned completed questionnaires. The target population for this study is personnel practitioners in South Africa, as represented by SABPP members at the time of sampling. However, it needs to be remembered that not all personnel practitioners are members of the SABPP. Also, that not all SABPP members were included in the study, and not all of those who were selected participated in the study. The findings discussed under this section are relevant to the characteristics of the **respondents**, defined as all those who were randomly selected from the SABPP membership list for participation in the study and whose responses were entered for data analysis. However, as probability sampling was employed, it may be expected that the respondents are representative of the study population. It is therefore necessary to first look at the characteristics of this population.

The SABPP generously provided actual membership figures for the year in which the membership list was used as sampling frame, that is 2002. **SABPP membership** figures for this period consisted mainly of the level Practitioner, who were in turn mostly registered as Generalists, as described in chapter 3 under 3.5.1. A finer breakdown of the registration level of members shows that 69% were Personnel Practitioners, 23% Associate Practitioners and 8% Students (i.e., Candidate and Candidate Associate Practitioners). Furthermore, 65% were registered as Generalists, 13% as Training and Development Specialists, 5% as Industrial Relations Specialists, and 3% as Personnel Services Specialists. A further 2% or less of members were registered in each of the remaining areas of specialisation (H. van Rensburg, personal communication, 14 July 2003).

The *registration* level and area of specialisation of **respondents** corresponded to some extent with that of the target population, although the Practitioners were over-represented (78.8%) and the Associates under-represented (16%). The proportion of Candidates (2.4%) and Candidate Associates (1.9%) amongst the respondents was also less than that in the target population, while 0.8% of respondents did not indicate their level of registration. As with actual membership figures, most respondents were registered as Generalists (76.6%). The figures for those registered in the different areas of specialisation fairly resembled actual SABPP membership figures for the year 2002, although 2.2% did not indicate a category of registration (see Table 4.1).

Table 4.1 Registration categories of respondents and actual SABPP corresponding figures

Registration category	**Respondent frequency**	**Respondent %**	**SABPP %**
Generalist	282	**76.6**	65
Training and development	22	6.0	13
Industrial relations	13	3.5	5
Recruitment and selection	10	2.7	3
Personnel services	8	2.2	2
Education and research	8	2.2	2
Psychologiae	3	0.8	2
Employee Assistance	0	0.0	1
Assessment centres	2	0.5	2
No response	8	**2.2**	NA

Respondents generally had many *years of experience* working within the HR field and were highly *qualified*. Two thirds (66.1%) had worked for 16 years or more in HR (see Table 4.2) and more than four fifths (82.8%) had obtained at least an under-graduate degree, with more than one half (58.6%) holding a post-graduate qualification (see Table 4.3). This would be expected given the requirements of registration with the Board, and that most SABPP members are, and most respondents were, registered as Practitioners.

Table 4.2 Respondents' years of experience working in the HR field

Number of years	**Frequency**	**%**
0 - 5 years	11	3.0
6 - 10 years	45	12.2
11 - 15 years	69	18.8
16 - 20 years	79	**21.5**
More than 20 years	164	**44.6**

Table 4.3 Respondents' highest academic qualifications

Qualification	**Frequency**	**%**
Matric (Grade 12)	4	1.1
Diploma	58	15.8
Degree	89	**24.2**
Honours degree	94	**25.5**
Masters degree	98	**26.6**
Doctorate	20	**5.4**
Post-doctorate	4	**1.1**
Other	1	0.3

As would be expected, respondents' years of experience was found to be associated with registration level. Practitioners were found to have worked longer in the HR field than Associates or Candidates (χ^2 = 27.8; *df* = 16; p = 0.033). Practitioner and Associate Practitioners also reported having higher academic qualifications than Candidate or Candidate Associate Practitioners (χ^2 = 68.91; *df* = 28; $p < 0.0001$). As may be expected, SABPP members who are therefore registered at higher levels tend to have more advanced tertiary qualifications than those at lower levels, as supported by the fairly strong and highly significant association between these two variables (*gamma* = -0.437, $p < 0.0001$). The direction of

association between these variables should be interpreted in the context of the order of the categories for items within the questionnaire (see 3.10.1 in chapter 3 and the wording of the original items in Appendix C). This applies for all analysis of association as reported within this chapter.

Respondents were also requested to name the *academic institution* where they had received their *most recent HR qualification*. This was an open-ended question, and resulted in 29 institutions being post-coded for data entry, including both local and international universities, technikons, business schools and organisations such as the Institute of People Management (IPM) and the South African National Defence Force (SANDF). Graduates of the University of South Africa (20.6%) and Rand Afrikaans University (14%) were well represented amongst the respondents, although a fair amount had also obtained their most recent HR qualification from the University of Pretoria (8.6%), the IPM (6.9%) and the University of Stellenbosch (6.6%). See Appendix G for a complete breakdown of academic institutions as indicated by the respondents who replied to this question (n = 349). All international institutions were combined into one category, but included universities, business schools and other training bodies in the United Kingdom, the United States and other European states (e.g., Netherlands).

The original list of 29 academic institutions was *recoded into three categories*, namely: (1) university, (2) technikon and college (including the IPM and SANDF), and (3) international. Of those who had responded to this question, 270 had received their most recent HR qualification from a university (77.4%), 67 from a technikon or college (19.2%), and 12 from an international institution (3.4%). The academic institution where respondents had received their most recent HR qualifications was found to be associated with their registration level, with Practitioners and Associate Practitioners accounting for the largest proportions of those with university or technikon and college qualifications, being 81.9% and 12.6%, or 62.7% and 34.3%, respectively ($\chi^2 = 32.55$; $df = 8$; $p < 0.0001$). It would therefore appear that SABPP members in higher levels of registration tend to be more highly qualified than those in lower levels, although this was a fairly weak but highly significant association (Cramer's $V = 0.216$; $p < 0.0001$).

The *year* in which the *most recent HR qualification* had been obtained ranged from 1964 to 2002, with a mean year of 1993 and a standard deviation of 7.57. This was found to be associated with years of experience in the HR field ($F = 3.10$; $df = 32$; $p < 0.0001$), with those qualifying in earlier years reported having more experience than those with more recent qualifications ($eta = 0.490$; $p < 0.0001$).

Over a third of the respondents were employed in companies with a *workforce* of 1000 or more people (39.2%), while just under a fifth were in the employ of companies with 100 or less employees (17.4%) or between 101 and 400 employees (17.7%) respectively (see Table 4.4). It should be noted that some respondents selected the 100 or less category but added in writing that they were self-employed as consultants. It is possible that other respondents are similarly employed and that the figure for this category may be an over-representation.

Table 4.4 Workforce size of organisations employing respondents

Number of employees	**Frequency**	**%**
100 or less	64	**17.4**
101 - 400	65	**17.7**
401 - 700	41	11.2
701 - 1000	53	14.4
1000 or more	144	**39.2**

More than half the respondents had some form of *employee assistance or wellbeing* programme available on site to care for the needs of troubled employees (59.8%) (see Table 4.5). This figure is slightly higher than the reported 45% of large companies in South Africa that have structured interventions to deal with employee's troubles (Sithole, 2001, p. 80). One explanation for this may be that the reported figure was published almost two years ago, and that more companies have implemented these programmes in the interim, as was the suggested trend. Having a general practitioner and/or nursing sister on site (54.1%) and an outside health contractor on call (31.3%) were also commonly reported. The percentages for positive responses to this question amount to more than 100, as this was a multiple response scale where respondents could select as many options as were relevant to their workplace.

Table 4.5 Health resources available at respondents' place of work

Health resource	**Yes %**	**No %**
Employee assistance/wellbeing programme	**59.8**	40.2
Psychologist	27.4	72.6
Social worker	27.4	72.6
Nursing sister and/or general practitioner	**54.1**	45.9
Outside contractor (psychologist, psychiatrist)	**31.3**	68.8
None	19.6	80.4

The availability of company *health facilities* was found to be associated with *workforce size*. Respondents from larger organisations more frequently indicated the availability of EAP's (χ^2 = 60.66; *df* = 4; $p < 0.0001$), psychologists (χ^2 = 36.69; *df* = 4; $p < 0.0001$), social workers (χ^2 = 38.57; *df* = 4; $p < 0.0001$), nursing sisters or general practitioners (χ^2 = 95.37; *df* = 4; $p < 0.0001$) and outside health contractors (χ^2 = 25.08; *df* = 4; $p < 0.0001$), while those from smaller companies more frequently indicated having no health facilities available for employees (χ^2 = 101.22; *df* = 4; $p < 0.0001$). Inferential statistics supported the finding that larger organisations more commonly have available the services of a nursing sister and/or general practitioner (*gamma* = -0.634; $p < 0.0001$) and an EAP (*gamma* = -0.527; $p < 0.0001$) than smaller companies. Furthermore, being in the employ of smaller organisations was strongly associated with having no health facilities on site (*gamma* = 0.698; $p < 0.0001$). Again, the direction of association should be read in the context of the order of item categories within the study questionnaire and the method of data coding.

Even though only 10.4% of the respondents indicated that they did not *refer employees* to company health resources as this was not applicable to them, a similar figure indicated that they did not refer employees to these resources at all (10.9%). Furthermore, 23.8% only rarely did so, with a further 31.1% only occasionally making use of these services (see Table 4.6).

Table 4.6 Frequency of referrals by respondents to company health resources

Referrals	**Frequency**	**%**
Never	40	**10.9**
Seldom	87	**23.8**
Occasionally	114	**31.1**
Frequently	80	21.9
Almost daily	7	1.9
Not applicable	38	**10.4**

Registration level was found to be associated with frequency of *referrals*. Practitioners made up the largest proportion of respondents who referred employees to company health resources frequently (76.3%) or almost on a daily basis (57.1%). However, when looking at figures within Practitioners as a group, 27.4% and 31.3% respectively indicated that they seldom or only occasionally referred to these facilities (χ^2 = 47.84; *df* = 20; $p < 0.0001$). The majority of Candidate Practitioners (57.1%) and Candidate Associates (66.7%) never referred to company health resources.

In **summary**, respondents were mainly registered as Personnel Practitioners, who in turn where mostly Generalists, as is the case with actual SABPP membership figures. The largest proportion were experienced and qualified practitioners, having worked at least 16 years or more in the HR field and with at least an undergraduate tertiary qualification. Most worked in large organisations and had available the services of some type of company health resource. However, referral to company health facilities was generally poor, with Practitioners making up the largest proportion of those who did refer employees.

The following section describes the feelings and beliefs of respondents about dealing with employee mental health issues at work. Attention is given to their feelings about adequateness of own training, the need to be able to deal with mental health/illness issues at work, as well as being supported by company structures, policies, and top management in dealing with mental health matters.

4.4 Views about dealing with employee mental health issues at work: overview

It is interesting to note that just under one half (48.7%) of all respondents felt that they were definitely or somewhat adequately *trained* to deal with mental health issues at work (see Figure 4.2). The inverse is that 45.6% in total felt that they were *not* adequately trained in this respect, while 5.7% were unsure. The majority also believed that there definitely or somewhat was a *need* for them being able to deal with employee mental health issues in the workplace (78%), with only 7.1% strongly disagreeing with this statement. Most also agreed that they were definitely or somewhat *supported by company policies* and structures (58.6%) and *top management* (59.9%) to deal with employee mental health issues, although more than a third did not agree that company policies (35.7%) or management (34.6%) supported their dealing with mental health/illness at work.

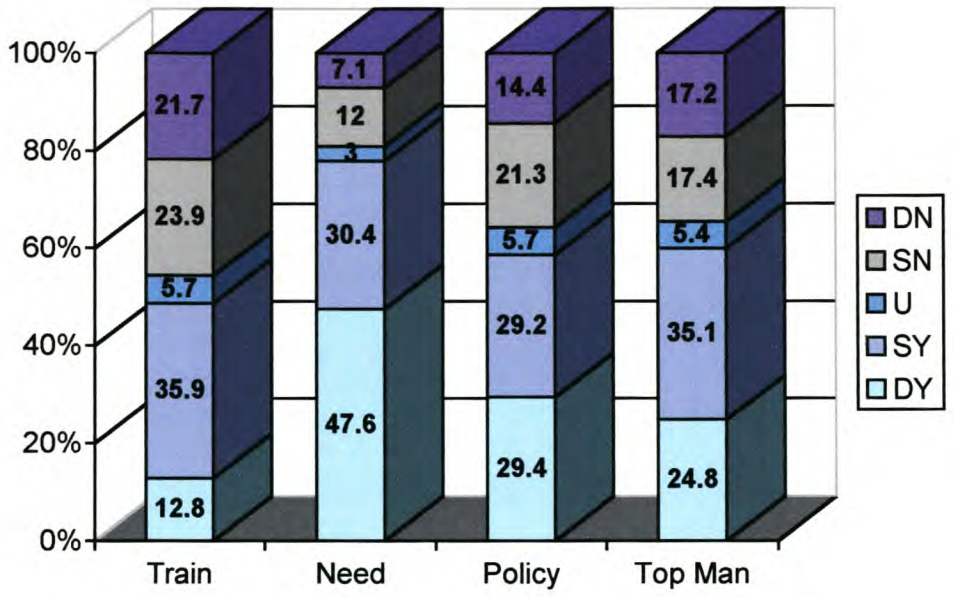

Figure 4.2 Respondents' views about dealing with employee mental health issues

Note. Train = feel adequately trained to deal with mental health issues at work; Need = feel there is a need to be able to deal with mental health issues at work; Policy = feel adequately supported by company policies and structures to deal with mental health issues at work; Top Man = feel adequately supported by top management to deal with mental health issues at work; DY = definitely yes; SY = somewhat yes; U = unsure; SN = somewhat no; DN = definitely no.

4.4.1 Views about feeling adequately trained to deal with mental health matters

Feeling adequately **trained** was found to be associated with *academic qualification*, with the majority of those with a matric (75%) or a diploma (58.6%) as highest academic qualification believing that they were definitely or somewhat not adequately equipped to deal with mental health issues at work ($\chi^2 = 43.04$; $df = 28$; $p = 0.034$). The largest proportion of those with undergraduate (48.3%) or honours (47.9%) degrees also felt that they were not adequately trained in mental health matters. On the other hand, most respondents holding a masters (62.3%) or a doctorate degree (65%) felt that they were adequately trained in this respect. An interesting finding is that one half (50%) of those with a post-doctorate qualification felt that they were somewhat adequately trained while the other half believed that they definitely did not have sufficient training in mental health matters. The finding of higher academic qualification being associated with increased feelings of being adequately trained to deal with mental health issues at work was a highly significant, albeit a fairly weak, relationship (*gamma* = -0.203; $p < 0.0001$).

4.4.2 Views about the need to be able to deal with mental health matters

Respondents' beliefs that there was a **need** for them to be able to deal with mental health issues at work were found to be associated with *academic qualification*. The majority of those who held only a matric (75%) did not believe that such a need existed while the majority of those with a diploma (69%), undergraduate (79.8%), honours (84.1%), masters (79.5%), or doctorate (80%) degree agreed with the need to be able to deal with employee mental health issues (χ^2 = 71.29; *df* = 28; $p < 0.0001$). The post-doctorates were once again equally split with one half agreeing that there was somewhat a need and the other half believing that there was somewhat no such need. One explanation for this finding may be that post-doctorate HR practitioners are likely to be employed in academic and/or executive positions. These positions are, however, arguably vital roleplayers in addressing mental health/illness issues in any organisation, including academic institutions (Sithole, 2001). The finding that belief in the necessity of being able to deal with employee mental health issues increased with higher academic qualification was significant, although this was a weak association (*gamma* = -0.185; $p = 0.003$).

Believing that there was a need to be able to manage mental health problems at work was also related to the frequency of *referrals* to company health resources. The largest proportion of respondents who referred employees to these resources on an almost daily basis (71.4%) definitely agreed with this statement, while 57.7% of those who strongly believed that there was no such need never or seldom referred employees (χ^2 = 63.54; *df* = 20; $p < 0.0001$). The association between a stronger belief in the need to be able to deal with mental health issues and an increase in referrals to company health facilities was a significant yet weak one (*gamma* = -0.182; $p = 0.004$).

Believing there was a need for being able to deal with mental health issues at work was also associated with respondents' feelings about the adequateness of their *training* to deal with such matters. More than three quarters (76.6%) of those who strongly believed that they were well trained in mental health matters also strongly agreed with this need, whereas a similar percentage (73.1%) of those who strongly felt that there was no such need also believed that they were definitely not adequately trained to deal with employee mental health issues at work (χ^2 = 97.55; *df* = 16; $p < 0.0001$). The association between strong beliefs in the necessity of dealing with employee mental health issues and strong beliefs in adequateness of own training was fairly strong and highly significant (*gamma* = 0.428; $p < 0.0001$).

4.4.3 Views about feeling supported by company policies and structures

Respondents who believed that they were supported by company **policies and structures** to deal with employee mental health issues generally had a better availability of *health resources* at their place of work. For example, 73.1% of those who definitely felt supported by policies and structures had an EAP available ($\chi^2 = 20.78$; $df = 4$; $p < 0.0001$), 64.5% had the services of a nursing sister or general practitioner on site ($\chi^2 = 15.05$; $df = 4$; $p = 0.005$), while 62.3% of those who definitely did not feel supported by company policies and structures had no health facilities available to employees ($\chi^2 = 17.48$; $df = 4$; $p = 0.002$).

4.4.4 Views about feeling supported by top management

Feeling supported by **top management** to deal with employee mental health issues was found to be associated with *referring* employees to company health resources, with 74.1% of respondents who indicated that they refer almost on a daily basis also reporting that they definitely felt supported by management ($\chi^2 = 48.48$; $df = 20$; $p < 0.0001$). Conversely, only 10% who felt that they definitely were supported by management never referred employees to company health resources.

In **summary**, even though the largest proportion of respondents indicated that they believed they were adequately trained to deal with employee mental health issues at work, more than one half (51.3%) did not feel adequately trained or were unsure. Feeling adequately trained was found to be associated with an increase in academic qualification. An overwhelming majority supported the notion of their being able to deal with mental health issues at work. This was found to be associated with higher academic qualification, increased referrals to company health facilities, and stronger beliefs about the adequateness of own training in mental health issues. Most respondents felt supported by company policies, structures and management to deal with employee mental health issues at work. Feeling supported by policies and structures was related to a better availability of company health facilities, while feeling supported by top management was related to an increase in the frequency of referrals to health facilities.

The rest of this chapter compares study findings with the research questions and assumptions set at the onset of this study. Assumptions referred to HR practitioner mental health literacy and attitudes. Research questions were also concerned with investigating whether mental health literacy differed for different mental illnesses, and whether any associations existed between respondent demographic and work characteristics and their mental health literacy and attitudes. These will be discussed under each section. Starting with Assumption 1, the following section therefore reports on respondent's ability to recognise mental illness.

4.5 Mental health literacy

The mental health literacy results will first be discussed by looking at group findings, and then a breakdown will be given relating to each of the three vignettes respondents were presented with.

Three sets of statements were used to assess the mental health literacy of respondents. The first section followed directly on the **vignette** and was aimed at determining whether respondents could *recognise* possible mental illness and correctly *identify* different disorders. The second and third set of statements assessed respondents' views about the *risk factors and causes* of mental illness, and beliefs about the best *treatment strategies* respectively.

4.5.1 Recognising mental illness

Determining whether HR practitioners could recognise mental illness was a stated research question for this study (see chapter 3). The first assumption to be tested therefore read:

> HR practitioners in South Africa do not *recognise* mental illness when confronted with a specific case study satisfying DSM-IV diagnostic criteria (i.e., either depression, panic disorder, or alcohol abuse).

4.5.1.1 Recognising mental illness: group results

In general, the largest proportion of respondents viewed the behaviour in the vignette as probably a **normal** response (34.2%) with a further 19.3% agreeing that it definitely was so (see Figure 4.3). The majority felt that the behaviour was definitely not or probably not typical of a **weak character** (82.4%). The majority were also of the view that a general **medical** condition, such as an ear infection, could not have led to the behaviour (56.4%), although 19.3% indicated that they were unsure about this. Even though the largest proportion of respondents indicated that that they believed the behaviour probably was typical of a **mental illness** (27.2%), almost a similar proportion felt that it probably was not (26.1%), while just over one fifth (20.7%) were unsure. Only ***6.8% agreed that the behaviour described in the vignette was definitely typical of a mental illness***. In total, only 34% believed that the described behaviour definitely or probably was a mental illness, even though the descriptions in the vignettes satisfied DSM-IV (APA, 1994) criteria for depression, panic disorder, or alcohol abuse.

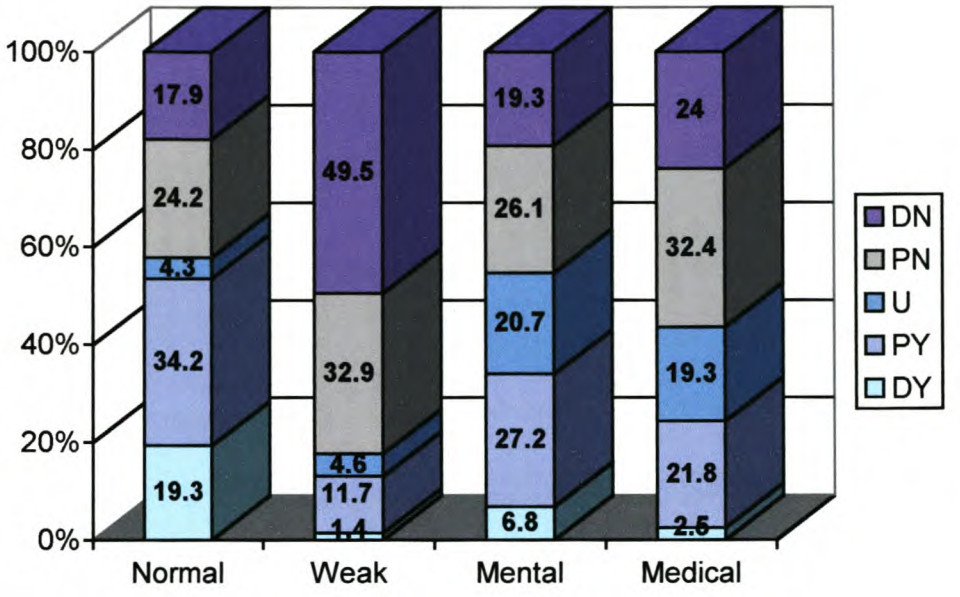

Figure 4.3 Respondents' ability to recognise mental illness

Note. Normal = a normal response; Weak = a weak character; Mental = a mental illness; Medical = a general medical problem; DY = definitely yes; PY = probably yes; U = unsure; PN = probably no; DN = definitely no.

4.5.1.2 Recognising mental illness: different disorders

The largest proportion of respondents who were presented with an alcohol abuse case study agreed that the behaviour probably or definitely was a **normal** response (59.8%), while one half of those with a depression case study indicated that it probably or definitely was not (50%) (χ^2 = 17.81; df = 8; p = 0.023). However, the majority of those with a panic disorder vignette (58.4%) agreed that it definitely or probably was a normal response (see Table 4.7).

Table 4.7 Viewing the behaviour in the vignette as a normal response

	Depression	**Panic disorder**	**Alcohol abuse**
Definitely yes %	14.2	**24.8**	**18.6**
Probably yes %	29.9	**33.6**	**41.2**
Unsure %	6.0	2.2	5.2
Probably no %	**30.6**	25.5	13.4
Definitely no %	**19.4**	13.9	21.6

The behaviour in the panic disorder (64.2%) and depression (56.7%) vignettes were most often rated as definitely not typical of a **weak character** ($\chi^2 = 75.03$; $df = 8$; $p < 0.0001$). The largest proportion of respondents who reacted to an alcohol abuse vignette felt less strongly about the behaviour not being typical of a weak character, with 40.2% indicating that it probably was not due to a weak character (see Table 4.8).

Table 4.8 Viewing the behaviour in the vignette as typical of a weak character

	Depression	**Panic disorder**	**Alcohol abuse**
Definitely yes %	1.5	0.0	3.1
Probably yes %	4.5	5.8	29.9
Unsure %	3.0	3.6	8.2
Probably no %	34.3	26.3	**40.2**
Definitely no %	**56.7**	**64.2**	18.6

Respondents with a depression vignette had contradicting views with almost equal proportions agreeing (41.8%) and disagreeing (41.0%) that the behaviour probably or definitely was typical of a **mental disorder** ($\chi^2 = 20.34$; $df = 8$; $p = 0.009$). Respondents with a panic disorder vignette were mostly unsure (29.9%) or felt that the behaviour probably or definitely was not indicative of a mental illness (42.4%). The vignette describing alcohol abuse was also rated by the majority of respondents who received this vignette as probably or definitely not typical of a mental illness (55.7%) (see Table 4.9).

Table 4.9 Viewing the behaviour in the vignette as typical of a mental illness

	Depression	**Panic disorder**	**Alcohol abuse**
Definitely yes %	**9.0**	5.1	6.2
Probably yes %	**32.8**	22.6	25.
Unsure %	17.2	**29.9**	12.4
Probably no %	**20.9**	**23.4**	**37.1**
Definitely no %	**20.1**	**19.0**	**18.6**

The majority of respondents rating a depression vignette felt that the described behaviour probably or definitely was not due to a general **medical** problem (73.9%) ($\chi^2 = 68.82$; $df = 8$; $p < 0.0001$). Most respondents with an alcohol abuse vignette were also of the opinion that the described behaviour probably or definitely was not due to a general medical problem (67%).

Conversely, the largest proportion of respondents with a panic disorder vignette felt that it probably was due to a general medical condition (40.4%), with a further 4.4% strongly agreeing with this statement. However, almost a quarter of the panic disorder respondents stated that they were unsure about the medical nature of the behaviour (23.5%) (see Table 4.10).

Table 4.10 Viewing the behaviour in the vignette as due to a general medical problem

	Depression	**Panic disorder**	**Alcohol abuse**
Definitely yes %	1.5	**4.4**	1.0
Probably yes %	6.7	**40.4**	16.5
Unsure %	17.9	**23.5**	15.5
Probably no %	**45.5**	18.4	**34.0**
Definitely no %	**28.4**	13.2	**33.0**

In **summary**, as a group, most respondents felt that the behaviour in the vignette was a normal response, while **only 6.8% agreed that it definitely was a mental illness**. The majority indicated that the behaviour described was not due to a general medical problem or typical of a weak character.

Regarding views about the different disorders respondents were presented with, the behaviour in the panic disorder and alcohol abuse vignettes was most often viewed as a normal response, while that in the depression vignette was most often seen as not normal. The majority in all three subgroups agreed that the behaviour was not typical of a weak character although this was least so with those who responded to the alcohol abuse vignette. This may indicate that HR practitioners as represented by respondents to this study are less sympathetic towards those who suffer from alcohol abuse than towards those with other mental disorders. Respondents in the depression vignette subgroup most often viewed the described behaviour as probably a mental illness, while the largest proportions in the panic disorder and alcohol abuse subgroups indicated respectively that they were unsure or that it probably was not a mental illness. Respondents were **poor at recognising mental illness**, with less than 10% in each of the three subgroups believing that the behaviour described in the vignette definitely was typical of a mental disorder. The panic disorder vignette was the case study most often rated as due to a general medical condition, with the depression vignette rated as least likely to be caused by a general medical problem. However, as described in chapter 2 of this study, depression could be due to a general medical problem.

The following section describes the associations obtained on comparing respondents' views about the behaviour described in the vignette and different respondent demographic and work variables.

4.5.1.3 Comparing ability to recognise mental illness with respondents' demographic and work characteristics

Bivariate analysis of frequencies showed that respondents' views about the behaviour described in the vignette being normal, typical of a weak character, or of a mental illness, were associated with their **demographic** variables pertaining to years of HR experience and highest academic qualification. The majority of respondents with less than 5 years (63.7%) and with 11 to 15 years (53.6%) of experience disagreed that the behaviour was a *normal* response, while the majority in all other years of experience categories agreed that it was ($\chi^2 = 28.43$; $df = 16$; $p = 0.028$). All respondents with a matric as highest academic qualification (100%) agreed that the behaviour was a normal response, as opposed to the 51.8% holding a diploma and the 75% holding a doctorate degree who disagreed with this statement ($\chi^2 = 53.23$; $df = 28$; $p = 0.003$).

Respondents with a matric were evenly split with 50% agreeing that the behaviour in the vignette was typical of someone with a *weak character* and the other half agreeing that it probably was not. The overriding majority of those with a doctorate (95%), however, felt that the behaviour was not typical of a weak character ($\chi^2 = 56.97$; $df = 28$; $p = 0.001$).

Being able to recognise the behaviour described in the vignette as typical of a *mental illness* was associated with years of HR experience and academic qualification. Most respondents with less than 5 years of experience agreed that it was a mental illness (54.6%), most of those with 5 to 10 years (60%) and 11 to 15 years (50.7%) disagreed, while most of those with 16 to 20 years (55.7%) and more than 20 years (59.4%) felt it probably was or were unsure ($\chi^2 = 27.28$; $df = 16$; $p = 0.038$). The majority of respondents who held a matric as highest academic qualification (75%) were unsure whether the behaviour in the vignette was typical of a mental illness, although 70% of those with a doctorate agreed that it was ($\chi^2 = 53.17$; $df = 28$; $p = 0.003$).

Comparing frequencies of views about the behaviour described in the vignette and **work** variables revealed that these were associated with frequency of referrals made to company health resources, beliefs about being adequately trained in mental health matters, and beliefs about the need to be able to deal with employee mental health issues at work. The majority of respondents who indicated that they never referred to company health resources (65%) agreed

that the behaviour was a *normal* response as opposed to the 60.5% who almost daily referred employees to health resources believing that the behaviour was not a normal response (χ^2 = 43.76; df = 20; p = 0.002).

The majority of respondents who felt that they were adequately trained to deal with mental health issues at work (54.9%) agreed that the behaviour in the vignette was definitely not typical of a *weak character*, while those who believed that they were not adequately trained were divided into two similar sized groups in terms of agreeing that it was a normal response (48.9%) and disagreeing (44.7%) with this statement (χ^2 = 30.35; df = 16; p = 0.016). Most respondents who agreed that there definitely existed a need for them being able to deal with mental health issues at work (62.3%) agreed that the behaviour was definitely not due to a weak character, while less of those who indicated that no such need existed (46.2%) felt that the behaviour was not typical of a weak character.

The largest proportion of those who never referred employees to a company health facility disagreed that the described behaviour was typical of a *mental illness* (45%), while the largest proportion of those who frequently referred agreed (42.6%) with this statement (χ^2 = 56.81; df = 20; $p < 0.0001$). The largest proportion of respondents who agreed that there definitely was a need for their being able to deal with employee mental health issues at work (29.7%) believed that the behaviour probably was due to a mental illness, while the majority of those who where unsure about this need (63.6%) were also unsure about whether the behaviour in the vignette was typical of a mental illness or not (χ^2 = 38.46; df = 16; p = 0.001).

In **summary**, respondents who agreed that the behaviour described in the vignette was a normal response generally had more years of experience in the HR field but tended to have lower academic qualifications. Those with lower academic qualifications also tended to be more of the view that the behaviour was typical of a weak character. However, respondents with very few years of experience (< 5) and those with many years of experience (> 16) tended to agree that the described behaviour was a mental illness, although many of these respondents were unsure about this. Again it would appear that academic qualification plays a role as those with lower qualifications tended to be unsure about whether the described behaviour was a mental illness while those with higher qualifications agreed that it was.

Viewing the behaviour in the vignette as a normal response was found to be associated with less frequently referring employees to company health resources and with agreeing about not being adequately trained to deal with employee mental health issues at work. Respondents who felt adequately trained to deal with mental health issues at work tended to view the behaviour in the

vignette as not typical of a weak character. Those who agreed that there existed a need for them to be able to deal with employee mental health issues also tended to be more of the view that the described behaviour was not due to a weak character than were those who felt that no such need existed. Viewing the behaviour in the vignette as a mental illness was associated with more frequently referring employees to company health resources and agreeing with the need to be able to deal with employee mental health issues at work.

The following section discusses the findings relating to the ability of respondents to identify different mental illnesses as covered by the three conditions described in the study vignettes.

4.5.2 Identifying mental illnesses

This study asked the research question whether HR practitioners in South Africa could identify different mental disorders. The second assumption to be tested was therefore stated as:

> HR practitioners in South Africa cannot *identify* different mental illnesses (i.e., depression, panic disorder, or alcohol abuse).

4.5.2.1 Identifying mental illnesses: group results

With the open-ended question where respondents where asked to **name** the mental illness depicted in the vignette, just over a third (34%) could provide the correct diagnosis, that is, depression, panic disorder or alcohol abuse (alcoholism). A further 18.5% could only identify the type of disorder in question (i.e., mood disorder, anxiety disorder, or substance abuse) or mentioned that it was a mental illness without specifying the type of disorder. More than a third (35.9%) provided an *incorrect* diagnosis or said that they did not know, while 11.7% believed that the behaviour in the case study was a stress-related problem (see Figure 4.4).

This statement was treated as a nominal variable requiring that the mode be determined as measure of central tendency. Responses were post-coded as: 1 = correct diagnosis given (e.g., depression); 2 = could identify the correct category of disorder (e.g., mood disorder) or indicated that it was a mental illness; 3 = attributed the behaviour in the vignette to stress, burnout, or work overload; 4 = incorrect diagnosis or did not know. This statistic revealed that the most common response was an **incorrect** one (mode = 4) although the variation ratio (64%) did not reveal this as a good description of overall dispersion. Nonetheless, it is important to

note that the ***largest proportion of respondents could not correctly name or did not know the diagnosis in the provided vignette.***

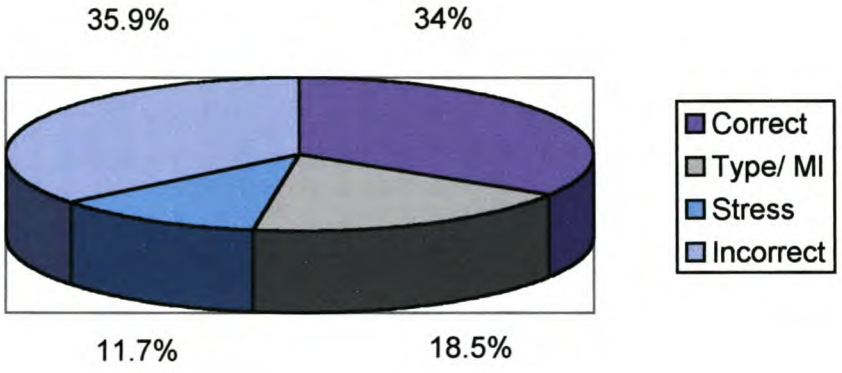

Figure 4.4 Respondents' ability to identify the mental disorder described in the vignette
Note. MI = mental illness

4.5.2.2 Identifying mental illnesses: different disorders

The largest proportion of respondents with an alcohol abuse or a depression vignette could correctly **name** the diagnosis for the described behaviour (51.5% and 49.3% respectively), while ***only 6.6% could correctly identify panic disorder*** ($\chi^2 = 106.54$; $df = 6$; $p < 0.0001$) (see Figure 4.5). The largest proportion of respondents with the panic disorder vignette provided an incorrect diagnosis or stated that they did not know (37.2%). However, 29.2% could identify the behaviour in this vignette as an anxiety disorder or mentioned that it was a mental illness but could not provide further information about the type of disorder. Depression was the condition least frequently cited as a stress-related problem (1.5%), while panic disorder was the condition most frequently regarded as due to stress, burnout or work overload (27%).

Respondents were therefore generally better at identifying mental disorders traditionally covered by HR training curricula (i.e., substance abuse) as opposed to those conditions covered by the popular media (i.e., mood disorders). However, they faired particularly poorly at identifying mental disorders not dealt with by most HR training courses (i.e., anxiety disorders), even though these conditions are highly prevalent within the working and general populations. The fact that many respondents provided an incorrect diagnosis for the panic disorder vignette, or viewed the described behaviour as a stress-related condition, underlines their lack of

knowledge and inability to identify mental conditions that have not traditionally received attention by the HR field.

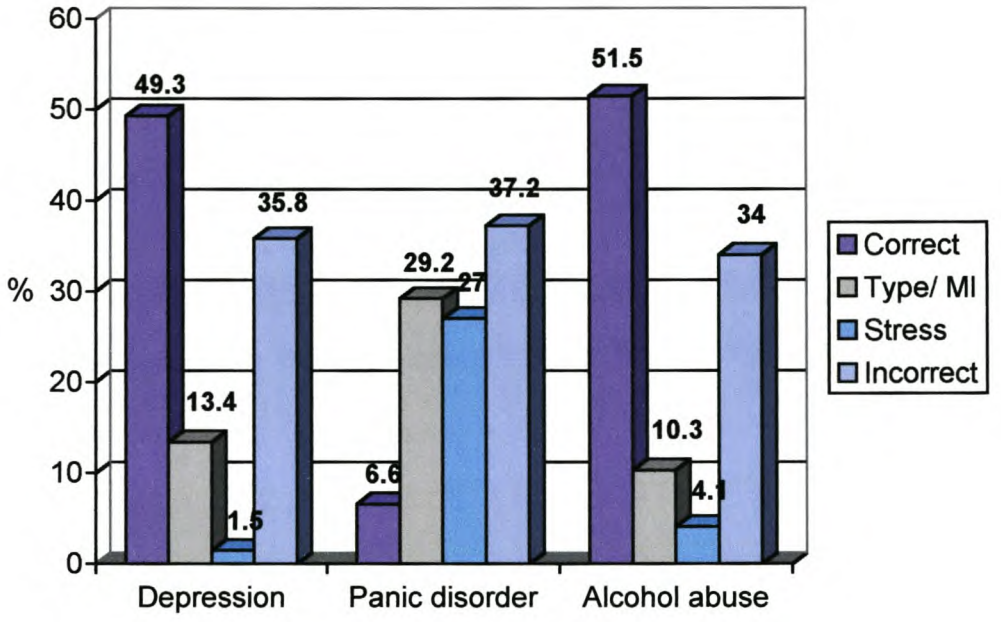

Figure 4.5 Respondents' ability to identify different mental disorders

Note. MI = mental illness

4.5.2.3 Comparing ability to identify different mental illnesses with respondents' demographic and work characteristics

Being able to name the diagnosis described in the vignette was found to be associated with highest *academic qualification*. The largest proportion of respondents with a matric as highest academic qualification (75%) gave an incorrect diagnosis or did not know, whereas the largest proportion of those with a masters degree (44.9%) could name the correct diagnosis ($\chi^2 = 58.59$; $df = 21$; $p < 0.0001$). A further 26.5% of those with a masters degree could correctly identify the category of disorder (i.e., mood, anxiety or substance abuse disorder). However, the largest proportion of those with a doctorate (60%) gave an incorrect diagnosis, although 35% could name the correct category of disorder. None of the other demographic or work variables were significantly associated with ability to identify mental illness.

4.5.2.4 Comparing ability to identify different mental illnesses with respondents' ability to recognise mental illness

Bivariate analysis of frequencies showed that the largest proportion of respondents who regarded the behaviour described in the vignette as definitely (42.3%) or probably (34.9%) a **normal** response provided an incorrect diagnosis for the behaviour, whereas the largest proportion who felt that it definitely was not a normal response (54.5%) could provide a correct diagnosis ($\chi^2 = 27.57$; $df = 12$; $p = 0.006$.).

The largest proportion of respondents who felt that the behaviour in the vignette was definitely typical of a **mental illness** (36%) could identify the correct category of disorder (i.e., mood, anxiety or substance abuse disorder), while the second largest proportion of those in strong agreement with the behaviour being a mental illness (32%) could name the correct diagnosis ($\chi^2 = 26.09$; $df = 12$; $p = 0.010$). In contrast to this finding, the largest proportion of respondents who felt that the behaviour was probably not a mental illness (40.6%) named an incorrect diagnosis. An interesting finding is that equivalent proportions of respondents who strongly disagreed that the behaviour was a mental illness provided a correct (39.4%) and incorrect diagnosis (39.4%). However, the finding that those who believed that the behaviour was a mental disorder tended to be able to provide the correct diagnosis and those who felt that it was not a mental illness tended to provide an incorrect diagnosis was a significant yet weak positive association (Cramer's $V = 0.154$; $p = 0.010$).

The majority of respondents who believed that the behaviour in the vignette was due to a general **medical** problem, such as an infection, provided an incorrect diagnosis (77.8%), while the largest proportion of those who strongly disagreed with this (43.2%) could provide a correct diagnosis ($\chi^2 = 37.99$; $df = 12$; $p < 0.0001$).

In **summary**, the largest proportion of respondents gave an incorrect answer or indicated that they did not know when asked to name the diagnosis portrayed in the case study.

Roughly one half of the depression and alcohol abuse subgroups could correctly name the diagnosis described in the vignette, while ***only 6.6% in the panic disorder subgroup could correctly identify*** the described behaviour. The panic disorder vignette was also the case study most frequently identified as a stress-related condition, while depression was least frequently cited as due to stress, burnout, or work overload.

Respondents with higher academic qualifications were also better able to provide the correct diagnosis for the behaviour described in the vignette than those with lower qualifications.

Respondents who could provide the correct diagnosis for the behaviour in the vignette generally believed that the behaviour was not a normal response, was typical of a mental illness, but not of a general medical problem.

The following section describes the mental health literacy of respondents in terms of their beliefs about the risk factors and causes of mental illness.

4.5.3 Beliefs about the risk factors and causes of mental illness

Another research question concerned with the mental heath literacy of HR practitioners in South Africa asked what they believed were the risk factors and causes of mental illness. The third assumption put to the test with this study therefore was:

> HR practitioners in South Africa lack knowledge regarding *the risk factors and causes* of mental illness (i.e., depression, panic disorder, and alcohol abuse).

4.5.3.1 Beliefs about the risk factors and causes of mental illness: group results

The second set of statements measuring respondents' mental health literacy assessed their beliefs about the risk factors and causes of mental illness. Respondents were asked to rate on a **5-point Likert-type scale** their degree of agreement with various possible risk factors and causes of the behaviour described in the vignette. The majority of respondents believed that the behaviour was probably caused by a stressful life event (59.2%) or unconscious conflict (55.2%), with a further 23.9% agreeing that it definitely was due to a stressful life event (see Table 1 of Appendix H). The majority disagreed strongly with the signs of the zodiac (70.4%), witchcraft and evil spirits (66%), or the will of God (55.2%) playing any role in the development of mental illness as described in the vignette. Large proportions of respondents also indicated that the behaviour in the vignette was probably not due to having grown up in a broken home (48.6%), or a lack of parental affection (47.6%), or having had overprotective parents (47.6%). The possible risk factors and causes of mental illness that respondents were most unsure about were brain disease (22.1%) and heredity/genetic (19.3%).

Frequencies in the "Definitely Yes" and "Probably Yes" categories were *combined* into one "Yes" category because of the low percentages within some of the contingency table cells (de Vaus, 1996). The same was done with the "No" categories. Furthermore, the original inventory

of risk factors and causes of mental illness was designed in such a way that it assesses beliefs within **six domains**, namely: biological factors, psychosocial stress, socialisation, intrapsychic factors, the state of society, and supernatural powers (Angermeyer & Matschinger, 1994). Three items collectively measure each domain, and these are consecutively placed within the original list of 18 items (see Table 2 of Appendix H).

Using **group mean frequency** scores for each of the six domains, it was found that the most frequently reported risk factors and causes of the behaviour in the vignettes were psychosocial stress (63.2%) and intrapsychic factors (45.8%) (see Figure 4.6). Supernatural powers (6.4%) were least often regarded as contributing towards the development of mental illness as portrayed in the vignettes.

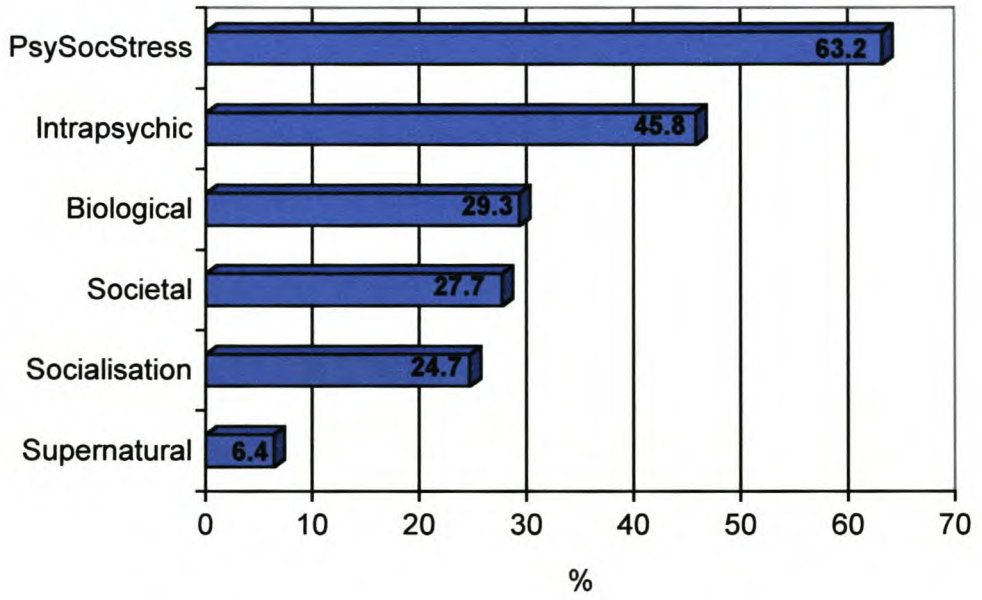

Figure 4.6 Mean frequencies of respondents' agreement with each of the risk factor and cause domains of mental illness

Note. PsySocStress = psychosocial stress

4.5.3.2 Beliefs about the risk factors and causes of mental illness: different disorders

The majority of respondents who reacted to a panic disorder (59.2%) or an alcohol abuse (52.6%) vignette believed that *relationship troubles* could definitely or probably have caused the described condition ($\chi^2 = 25.73$; $df = 8$; $p = 0.001$) (see Table 3 of Appendix H). *Work difficulties* were regarded by the majority of those responding to the panic disorder vignette

(73.7%) as probably playing a role in the development of the described behaviour, although most with a depression vignette disagreed (60.4%) with this ($\chi^2 = 91.99$; $df = 8$; $p < 0.0001$) (see Table 4 of Appendix H). A *stressful life event* was most frequently reported as definitely a cause of depression (51.5%), while most respondents with a panic disorder (78.8%) and an alcohol abuse (57.7%) vignette believed it was only a probable cause of the described behaviour ($\chi^2 = 138.33$; $df = 8$; $p < 0.0001$) (see Table 5 of Appendix H).

The majority of respondents with a depression vignette believed that the behaviour in the vignette was probably or definitely not (60.1%) due to a *brain disease* (see Table 6 of Appendix H). The majority responding to a panic disorder (66.4%) or an alcohol abuse (62.9%) case study felt that brain disease could probably have caused the behaviour or reported that they were unsure about this ($\chi^2 = 17.67$; $df = 8$; $p = 0.024$). Depression was regarded as probably or definitely not (51.5%) caused by *heredity or genetic* factors, while the largest proportions of respondents with a panic disorder (42.3%) or an alcohol abuse (37.1%) vignette believed that these factors probably did not cause the described behaviour (see Table 7 of Appendix H). However, roughly a fifth in all three groups of respondents were unsure about the role of heredity and genetic factors, the largest proportion being so in the case of panic disorder (21.2%). This finding was not significant at the 5% level ($p = 0.055$). The majority of respondents with a depression (66.4%) or a panic disorder (58.4%) vignette believed that a *bodily weakness* could probably or definitely not have caused the described behaviour (see Table 8 of Appendix H). On the other hand, the majority of those with an alcohol abuse case study (50.5%) believed that a constitutional weakness could definitely or probably have caused the described problem ($\chi^2 = 45.56$; $df = 8$; $p < 0.0001$).

Depression (79.1%) and panic disorder (76.6%) were regarded by the majority of respondents reacting to these two vignettes as probably or definitely not due to a *lack of willpower* (see Table 9 of Appendix H). The inverse was true for alcohol abuse where the majority were less sympathetic and believed that the described behaviour was probably or definitely (63.9%) due to a lack of willpower ($\chi^2 = 96.40$; $df = 8$; $p < 0.0001$). More than one half of the respondents in the depression vignette group (52.2%) believed that having too high *self-expectations* could definitely or probably not have caused the described behaviour (see Table 10 of Appendix H). However the largest proportions in the panic disorder (56.9%) and alcohol abuse (44.3%) groups believed that setting too high expectations of oneself could probably have lead to the described condition ($\chi^2 = 26.56$; $df = 8$; $p = 0.001$). The majority of respondents in the three vignette groups believed that *unconscious conflict* could probably have caused the described behaviour (see Table 11 of Appendix H). This was least so for the depression (51.5%) vignette and most so for the alcohol abuse (57.7%) vignette ($\chi^2 = 16.94$; $df = 8$; $p = 0.031$).

The majority of those responding to a depression vignette (65.7%) did not believe that growing up in a *broken home* was in any way responsible for the described behaviour (see Table 12 of Appendix H). The largest proportions of those reacting to a panic disorder (48.9%) or an alcohol abuse (44.3%) vignette also felt that coming from a broken would probably not have caused the described behaviour, although fairly large proportions within these two groups indicated that they were unsure (21.2% and 19.6% respectively) about this ($\chi^2 = 15.74$; $df = 8$; $p = 0.046$). A *lack of parental affection* was regarded by more than one half of the respondents with a depression (52.2%) and a panic disorder (50.4%) vignette as probably not the cause of the behaviour (see Table 13 of Appendix H). Those who had received an alcohol abuse vignette were in less agreement, with over a third each believing that a lack of parental affection could probably have (34%) or probably not have (37.1%) caused the described behaviour ($\chi^2 = 17.76$; $df = 8$; $p = 0.023$). More than one half of the respondents reacting to the depression (50.7%) and panic disorder (54%) vignettes felt that *overprotective parents* could probably not have caused the described problem (see Table 14 of Appendix H). Again, those responding to the alcohol abuse vignette were roughly divided into two similar sized groups who agreed (36.1%) and disagreed (34%) with the probable role of overprotective parents causing the described behaviour ($\chi^2 = 21.02$; $df = 8$; $p = 0.007$).

Respondents with a depression (72.4) or a panic disorder (63.9%) vignette generally believed that a *loss of traditional values* could probably or definitely not have caused the described behaviour (see Table 15 of Appendix H). However, the largest proportion of those responding to an alcohol abuse vignette believed that the loss of traditional values in society could probably have caused the behaviour (37.1%), although a further 34% indicated that this was probably not the case ($\chi^2 = 35.63$; $df = 8$; $p < 0.0001$). The majority of respondents in the depression vignette group believed that a *decay of the natural ways of life* probably or definitely could not (64.9%) have cause the described behaviour (see Table 16 of Appendix H). The largest proportion of those responding to the panic disorder vignette (40.4%) also believed that a decay in the natural ways of life probably could not have caused the behaviour; whereas the largest proportion in the alcohol abuse group agreed that it probably (38.1%) played a role ($\chi^2 = 33.79$; $df = 8$; $p < 0.0001$). Depression (74.7%) and alcohol abuse (66%) were viewed by the majority with these vignettes as probably or definitely not due to the *exploitation of people in an industrial society* (see Table 17 of Appendix H). However, the largest proportion of respondents reacting to the panic disorder vignette (40.9%) agreed that exploitation probably could have caused the described condition ($\chi^2 = 45.27$; $df = 8$; $p < 0.0001$).

Respondents reacting to the alcohol abuse vignette felt strongly about the *will of God* not (79.4%) playing a role in the development of the described behaviour (see Table 18 of Appendix H). Those responding to the depression (46.3%) and panic disorder (46.7%) vignettes also agreed that the will of God definitely did not play a role, although this was less so than with the alcohol abuse group (χ^2 = 40.83; *df* = 8; $p < 0.0001$). *Witchcraft* and the possession by *evil spirits* were regarded by all three groups of respondents as definitely not the cause of the described behaviour (see Table 19 of Appendix H). This was more so for the alcohol abuse (77.3%) and least so for the panic disorder (55.5%) vignettes (χ^2 = 24.17; *df* = 8; p = 0.002). The role of the *zodiac signs* in the development of mental illness was strongly disputed by those responding to the alcohol abuse (78.4%) and depression (74.6%) vignettes (see Table 20 of Appendix H). Most of the respondents with a panic disorder vignette also believed that the signs of the zodiac definitely did not (60.6%) cause the described behaviour, although 14.6% indicated that they were unsure about this (χ^2 = 17.49; *df* = 8; p = 0.025).

4.5.3.3 Beliefs within the six risk factor and cause domains

Comparison of means on the 5-point Likert-type scale and one-way analysis of variance with grouped data within the six **domains** (see Table 2 of Appendix H) showed that respondents with a panic disorder vignette tended to agree ($\bar{x}$ = 2.29; *SD* = 0.54) that *psychosocial stress* could have caused the described behaviour (*F* = 21.070; *df* = 2; $p < 0.0001$) but tended to be unsure ($\bar{x}$ = 3.06; *SD* = 0.68) about the role of *intrapsychic factors* (*F* = 21.847; *df* = 2; $p < 0.0001$). Respondents reacting to the depression vignette were generally inclined to disagree ($\bar{x}$ = 3.75; *SD* = 0.86) that the present *state of society* could have caused the described condition (*F* = 12.536; *df* = 2; $p < 0.0001$) and tended to be unsure ($\bar{x}$ = 3.48; *SD* = 0.79) about whether *biological factors* could have played a role (*F* = 6.814; *df* = 2; p = 0.001). Alcohol abuse was on average not regarded ($\bar{x}$ = 4.67; *SD* = 0.54) as being caused by *supernatural powers* (*F* = 12.124; *df* = 2; $p < 0.0001$), although those who responded to this vignette were generally unsure ($\bar{x}$ = 3.15; *SD* = 0.88) about whether *socialisation* could have played a role (*F* = 7.026; *df* = 2; p = 0.001).

Respondents' agreement with the risk factors and causes of mental illness within the six domains are graphically presented in Figure 4.7, which shows the **mean frequency** scores for each vignette. As with the group mean scores (see Figure 4.6), the majority of respondents across all three diagnoses tended to favour the causal role of psychosocial stress and intrapsychic factors and agreed the least with supernatural powers having caused the behaviour described in the particular vignette. Psychosocial stress was most frequently rated as a cause for the panic disorder vignette (77.9%), while intrapsychic factors were the favoured cause with the

alcohol abuse vignette (56%). Depression was the condition least often regarded as being caused by biological factors (24.9%) or the state of society (18.1%). Respondents most frequently agreed with the causal role of socialisation when responding to an alcohol abuse vignette (34.4%), although this was the condition least frequently rated as being caused by supernatural powers (1.7%).

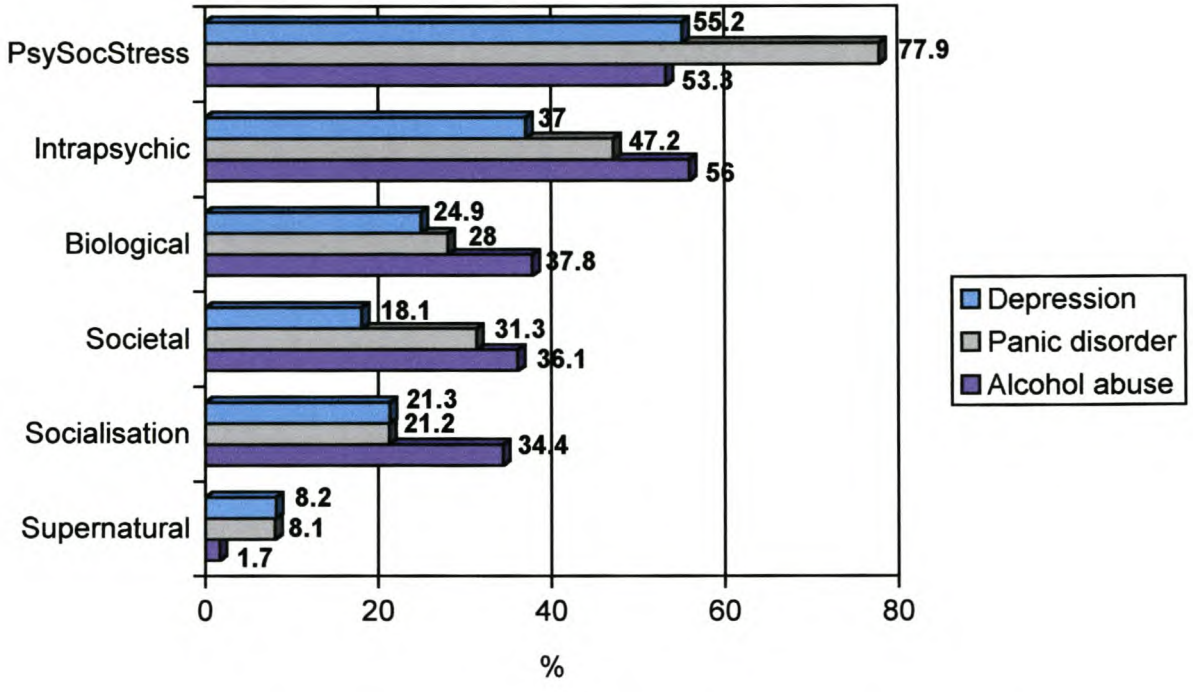

Figure 4.7 Mean frequencies of respondents' agreement with each of the risk factor and cause domains for depression, panic disorder, or alcohol abuse

Note. PsySocStress = psychosocial stress

In **summary**, the majority of respondents agreed that psychosocial stress and intrapsychic factors could have caused the behaviour in the vignette, while the role of supernatural powers in the aetiology of the described conditions was less favoured.

The majority of respondents reacting to a depression vignette agreed that a stressful life event could have caused the behaviour, while a lack of willpower and witchcraft or the possession by evil spirits were not seen as possible causes. The majority of those responding to a panic disorder case study agreed that difficulties at work or a stressful life event were possible causes of the described behaviour. A lack of willpower and the signs of the zodiac were not regarded

as causes of panic disorder, however, many were unsure about the role of heredity/genetic or brain disease in the development of this condition. Respondents who were asked to rate possible causes for the alcohol abuse vignette generally disagreed that the will of God, signs of the zodiac, and witchcraft or possession by evil spirits could have caused the behaviour. However, they tended to agree that alcohol abuse was due to a lack of willpower.

With reference to the six domains of beliefs about the risk factors and causes of mental illness, the majority of respondents across all three vignettes agreed that psychosocial stress and intrapsychic factors could have caused the described behaviour, and disagreed that supernatural powers could have played a role. Respondents with a depression vignette tended to be unsure about the causal role of biological factors, although they were inclined to disagree that the state of society could have caused the behaviour in the vignette. Those with an alcohol abuse vignette were generally unsure whether socialisation played a role in the development of the described behaviour, whereas those with a panic disorder vignette tended to be unsure about intrapsychic factors.

The following two sections compare respondents' beliefs about the risk factors and causes of mental illness with their demographic and work characteristics, and with their ability to recognise and identify mental illness.

4.5.3.4 Comparing beliefs about the risk factors and causes of mental illness with respondents' demographic and work characteristics

Comparison of means and one-way analysis of variance were preformed on the original data (i.e., where response categories on the 5-point Likert-type scale were not combined) to determine whether any associations existed between beliefs about the causes of mental illness within the six domains and respondent **demographic** variables. Candidate Practitioners tended to disagree ($\bar{x} = 3.96$; $SD = 0.51$) with biological factors causing the behaviour in the vignette, while Personnel Practitioners tended to be unsure ($\bar{x} = 3.22$; $SD = 0.79$) about this ($F = 5.953$; $df = 4$; $p < 0.0001$). Respondents with a matric as highest academic qualification were generally unsure ($\bar{x} = 3.33$; $SD = 0.61$) whether biological factors could have caused the described behaviour, whereas those who held a doctorate degree mostly disagreed ($\bar{x} = 4.00$; $SD = 0.72$) with biological factors playing a role in the aetiology of mental illness as depicted in the vignettes ($F = 2.060$; $df = 7$; $p = 0.047$).

With reference to **work** variables, respondents who seldom referred employees to company health facilities tended to agree ($\bar{x}$ = 2.38; *SD* = 0.060) that psychosocial stress could have caused the described behaviour, while those who referred almost on a daily basis were significantly more inclined to be unsure ($\bar{x}$ = 2.86; *SD* = 0.86) about this (*F* = 2.318; *df* = 5; *p* = 0.043).

4.5.3.5 Comparing beliefs about the risk factors and causes of mental illness with respondents' ability to recognise and identify mental illness

On comparing mean scores of respondents' beliefs about the different causes of mental illness and their ability to **recognise and identify** mental illness, it was found that those who definitely agreed that the behaviour in the vignette was due to a *weak character* tended to agree that intrapsychic factors ($\bar{x}$ = 2.40; *SD* = 1.30), socialisation ($\bar{x}$ = 2.20; *SD* = 1.45), and the current state of society ($\bar{x}$ = 2.33; *SD* = 1.22) could have caused the behaviour in the vignette. On the other hand, those who strongly disagreed that the behaviour was due to a weak character tended to be unsure or to somewhat agree that intrapsychic factors ($\bar{x}$ = 3.31; *SD* = 0.74; *F* = 11.772; *df* = 4; *p* < 0.0001), socialisation ($\bar{x}$ = 3.59; *SD* = 0.88; *F* = 5.94; *df* = 4; p < 0.0001), and the state of society ($\bar{x}$ = 3.46; SD = 0.88; *F* = 4.717; *df* = 4; *p* = 0.001) could have played a role in the development of the problem.

Respondents who strongly agreed that the behaviour in the vignette was typical of a *mental illness* tended to agree that psychosocial stress ($\bar{x}$ = 2.48; *SD* = 0.82) could lead to the behaviour in the vignette, while those who felt that the behaviour was definitely not a mental illness tended to be more unsure ($\bar{x}$ = 2.81; *SD* = 0.79) about this (*F* = 3.235; *df* = 4; *p* = 0.013). However, those who agreed that the behaviour was definitely typical of a mental illness were generally unsure ($\bar{x}$ = 3.07; *SD* = 0.76) about the role of biological factors in the aetiology of the described behaviour, while those who felt that it definitely was not typical of a mental illness were more inclined to disagree ($\bar{x}$ = 3.55; *SD* = 0.85) that biological factors could have caused the problem (*F* = 3.104; *df* = 4; *p* = 0.016).

Believing that the behaviour in the vignette was definitely due to a general *medical* condition was found to be associated with a tendency to agree or to be unsure ($\bar{x}$ = 2.52; *SD* = 0.53) about the role of biological factors in the development of the condition in the vignette, while believing that the behaviour was definitely not due to a medical illness was associated with a tendency to disagree ($\bar{x}$ = 3.64; *SD* = 0.85) that biological factors could have played a role (*F* = 7.67; *df* = 4; *p* < 0.0001). Respondents who strongly agreed that the behaviour was due to a general medical condition were inclined to agree ($\bar{x}$ = 2.33; *SD* = 0.67) that intrapsychic factors could have

caused the problem, whereas those who strongly disagreed with the behaviour being due to a general medical condition tended to be unsure ($\bar{x}$ = 3.07; *SD* = 0.86) about the role of intrapsychic factors ($F = 3.085$; $df = 4$; $p = 0.016$).

Respondents who could correctly ***name*** the diagnosis in the vignette tended to strongly disagree ($\bar{x}$ = 4.69; *SD* = 0.51) that supernatural powers could have caused the described behaviour, whereas those who provided an incorrect diagnosis disagreed less strongly ($\bar{x}$ = 4.17; *SD* = 0.76) with the role of supernatural powers ($F = 12.91$; $df = 3$; $p < 0.0001$). Respondents who indicated that the behaviour in the vignette was due to a stress-related problem tended to agree ($\bar{x}$ = 2.28; *SD* = 0.45) that psychosocial stress could have caused the described condition ($F = 7.73$; $df = 3$; $p < 0.0001$).

In **summary**, respondents' registration level and highest academic qualification were found to be associated with beliefs about the role of biological factors, while frequency of referrals to company health resources were associated with beliefs about psychosocial stress causing mental illness.

Respondents who felt that the behaviour in the vignette was typical of a weak character tended to agree that intrapychic factors, socialisation and the state of society could have caused the described behaviour. Believing that the behaviour was a mental illness was found to be associated with favouring psychosocial stress as a determining factor in the development of the condition, although these respondents tended to be unsure about the role of biological factors. However, those who agreed that the behaviour in the vignette was due to a general medical condition tended to agree that biological and intrapsychic factors could have played a role. Respondents who could correctly name the diagnosis in the vignette generally disagreed that supernatural powers could have caused the condition, whereas those who believed that the described behaviour was a stress-related problem agreed that psychosocial stress could have caused the behaviour in the vignette.

The following section describes the mental health literacy of respondents in relation to their beliefs about the best treatment strategies for mental illness.

4.5.4 Beliefs about the best treatment strategies for mental illness

As this study set a research question to ascertain the treatment strategies advocated by HR practitioners in South Africa, the fourth assumption to be tested read:

HR practitioners in South Africa lack knowledge regarding the appropriate *treatments* for mental illness (i.e., depression, panic disorder, and alcohol abuse).

4.5.4.1 Beliefs about the best treatment strategies for mental illness: group results

Respondents were presented with a list of possible treatment strategies and asked to rate on a 3-point numerical rating scale whether they considered each to be helpful, harmful, or neither for the person described in the **vignette**. The majority viewed consulting a counsellor (95.4%), psychologist (92.7%) and close family (81.5%) as *helpful* (see Table 21 of Appendix H). Psychotherapy (86.7%), physical activity (83.2%) and getting out more (65.7%) were also considered to be helpful strategies for dealing with the described behaviour. Electro-convulsive therapy (62.8%) and sleeping pills (51.4%) were most frequently reported as *harmful*, while close to one half of all respondents also viewed admission to a psychiatric ward (46.2%) as harmful for the person in the vignette. Consulting a naturopath (63.9%), or taking vitamins (53.4%), pain relievers (51.8%) or antipsychotics (51.4%) were regarded by the majority of respondents as *neither* helpful nor harmful.

Univariate analysis of frequencies showed that telephone counselling (62%) was more frequently rated as helpful for the person in the vignette than was taking antidepressants (43.8%). Respondents rated physical activity (83.2%) as a helpful treatment strategy more frequently than they did for consulting a psychiatrist (78%). Conversely, electro-convulsive therapy (62.8%) and being admitted to a psychiatric ward (46.2%) were more frequently rated as harmful than were pain relievers (38.7%), tranquillisers (41%) or antibiotics (42%). Consulting a counsellor, social worker, close family or friends were the treatment options least frequently reported as harmful, with less than one percent of the respondents indicating so for each of these options.

The original list of 21 items represents three **subscales**, namely a seven-item Psychological subscale, an eight-item Medical subscale, and a six-item Lifestyle subscale (Jorm et al., 1997c). Table 22 of Appendix H lists the original items within each subscale. The majority of respondents rated ***psychological treatment strategies*** as helpful for the person in the vignette, with the exception of hypnotherapy (see Figure 4.8). The largest proportion of respondents felt that hypnosis would be neither helpful nor harmful (47.3%) for the person in the vignette. The psychological treatment options most frequently rated as helpful for the person in the vignette were consulting a counsellor (95.4%), seeing a psychologist (92.7%), and going for

psychotherapy (86.7%). These were also the three treatment options generally regarded as most helpful for the person in the vignette. It may be worthy to note that consulting a counsellor was more frequently rated as helpful than was consulting a psychologist, which in turn out-rated seeking care from a psychiatrist (78%). Hypnosis (8.7%) and consulting a psychiatrist (5.7%) were the psychological treatment options most frequently reported as harmful.

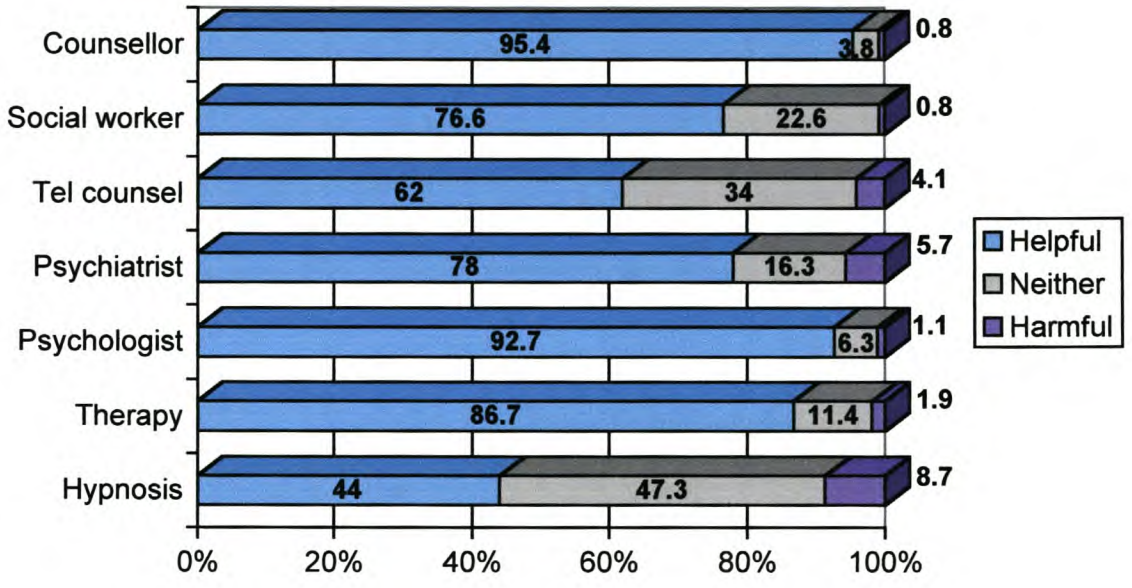

Figure 4.8 Beliefs about psychological treatment strategies

Note. Tel counsel = telephone counselling; Therapy = psychotherapy

Medical treatment strategies were generally regarded as harmful, or as neither harmful nor helpful, with the exception of antidepressants (see Figure 4.9). The largest proportion of respondents rated antidepressants as helpful (43.8%), although 32.3% regarded them as neither helpful nor harmful with a further 23.9% believing that they would be harmful for the person in the vignette. The medical treatment options most frequently reported as harmful were electro-convulsive therapy (62.8%), sleeping pills (51.4%), and admittance to a psychiatric ward (46.2%). These three strategies also constituted the general treatment options most frequently cited as harmful. Even though not in the majority, tranquillisers (24.2%) were more frequently regarded as helpful than was admittance to a psychiatric ward (19.4%). Furthermore, being admitted to a psychiatric ward (46.2%) was more frequently rated as harmful than was taking a pain reliever (38.7%) or an antibiotic (42%).

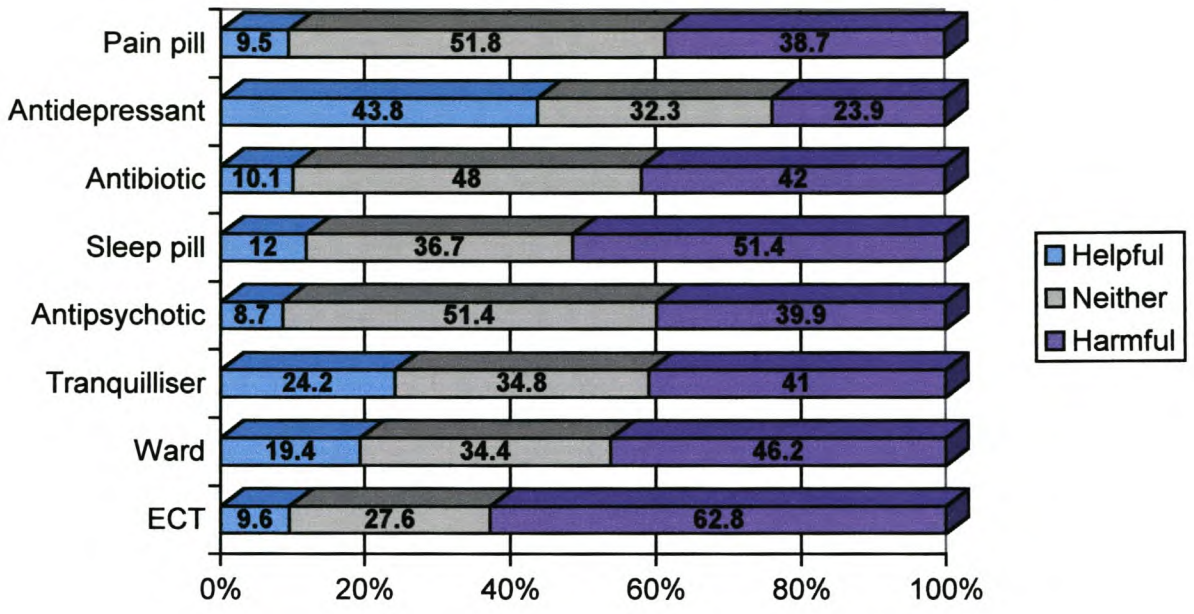

Figure 4.9 Beliefs about medical treatment strategies

Note. Pain pill = pain relievers; Sleep pill = sleeping pills; Ward = psychiatric ward; ECT = electro-convulsive therapy

The majority of respondents regarded ***lifestyle treatment strategies*** as helpful for the person in the vignette, with the exceptions of consulting a naturopath or taking vitamins (see Figure 4.10). The majority believed that consulting a naturopath (63.9%) or taking vitamins (53.4%) would be neither helpful nor harmful to the person in the vignette. Physical activity (83.2%) was the lifestyle strategy most frequently reported as helpful, while the role of close family (81.5%) and friends (78.8%) out-rated that of getting out more (65.7%). The lifestyle strategies least frequently reported as harmful were to consult close family and friends (0.8% for each).

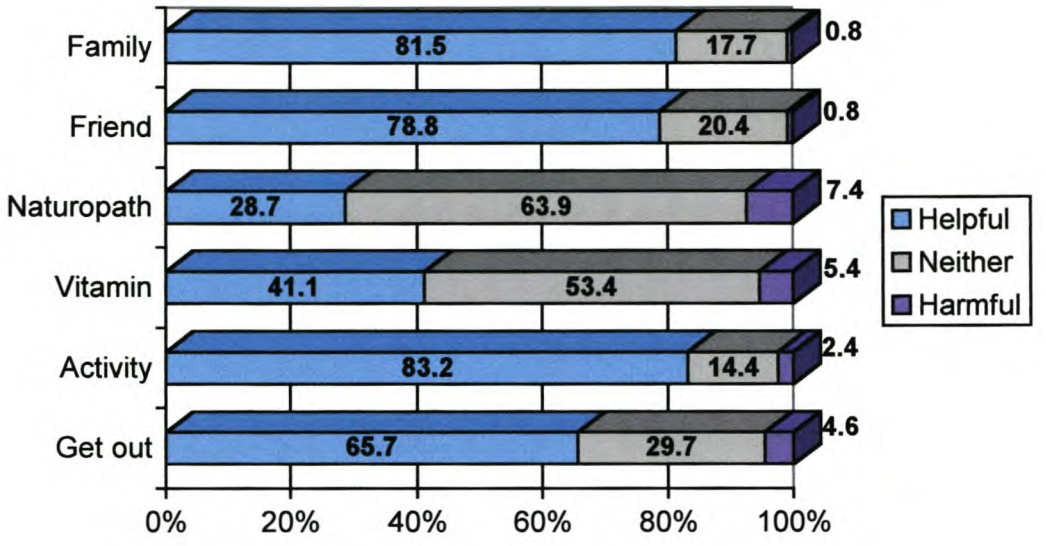

Figure 4.10 Beliefs about lifestyle treatment strategies

4.5.4.2 Beliefs about the best treatment strategies for mental illness: different disorders

The majority of respondents reacting to the depression, panic disorder and alcohol abuse vignettes rated **psychological** treatment strategies as helpful, with the exception of hypnosis. See Figure 4.11, where the *frequencies of helpful and harmful* responses are graphically presented, and *harmful responses have been recoded as negative*. Those who were responding to the depression vignette (52.2%) were mostly of the opinion that *hypnosis* would be neither helpful nor harmful. This finding was not significant at the 5% level (See Table 23 of Appendix H). *Psychotherapy*, even though rated as helpful for all three conditions, was more frequently viewed as helpful by those responding to a depression (94%) vignette and least frequently by those responding to a panic disorder (80.3%) vignette (χ^2 = 14.51; df = 4; p = 0.006). Consulting a counsellor or a psychologist was consistently rated most frequently as helpful for the person in all three case studies. Following hypnotherapy, telephone counselling was the psychological treatment strategy least frequently rated as helpful by respondents reacting to the depression, panic disorder, or alcohol abuse vignettes. Conversely, hypnotherapy, consulting a psychiatrist, and telephone counselling were most frequently rated as harmful for all three conditions.

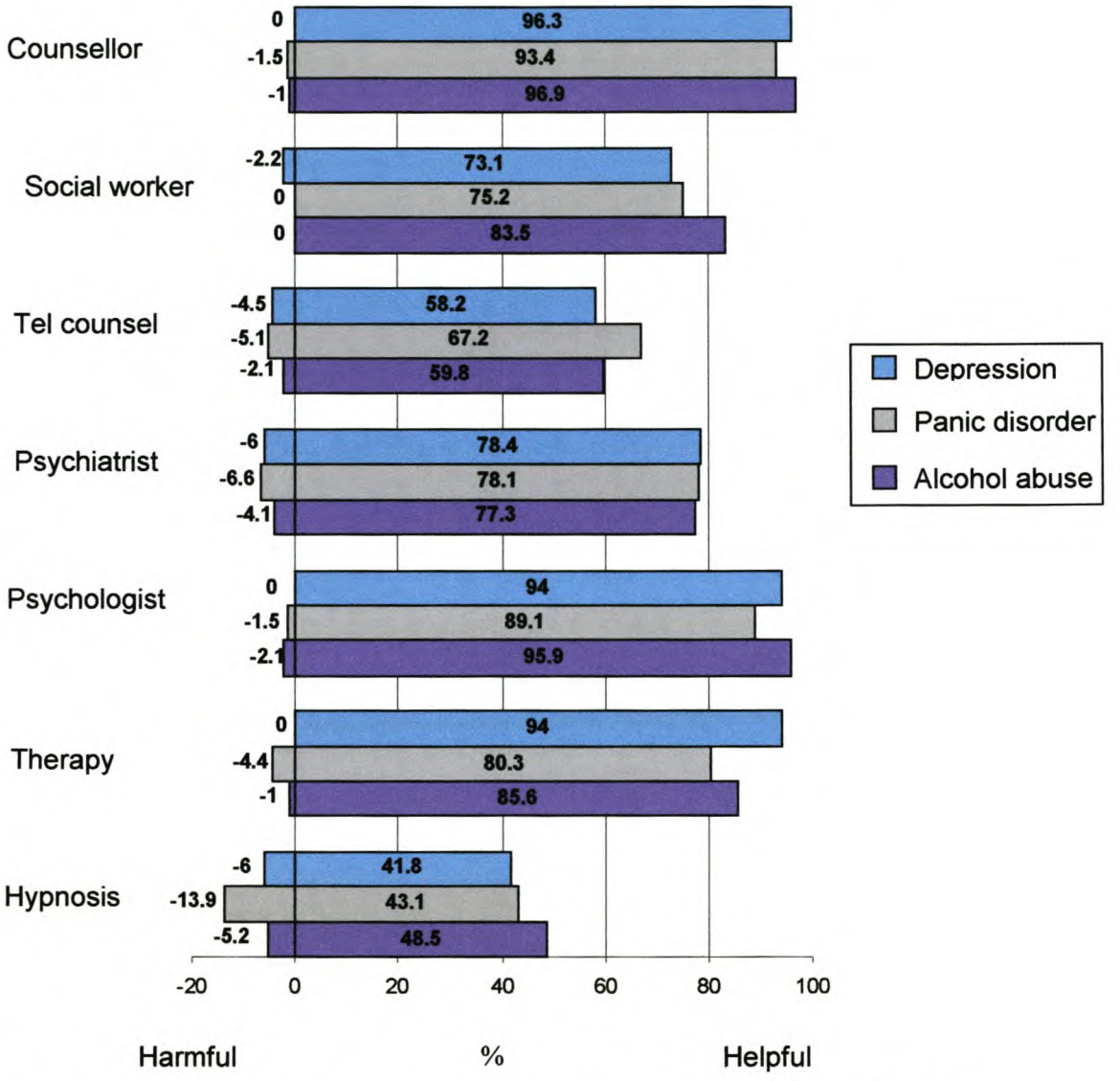

Figure 4.11 Respondents' beliefs about the helpfulness and harmfulness of psychological treatment strategies for depression, panic disorder, or alcohol abuse

Note. Tel counsel = telephone counselling; Therapy = psychotherapy

Medical treatment strategies were consistently rated as harmful or neither helpful nor harmful by respondents reacting to the depression, panic disorder, or alcohol abuse vignettes, with the exception of antidepressants (see Figure 4.12, which shows harmful versus helpful responses). The majority of respondents reacting to the depression vignette (55.2%) believed *antidepressants* to be helpful (χ^2 = 18.65; *df* = 4; *p* = 0.001). The largest proportion of respondents with a panic disorder vignette (42.3%) also believed that antidepressants would be helpful, although 35.8% indicated that these drugs would be neither helpful nor harmful (see Table 24 of Appendix H). *Pain relievers* were rated by the majority of those responding to a

panic disorder (55.9%) or a depression (54.5%) vignette as neither helpful nor harmful, while the majority with an alcohol abuse (52.6%) vignette regarded pain relievers as harmful for the person in the vignette ($\chi^2 = 14.80$; $df = 4$; $p = 0.005$).

The majority of respondents with a depression (51.9%) vignette rated *antibiotics* as harmful, whereas the majority responding to an alcohol abuse (58.8%) vignette regarded these medications as neither helpful nor harmful for the person in the vignette ($\chi^2 = 13.49$; $df = 4$; $p = 0.009$). Most respondents with an alcohol abuse (62.9%) or a depression (55.2%) vignette regarded *sleeping pills* as harmful, while the largest proportion of those with a panic disorder (47.4%) vignette viewed these pills as neither helpful nor harmful for the described person ($\chi^2 = 15.21$; $df = 4$; $p = 0.004$). *Antipsychotics* were most frequently rated as neither harmful nor helpful for the panic disorder (58.1%) and depression (52.2%) vignettes, while the largest proportion of respondents with an alcohol abuse (47.9%) vignette felt that they would be harmful ($\chi^2 = 20.71$; $df = 4$; $p < 0.0001$). The largest proportions of respondents viewed *tranquillisers* as harmful for the alcohol abuse (54.6%) and the depression (44.8%) vignettes ($\chi^2 = 24.24$; $df = 4$; $p < 0.0001$). However, just over a third of those with a panic disorder vignette viewed tranquillisers each as helpful (35.8%) or as neither helpful nor harmful (36.5%).

The largest proportion of all three groups of respondents consistently viewed admission to a *psychiatric ward* as harmful. This was most so for the alcohol abuse (47.4%) vignette and least so for the panic disorder (45.2%) vignette ($\chi^2 = 13.08$; $df = 4$; $p = 0.011$). The majority also consistently viewed *electro-convulsive therapy* (ECT) as harmful, particularly those rating treatments for the depression (69.2%) vignette ($\chi^2 = 10.78$; $df = 4$; $p = 0.029$). Even though in small numbers, it is interesting to note that almost 10% of those with a panic disorder (9.5%) and an alcohol abuse (6.3%) vignette believed that ECT would be helpful for the described person.

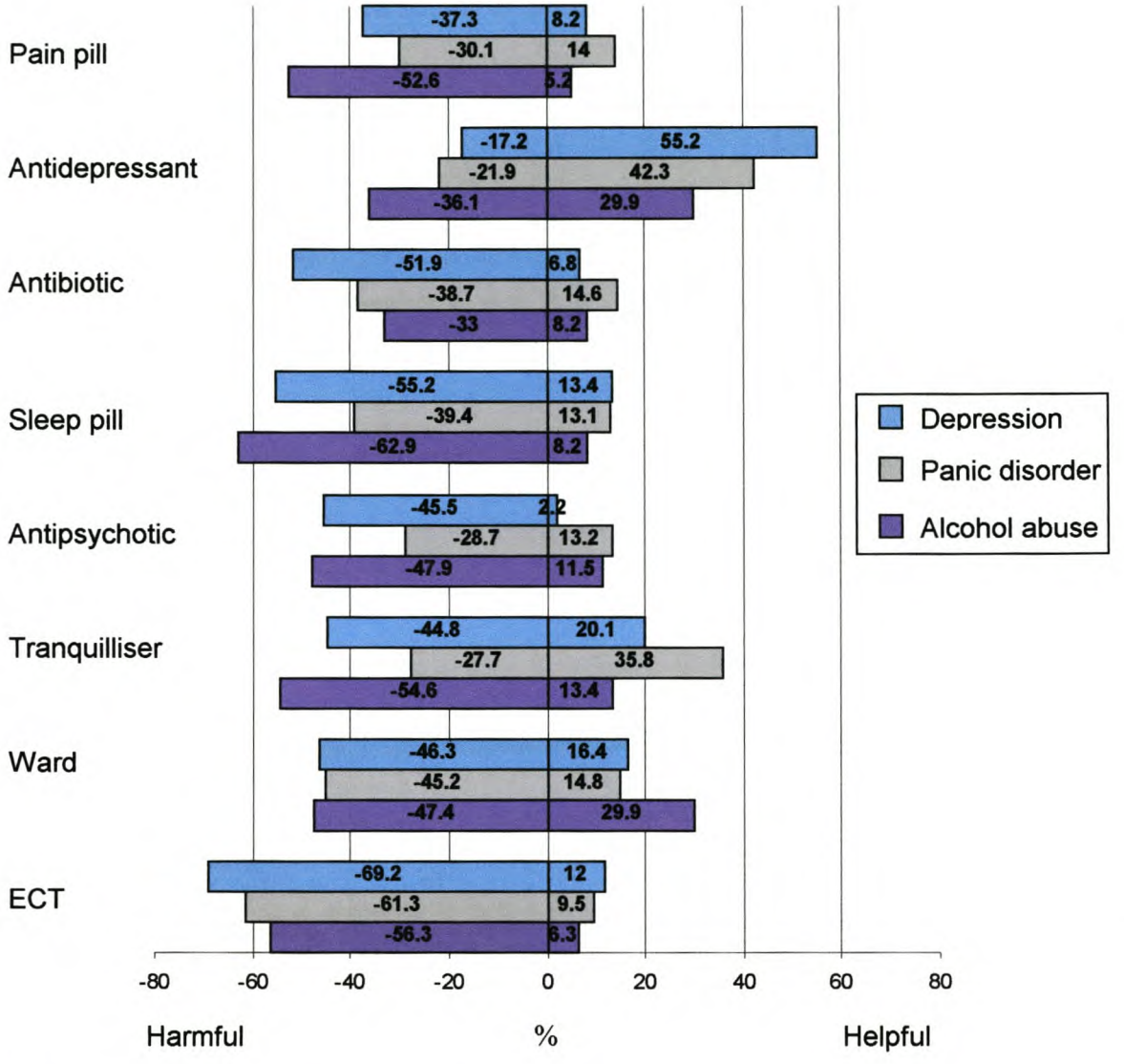

Figure 4.12 Respondents' beliefs about the helpfulness and harmfulness of medical treatment strategies for depression, panic disorder, or alcohol abuse

Note. Pain pill = pain relievers; Sleep pill = sleeping pills; Ward = psychiatric ward; ECT = electro-convulsive therapy

Respondents in all three groups were mostly of the opinion that **lifestyle** treatment strategies would be helpful for the person described in the vignette (see Figure 4.13). However, the majority viewed consulting a *naturopath* or taking *vitamins* as neither helpful nor harmful, although these findings were not significant at the 5% level (see Table 25 of Appendix H). The majority in all three groups favoured consulting close family as an option for the person in the vignette. This was most frequently rated as helpful with the depression (87.3%) vignette, and least frequently with the panic disorder (73.7%) vignette ($\chi^2 = 12.00$; $df = 4$; $p = 0.017$). Calling

on close *friends* was viewed by the majority as helpful, particularly with the depression (87.3%) vignette, and the least so with the panic disorder (67.2%) vignette (χ^2 = 20.63; *df* = 4; $p <$ 0.0001). The majority of respondents in the three vignette groups believed that *getting out more* would be helpful for the person in the vignette. Getting out more was most frequently favoured by respondents with a depression (80.5%) vignette and least frequently rated as beneficial with the panic disorder (56.9%) vignette (χ^2 = 21.54; *df* = 4; $p < 0.0001$). It is interesting to note that the condition where getting out more was most frequently rated as harmful was alcohol abuse (7.2%).

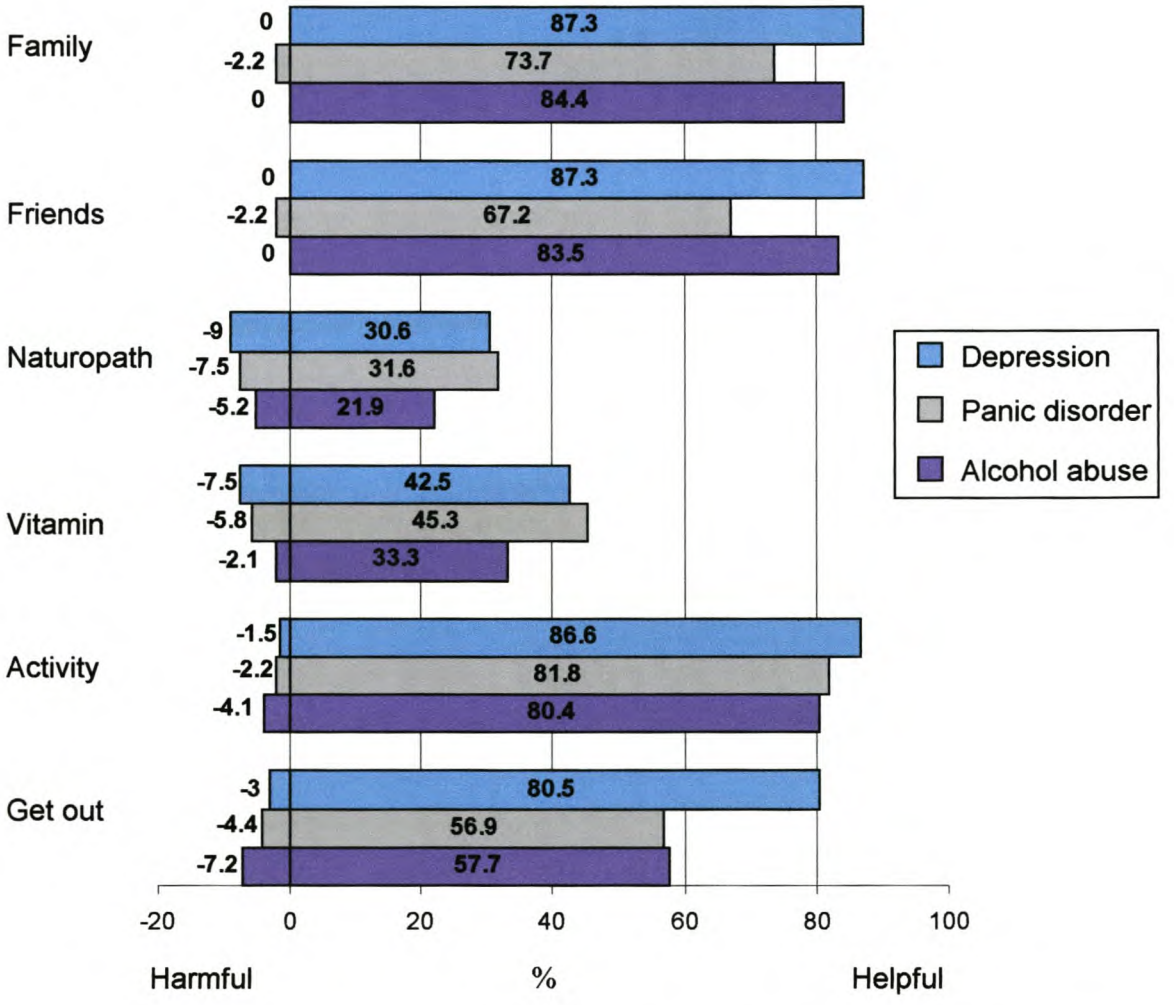

Figure 4.13 Respondents' beliefs about the helpfulness and harmfulness of lifestyle treatment strategies for depression, panic disorder, or alcohol abuse

Respondents were therefore generally more positively inclined towards psychological and lifestyle treatments strategies, and more negative about medical treatments, irrespective of the

condition described in the vignettes. This is graphically presented in Figure 4.14, where the median, interquartile range and outliers regarding respondents' views about the use of the three treatment strategies are given for each of the conditions covered by the three vignettes.

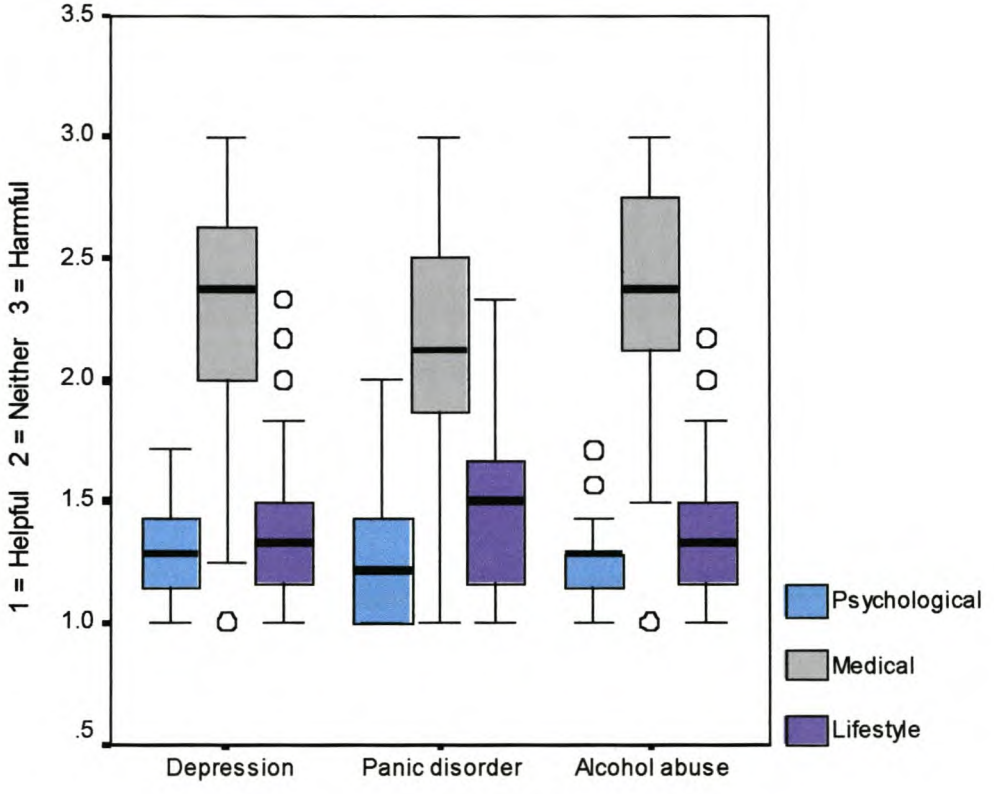

Figure 4.14 Box-and-whisker plot of respondents' views about the use of psychological, medical and lifestyle treatment strategies for each of the three vignettes

Psychological treatment strategies were more favourably rated as treatment for depression, panic disorder and alcohol abuse than were lifestyle treatments. This appeared to be the case particularly with the panic disorder vignette. Medical treatment strategies were generally regarded as not being of much use or as harmful, although this appeared to be least so for the panic disorder vignette. This was confirmed with comparison of means and one-way analysis of variance. Psychological treatments had mean scores of less that 1.3 (thus regarded as helpful) for all three vignettes, which were not significantly associated with any particular vignette (F = 1.651; df = 3; p = 0.193). Respondents' mean score for medical treatments for the panic disorder ($\bar{x}$ = 2.17; SD = 0.43) vignette was significantly lower than that for the depression ($\bar{x}$ = 2.29; SD = 0.39) and the alcohol abuse ($\bar{x}$ = 2.35; SD = 0.41) vignettes (F = 5.380; df = 2; p = 0.005). Lifestyle treatments were most favourably rated for the depression ($\bar{x}$ = 1.35; SD =

0.28) vignette, and, even though also considered to be helpful, least so for the panic disorder ($\bar{x}$ = 1.45; *SD* = 0.32) vignette (F = 4.766; df = 2; p = 0.009).

In **summary**, most respondents agreed that psychological and lifestyle treatment strategies would be helpful for the person in the vignette and that medical treatments would be harmful, or neither helpful nor harmful.

The majority of the respondents believed that psychological treatment strategies would be helpful for the person in the vignette, irrespective of the described mental condition. Consulting a counsellor, a psychologist or going for psychotherapy were particularly favoured treatments. Medical treatments were mainly regarded as neither helpful nor harmful, or as harmful. Antidepressants were, however, believed to be helpful for the person in the depression, and to some extent, in the panic disorder, vignettes. Electro-convulsive therapy and admission to a psychiatric ward were the medical treatments most frequently rated as harmful, particularly for depression and alcohol abuse. Respondents answering to all three vignettes consistently favoured lifestyle treatment strategies. Approaching close family and friends, and getting out more, were most frequently rated as helpful, especially so for the person described in the depression vignette.

The following section compares respondent's beliefs about the best treatment strategies for mental illness with their demographic and work characteristics. This is followed by a comparison of their beliefs about best treatments with their ability to recognise and identify mental illness, and with their beliefs about the risk factors and causes of mental illness.

4.5.4.3 Comparing beliefs about the best treatment strategies with respondents' demographic and work characteristics

With comparison of means and one-way analysis of variance no significant associations were found between respondents' **demographic** variables and their beliefs about the different treatment strategies, with the exception of highest academic *qualification*. Respondents with a matric ($\bar{x}$ = 1.92; *SD* = 0.29) or diploma ($\bar{x}$ = 1.52; *SD* = 0.36) as highest qualification tended to view lifestyle treatment options as neither helpful nor harmful, whereas those with a doctorate ($\bar{x}$ = 1.37; *SD* = 0.24) or post-doctorate ($\bar{x}$ = 1.33; *SD* = 0.27) degree tended to believe lifestyle options would be helpful (F = 3.695; df = 7; p = 0.001). No significant associations were found between respondents' **work** variables and their beliefs about the different treatment strategies.

4.5.4.4 Comparing beliefs about the best treatment strategies with respondents' ability to recognise and identify mental illness

Comparison of means and one-way analysis of variance were used to investigate the existence of associations between respondents' ability to **recognise** and **identify mental illnesses** and their beliefs about the different treatment strategies. Those who believed that the behaviour in the vignette was definitely due to a *weak character* were inclined to view lifestyle treatment strategies as neither helpful nor harmful ($\bar{x}$ = 1.70; *SD* = 0.42), whereas those who felt that the behaviour was definitely not typical of a weak character were more in favour ($\bar{x}$ = 1.38; *SD* = 0.30) of lifestyle treatments (F = 5.966; df = 4; $p < 0.0001$). Viewing the behaviour in the vignette as definitely indicative of a *mental illness* was found to be associated with a tendency to view lifestyle treatments as neither helpful nor harmful ($\bar{x}$ = 1.60; *SD* = 0.40), while viewing the behaviour as definitely not a mental illness was associated with a tendency to view these treatments as helpful ($\bar{x}$ = 1.45; *SD* = 0.31; F = 4.967; df = 4; p = 0.001). Respondents who felt that the behaviour in the vignette was definitely due to a general *medical* condition were inclined to view medical treatment strategies as neither helpful nor harmful ($\bar{x}$ = 1.83; *SD* = 0.43), although this was significantly less so than with those who believed that the behaviour was definitely not due to a general medical condition ($\bar{x}$ = 2.30; *SD* = 0.41; F = 4.198; df = 4; p = 0.002).

4.5.4.5 Comparing beliefs about the best treatment strategies with beliefs about the risk factors and causes of mental illness

Correlating beliefs about the different **risk factors and causes** of the behaviour in the vignette with the three treatment strategies showed that those who favoured a *biological* cause were inclined to believe that psychological (r = 0.226; $p < 0.0001$) and medical (r = 0.156; p = 0.003) treatments would be helpful. Respondents who believed that *intrapsychic* factors caused the behaviour, tended to agree that medical treatments would be helpful for the person in the vignette (r = 0.177; p = 0.001). Those who felt that *socialisation* played a role in the development of the behaviour in the vignette tended to agree that psychological treatments would help the described person (r = 0.120; p = 0.021). Psychological treatments were, however, generally regarded as harmful by the respondents who believed that the behaviour in the vignette had been caused by *supernatural* powers (r = -0.141; p = 0.007).

The weak associations between beliefs about the causes and best treatment strategies for the described behaviour may be explained by way of what Jorm et al. (1997c, p.472) term "treatment ideologies". These refer to positive and negative beliefs about different treatments.

Therefore, respondents may tend to have a more favourable view of, for example, psychological treatments in general and be more opposed in general towards medical treatments. This would appear to be the case with the HR practitioners who took part in this study.

In **summary**, beliefs about the different treatment strategies were found to be associated with academic qualification, although no other significant associations could be found between treatment beliefs and respondents' demographic or work variables.

Respondents who believed that the behaviour in the vignette was definitely not due to a weak character or typical of a mental illness tended to believe that lifestyle treatments would be helpful. On the other hand, those who were of the opinion that the described behaviour was definitely due to a weak character or typical of a mental illness tended to believe that lifestyle treatments would be neither helpful nor harmful. Respondents who felt that the behaviour was definitely not due to a general medical condition tended to believe that medical treatments would neither be helpful nor harmful.

Beliefs about the risk factors and causes of the behaviour in the vignettes were found to be weakly associated with beliefs about the different treatment strategies. This may correspond with the notion of treatment ideologies, where different treatment strategies are generally viewed as negative or positive. Respondents who believed that the behaviour had been caused by biological factors were inclined to favour psychological and medical treatment strategies. Beliefs that the behaviour was due to intrapsychic factors were associated with believing that medical treatments would be helpful, while psychological treatments were generally favoured by those who believed that socialisation had caused the behaviour. Psychological treatments were, however, regarded as harmful by those who believed that the behaviour had been caused by supernatural powers.

The following section describes the attitudes of respondents towards the mentally ill in terms of the concepts measured by the four subscales of the CAMI.

4.6 Mental health attitudes

Investigating the attitudes of HR practitioners towards the mentally ill was also set as a research question for this study. The fifth assumption was therefore set as:

> HR practitioners in South Africa hold negative *attitudes* towards the mentally ill as measured by the Community Attitudes toward the Mentally Ill scale (i.e., score high on the Authoritarianism and Social Restrictiveness subscales, and score low on the Benevolence and Community Mental Health Ideology subscales).

HR practitioners who took part in this survey held mainly positive attitudes towards the mentally ill as measured by aggregated scores on the four subscales of the *Community Attitudes toward the Mentally Ill* (CAMI) scale.

Before determining aggregate scores for each subscale, the responses to one half of each subscale (i.e., five items) were **recoded** to correct for the combination of positively and negatively worded statements that were incorporated in the original design of the CAMI scale to prevent response sets. With the recoded data, it was found that as a **group**, respondents had a relatively low mean score ($\bar{x}$) on the Authoritarianism and Social Restrictiveness subscales, and a relatively high mean score on the Benevolence and Community Mental Health Ideology (CMHI) subscales. This suggests a *positive* attitude towards the mentally ill on all four dimensions as measured by the CAMI. Respondents tended to be slightly more benevolent ($\bar{x}$ = 41.17; SD = 4.63) than follow a community mental health ideology ($\bar{x}$ = 36.91; SD = 5.44), and favoured authoritarianism sentiments ($\bar{x}$ = 20.76; SD = 5.00) slightly less than social restrictiveness sentiments ($\bar{x}$ = 22.01; SD = 4.86). This is graphically presented in Figure 4.15, where the median, interquartile range and distribution range are shown for each subscale, as well as the position of outliers. However, when looking at group scores on the **individual items** of these subscales, subtle *negative* attitudes where found.

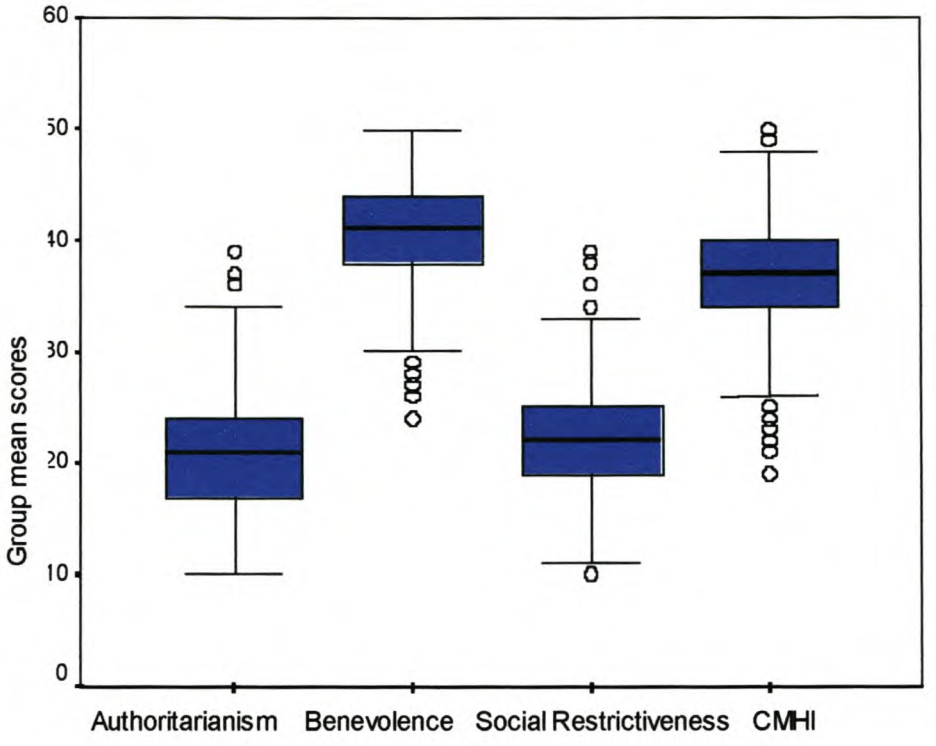

Figure 4.15 Box-and-whisker plot of recoded group scores on the four CAMI subscales

4.6.1 Authoritarianism

Respondents as a group tended to report *positive* attitudes towards the mentally ill as assessed by the CAMI subscale measuring authoritarian sentiments. For example, mean scores on the five-point Likert scale suggest that they strongly disagreed with locking-up the mentally ill as means of treatment ($\bar{x}$ = 4.70; *SD* = 0.63) and disagreed with hospitalising people at the first signs of mental illness ($\bar{x}$ = 4.07; *SD* = 0.92) (see Table 1 of Appendix I). Respondents also firmly agreed with the statement that the mentally ill should not be treated as outcasts ($\bar{x}$ = 1.77; *SD* = 1.17), and that mental illness may potentially affect anyone ($\bar{x}$ = 1.77; *SD* = 0.77).

However, a closer inspection of the frequency distribution reveals the possibility of subtle negative attitudes towards the mentally ill. Even though the majority disagreed that *hospitalisation* was called for at the first signs of mental illness (84.6%), almost a third disagreed (30.4%) with the statement that mental hospitals are outdated means of treating these patients (see Table 1 of Appendix I). This may imply that these respondents believe mental institutions are appropriate treatment strategies or that persons with mental illness should be treated in mental institutions. A comparison of means using one-way analysis of variance

(ANOVA) indicated a statistically significant association between agreeing with the ***hospitalisation*** of person's with mental illness and believing that mental hospitals are *outdated* treatments strategies (see Table 4.11). This was supported by correlation analysis, which revealed that a fairly weak negative but highly significant relationship existed between these two variables.

Table 4.11 Statistically significant associations between responses to Authoritarianism items

Authoritarianism items	**ANOVA**	**Correlation**
As soon as a person shows signs of mental disturbance, he should be *hospitalised.* Mental hospitals are *outdated means* of treating the mentally ill.	$F = 4.331$ $df = 4$ $p = 0.002$	$r = -0.201$ $p < 0.0001$
The best way to handle the mentally ill is keep them behind *locked doors.* Less emphasis should be placed on *protecting* the public from the mentally ill.	$F = 0.488$ $df = 4$ $p = 0.745$	
Less emphasis should be placed on *protecting* the public from the mentally ill. There is something about the mentally ill that makes it easy to *tell them apart* from normal people.	$F = 8.098$ $df = 4$ $p < 0.0001$	$r = -0.256$ $p < 0.0001$
Less emphasis should be placed on *protecting* the public from the mentally ill. As soon as a person shows signs of mental disturbance, he should be *hospitalised.*	$F = 12.006$ $df = 4$ $p < 0.0001$	$r = -0.312$ $p < 0.0001$
Less emphasis should be placed on *protecting* the public from the mentally ill. Mental patients need the same kind of control and *discipline* as a young child.	$F = 10.708$ $df = 4$ $p < 0.0001$	$r = -0.292$ $p < 0.0001$

Furthermore, contrasted by the overwhelming majority who disagreed with treating the mentally ill behind locked doors (97.5%), almost a third disagreed that less emphasis should be placed on *protecting the public* from the mentally ill (29.1%). This may imply that these respondents possibly believe that the public should be protected from the mentally ill, indicating a possible fear of those with mental illness or the belief that the mentally ill may be harmful or dangerous.

Although no evidence was found of a relationship between beliefs about treating the mentally ill behind *locked doors* and ***protecting the public*** from mental patients, significant associations were found between the latter mentioned variable and other items on the Authoritarianism subscale (see Table 4.11). One-way analysis of variance showed highly significant associations between beliefs about protecting the public and believing that it is easy to *tell the mentally ill apart* from so-called normal people, that *hospitalisation* is called for at the first signs of mental illness, and believing that mental patients need the same kind of *discipline* and control as young children. With correlation analysis it was found that respondents who disagreed with less emphasis being placed on protecting the public from the mentally ill tended to agree that one can easily tell the mentally ill apart from other people, that persons should be hospitalised at the first signs of mental illness, and that the mentally ill need to be disciplined and controlled like children. This may indicate that these respondents believe in the common myths of the mentally ill being somehow very "different" from so-called normal people, that they should be taken out of society and treated in hospitals, that they are irresponsible and childlike, and that they pose a threat to the public. Furthermore, this may arguably be interpreted as a finding that some respondents adhere to the belief that the mentally ill are violent and dangerous.

4.6.2 Benevolence

HR practitioners who acted as respondents to this study showed mostly *positive* attitudes towards the mentally ill as measured by the Benevolence subscale of the CAMI. Mean item scores showed that respondents as a group generally agreed that society should be more tolerant of the mentally ill ($\bar{x}$ = 1.74; *SD* = 0.68) and has the responsibility of providing the best possible care for those with mental illness ($\bar{x}$ = 1.89; *SD* = 0.94) (see Table 2 of Appendix I). Respondents also tended to disagree with the statement that increased spending on the mentally ill would be a waste of tax monies ($\bar{x}$ = 4.32; *SD* = 0.71) or that the mentally ill do not deserve our sympathy ($\bar{x}$ = 4.30; *SD* = 0.87).

However, analysis of frequencies revealed that even though the majority agreed that more tax money should be spent on caring for the mentally ill (82.6%), that society should be more tolerant of the mentally ill (94.3%), and should provide the best possible care (88.9%), some respondents nonetheless agreed that the mentally ill are a burden to society (13.4%). One-way analysis of variance showed that an association existed between agreeing that the mentally ill are a ***burden*** and beliefs about the amount of tax monies allocated to mental health care, being more tolerant, and providing the best possible care (see Table 4.12). Correlation analysis supported this finding and showed that a negative, fairly weak but highly significant relationship existed between believing that the mentally ill are a burden to society and agreeing

that more *tax money* should be spent on their care, that society should be more *tolerant* and that society has the responsibility of providing the *best possible care* for the mentally ill. This may indicate that while the majority had sincere benevolent attitudes towards the mentally ill, some felt that caring for the mentally ill should not be at society's expense.

Table 4.12 Statistically significant associations between responses to Benevolence items

Benevolence items	**ANOVA**	**Correlation**
The mentally ill are a *burden* on society. More *tax monies* should be spent on the care and treatment of the mentally ill.	$F = 4.331$ $df = 4$ $p = 0.002$	$r = -0.281$ $p < 0.0001$
The mentally ill are a *burden* on society. We need to adopt a far more *tolerant* attitude toward the mentally ill in our society.	$F = 4.331$ $df = 4$ $p = 0.002$	$r = -0.209$ $p < 0.0001$
The mentally ill are a *burden* on society. We have a responsibility to provide the *best possible care* for the mentally ill.	$F = 4.331$ $df = 4$ $p = 0.002$	$r = -0.160$ $p = 0.002$

4.6.3 Social restrictiveness

Groups mean scores on the subscale assessing social restrictiveness sentiments showed that respondents held mainly *positive* attitudes towards the mentally ill regarding this concept. On average, respondents disagreed that the mentally ill should be isolated from the rest of the community ($\bar{x} = 4.29$; $SD = 0.73$), and agreed that they should not be denied their individual right ($\bar{x} = 1.99$; $SD = 1.10$), that no one has the right to exclude the mentally ill from their neighbourhood ($\bar{x} = 1.83$; $SD = 0.84$), and that they should be encouraged to assume the responsibilities of normal life ($\bar{x} = 1.80$; $SD = 0.77$) (see Table 3 of Appendix I).

Analysis of frequencies showed that the majority disagreed with the mentally ill not been given any *responsibility* (82.4%), implying that they should be given responsibilities. A further 88.8% agreed that no one has the right to *exclude* the mentally ill from their neighbourhood while 92.1% agreed that the mentally ill should be *encouraged* to assume the

responsibilities of normal life. In contrast to these findings, however, almost one third agreed that those with a history of mental illness should be excluded from taking a *public office* position (29.1%), while close to one quarter of the respondents agreed that they did not want to *live next door* to someone who had been mentally ill (23.9%). Furthermore, just over a quarter

disagreed that the mentally ill are far less of a *danger* than most people suppose (25.5%) and close to a third disagreed that women who had once been mental patients could be trusted as *babysitters* (32%).

One-way analysis of variance showed that statistically significant associations existed between believing the mentally ill should *not be given any* ***responsibility*** and that ex-mental patients should be excluded from *public office*, and with believing that the mentally ill should be *encouraged* to assume the responsibilities of normal life (see Table 4.13). Correlation analysis determined that a fairly weak positive yet highly significant relationship existed between agreeing that the mentally ill should not be given any *responsibility* and agreeing that they should be *excluded from taking public office*. A fairly weak negative but highly significant association was found between agreeing that the mentally ill should be *encouraged* to assume the responsibilities of normal life and agreeing that they should not be given any *responsibility*.

Table 4.13 Associations between responses to selected Social Restrictiveness items

Social restrictiveness items	**ANOVA**	**Correlation**
The mentally ill should not be given any *responsibility*. Anyone with a history of mental problems should be excluded from taking *public office*.	$F = 8.989$ $df = 4$ $p < 0.0001$	$r = 0.277$ $p < 0.0001$
The mentally ill should not be given any *responsibility*. Mental patients should be *encouraged* to assume the responsibilities of normal life.	$F = 14.988$ $df = 4$ $p < 0.0001$	$r = -0.243$ $p < 0.0001$
I would not want to *live next door* to someone who has been mentally ill. No one has the right to *exclude* the mentally ill from their neighbourhood.	$F = 6.694$ $df = 4$ $p < 0.0001$	$r = -0.252$ $p < 0.0001$
The mentally ill are far less of a *danger* than most people suppose. Most women who were once patients in a mental hospital can be trusted as *babysitters*.	$F = 1.603$ $df = 4$ $p = 0.173$	
I would not want to *live next door* to someone who has been mentally ill. Most women who were once patients in a mental hospital can be trusted as *babysitters*.	$F = 3.110$ $df = 4$ $p = 0.015$	$r = -0.136$ $p < 0.009$

Table 4.13 continued

The mentally ill are far less of a *danger* than most people suppose. The mentally ill should be *isolated* from the rest of the community.	$F = 4.893$ $df = 4$ $p = 0.001$	$r = -0.139$ $p = 0.008$

Furthermore, an association was found between agreeing about ***not wanting to live door*** to ex-mental patients and agreeing that no one has the right to *exclude* the mentally ill from their neighbourhood (see Table 4.13). Correlation analysis showed that this was a fairly weak negative yet highly significant relationship. Although a significant association could not be found between believing that the mentally ill are less of a ***danger*** than most people suppose and believing that ex-mental patients cannot be trusted as *babysitters*, an association was found between not wanting to *live next door* to an ex-patient and believing that ex-patients could make trusted *babysitters*. This proved to be a weak negative significant relationship. A significant association was also found between agreeing that the mentally ill are less of a *danger* than most people suppose and agreeing that the mentally ill should be *isolated* from the rest of the community. This also proved to be a weak negative, significant relationship.

From the above determinations it may arguably be deduced that respondents tend to believe that the mentally ill should be given responsibilities but not those where they are in public decision-making positions or where they are responsible for the wellbeing or lives of others, particularly the young and the defenceless. Furthermore, it would appear that even though most respondents advocate dispelling the myth of the mentally ill being dangerous or needing to be feared, some nonetheless tend to regard the mentally ill as possibly dangerous and do not want to be in too close quarters with them outside of the workplace and prefer that they be isolated from the rest of the community.

4.6.4 Community mental health ideology (CMHI)

As with the three other subscales of the CAMI, respondent group means generally showed *positive* attitudes towards the mentally ill on the subscale assessing beliefs about a community mental health ideology. Mean item scores showed that respondents generally agreed that being part of a normal community would be the best therapy for many mental patients ($\bar{x} = 1.93$; $SD = 0.68$) and that mental health facilities should be provided through community based facilities ($\bar{x} = 1.98$; $SD = 0.74$) (see Table 4 of Appendix I). The general consensus was also to disagree that residents had reason to resist mental health facilities in their neighbourhoods ($\bar{x} = 3.76$; SD

= 0.95) and that mental health facilities should be kept out of residential areas ($\bar{x}$ = 3.72; *SD* = 0.98). An interesting finding was that very few of the mean CMHI subscale scores convey strong feelings (i.e., where $\bar{x} > 4$ or $\bar{x} < 2$).

Analysis of frequencies showed that while the majority agreed that the *best therapy* for many of the mentally ill is to be part of a normal community (89.1%) and that mental health facilities should be provided through *community-based* facilities (88.3%), a fair amount disagreed with the statement that locating mental health services in residential areas does not *endanger* the residents (18.8%) or that residents have nothing to *fear* from the mentally ill coming into residential areas to obtain services (22.3%). The theme of fear and danger is further supported by the 26.3% who agreed that having the mentally ill live in residential areas is good therapy but *too risky* to local residents and the 19.6% who agreed that it is *frightening* to think of the mentally ill living in residential neighbourhoods. A further 29.1% agreed that locating mental health facilities in residential areas would *downgrade* the neighbourhood.

One-way analysis of variance showed that all the abovementioned CMHI variables were significantly associated with one another at the 0.01 level. Correlation analysis helped to determine the direction and strength of these associations. Respondents who disagreed that mental health services in residential areas did not ***endanger*** local residents also tended to disagree that residents have nothing to *fear* from the mentally ill coming into residential areas to obtain services (see Table 4.14). These respondents, however, tended to agree that residents had good reason to *resist* the location of mental health services in their neighbourhoods, that mental health facilities should be *kept out* of residential areas, and that that it was *frightening* to think about the mentally ill living in residential neighbourhoods.

Table 4.14 Associations between believing that locating mental health facilities in residential neighbourhoods does not endanger local residents, and other CMHI items

CMHI items	**ANOVA**	**Correlation**
Locating MH services in residential neighbourhoods does not *endanger* local residents. Residents have nothing to *fear* from people coming into their neighbourhoods to obtain MH services.	$F = 14.492$ $df = 4$ $p < 0.0001$	$r = 0.325$ $p < 0.0001$
Locating MH services in residential neighbourhoods does not *endanger* local residents. Local residents have good reason to *resist* the location of MH services in their neighbourhoods.	$F = 20.019$ $df = 4$ $p < 0.0001$	$r = -0.246$ $p < 0.0001$

Table 4.14 continued

Locating MH services in residential neighbourhoods does not *endanger* local residents. MH facilities should be *kept out* of residential neighbourhoods.	$F = 15.853$ $df = 4$ $p < 0.0001$	$r = -0.239$ $p < 0.0001$
Locating MH services in residential neighbourhoods does not *endanger* local residents. It is *frightening* to think of people with mental problems living in residential neighbourhoods.	$F = 7.175$ $df = 4$ $p < 0.0001$	$r = -0.123$ $p = 0.018$

Note. MH = mental health

Respondents who disagreed that residents had nothing to ***fear*** from people coming into residential areas to obtain mental health services tended to agree that residents had good reason to *resist* the location of mental health services in their neighbourhoods (see Table 4.15). They also tended to agree that having patients live in residential areas may be good therapy but the *risks* to local residents are too high, and that it was *frightening* to think of the mentally ill living in residential neighbourhoods.

Table 4.15 Associations between believing that residents have nothing to fear from people coming into their neighbourhoods to obtain MH services, and other CMHI items

CMHI items	**ANOVA**	**Correlation**
Residents have nothing to *fear* from people coming into their neighbourhoods to obtain MH services. Local residents have good reason to *resist* the location of MH services in their neighbourhoods.	$F = 15.766$ $df = 4$ $p < 0.0001$	$r = -0.263$ $p < 0.0001$
Residents have nothing to *fear* from people coming into their neighbourhoods to obtain MH services. Having mental patients live in residential neighbourhoods might be good therapy but the *risks* to residents are too great.	$F = 8.536$ $df = 4$ $p < 0.0001$	$r = -0.214$ $p < 0.0001$
Residents have nothing to *fear* from people coming into their neighbourhoods to obtain MH services. It is *frightening* to think of people with mental problems living in residential neighbourhoods.	$F = 8.803$ $df = 4$ $p < 0.0001$	$r = -0.200$ $p < 0.0001$

Note. MH = mental health

HR practitioners who participated in this study and agreed that it was ***frightening*** to think of the mentally ill living in residential areas also tended to agree with *resisting* the placement of mental health facilities in residential areas (see Table 4.16). Furthermore, respondents who agreed that it was frightening to think of mental patients living in residential areas also tended to agree with *keeping mental health facilities out* of residential areas, and that the *risks* were too high to have mental patients live in residential areas even though this may be good therapy.

Table 4.16 Associations between believing that it is frightening to think of people with mental problems living in residential areas, and other CMHI items

CMHI items	**ANOVA**	**Correlation**
It is *frightening* to think of people with mental problems living in residential neighbourhoods. Local residents have good reason to *resist* the location of MH services in their neighbourhoods.	$F = 21.295$ $df = 4$ $p < 0.0001$	$r = 0.283$ $p < 0.0001$
It is *frightening* to think of people with mental problems living in residential neighbourhoods. MH facilities should be *kept out* of residential neighbourhoods.	$F = 10.749$ $df = 4$ $p < 0.0001$	$r = 0.260$ $p < 0.0001$
It is *frightening* to think of people with mental problems living in residential neighbourhoods. Having mental patients live in residential neighbourhoods might be good therapy but the *risks* to residents are too great.	$F = 8.446$ $df = 4$ $p < 0.0001$	$r = 0.244$ $p < 0.0001$

Note. MH = mental health

Respondents who agreed that locating mental health facilities in residential areas would ***downgrade*** the neighbourhood also tended to agree that residents had good reason to *resist* the placement of these facilities in their neighbourhoods (see Table 4.17). These respondents also tended to agree that mental health services should be *kept out* of residential areas, and that it was *frightening* to think of the mentally ill living in residential areas.

Table 4.17 Associations between believing that locating mental health facilities in a residential area downgrades the neighbourhood, and other CMHI items

CMHI items	ANOVA	Correlation
Locating MH facilities in a residential area *downgrades* the neighbourhood. Local residents have good reason to *resist* the location of MH services in their neighbourhoods.	$F = 14.072$ $df = 4$ $p < 0.0001$	$r = 0.343$ $p < 0.0001$
Locating MH facilities in a residential area *downgrades* the neighbourhood. MH facilities should be *kept out* of residential neighbourhoods.	$F = 9.161$ $df = 4$ $p < 0.0001$	$r = 0.271$ $p < 0.0001$
Locating MH facilities in a residential area *downgrades* the neighbourhood. It is *frightening* to think of people with mental problems living in residential neighbourhoods.	$F = 8.191$ $df = 4$ $p < 0.0001$	$r = 0.236$ $p < 0.0001$

Note. MH = mental health

It would therefore appear as though HR practitioners who took part in this survey mostly agreed in principle with a community mental health ideology. However, a fair amount may possibly adhere to the myth of the mentally ill being violent and dangerous and therefore needing to be feared. Furthermore, respondents who tended to hold danger/fear beliefs about the mentally ill also tended to want to place some distance between their private lives (i.e., residential area) and the mentally ill or mental health facilities.

The finding that some respondents felt that placing mental health facilities in residential areas would downgrade these neighbourhoods may be related to beliefs that *others'* hold negative attitudes towards the mentally ill. This may correspond with findings by Jorm et al. (1999) who investigated beliefs about the long-term outcomes for the mentally ill after treatment and found that negative outcomes were associated with agreeing that the mentally ill would be discriminated against. However, the association between believing mental health facilities would downgrade neighbourhoods and admitting that it was frightening to think about mental patients in residential neighbourhoods may dismiss Jorm et al.'s finding in this case. It is possible that these respondents fear the mentally ill but would rather admit to an "objective" reason for not wanting the mentally ill in residential areas (i.e., downgrade the area), than admit to their own emotional reaction (i.e., fear).

4.6.5 Comparing the four CAMI subscales

Using Pearson's correlation coefficient (r) the **four subscales of the CAMI** scale were compared with one another. A moderate negative relationship was found between the Authoritarianism subscale and the Benevolence subscale, while the relationship with the CMHI subscale was also negative but fairly weak (see Table 4.18). Authoritarianism had a positive moderate relationship with social restrictiveness. These associations, as with all other correlations within this correlation matrix, were highly significant ($p < 0.0001$). The Benevolence subscale was found to have a strong negative relationship with the Social Restrictiveness subscale, and a moderate positive relationship with the CMHI subscale. The relationship between the Social Restrictiveness and CMHI subscales proved to be a strong negative one.

These findings are in line with the original design of the CAMI, where authoritarianism and social restrictiveness sentiments encompass negative attitudes towards the mentally ill, while benevolence and community mental health ideology sentiments encompass positives attitudes. Therefore it would be expected that respondents who agree with authoritarianism and social restrictiveness statements would disagree with benevolence and CMHI statements. It is important to note, however, that attitudes are multi-dimensional and complex. It is possible for an individual to, for example, mostly agree with authoritarianism sentiments but also agree with certain benevolence and CMHI statements (Taylor & Dear, 1981). This would explain why the strengths of the achieved associations range from fairly weak to fairly strong. General trends in respondents' attitudes towards the mentally ill may, however, be observed and compared. The finding that the subscales assessing negative attitudes did not have positive relationships with those assessing positive attitudes finds support for the underlying concepts the four subscales are purported to measure.

Table 4.18 Correlation matrix of the four CAMI subscales

	Authoritarianism	Benevolence	Social restrictiveness	CMHI
Authoritarianism	1.000 .	-.476** .000	.409** .000	-.247** .000
Benevolence	-.476** .000	1.000 .	-.550** .000	.469** .000
Social restrictiveness	.409** .000	-.550** .000	1.000 .	-.607** .000
CMHI	-.247** .000	.469** .000	-.607** .000	1.000 .

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

4.6.6 Comparing mental health attitudes with demographic and work variables

Demographic and work variables were compared with group mean scores on the CAMI scale utilising comparison of means and one-way analysis of variance. Regarding respondents ***demographic*** characteristics, holding *authoritarianism* sentiments was found to be associated with registration level, academic qualification, and academic institution (recoded data) where most recent HR qualification had been obtained. Respondents who were *registered* at the level Candidate Practitioner had the lowest mean score on the Authoritarianism subscale, and therefore more positive attitudes, compared with other respondents ($\bar{x}$ = 19.83; *SD* = 4.31). Associate Practitioners, on the other hand, had the highest mean score ($\bar{x}$ = 22.86; *SD* = 5.54), indicating more negative attitudes towards the mentally ill concerning the underlying concept assessed with this subscale ($F = 3.484$; $df = 4$; $p = 0.008$).

Respondents with a matric as highest academic *qualification* were the most *authoritarian* ($\bar{x}$ = 25.25; *SD* = 4.79), while the post-doctorates had the lowest average score ($\bar{x}$ = 16.25; *SD* = 3.77) and therefore held more positive attitudes towards the mentally ill regarding the underlying concept measured on this subscale ($F = 3.342$; $df = 7$; $p = 0.002$). Respondents who had received their most recent HR qualification from a local university had a lower authoritarianism mean score ($\bar{x}$ = 20.36; *SD* = 5.06), and therefore more positive attitude, than those with an international ($\bar{x}$ = 20.83; *SD* = 4.17) or technikon/college qualification ($\bar{x}$ = 22.18; *SD* = 4.82; $F = 3.585$; $df = 2$; $p = 0.029$).

Respondents' mean scores on the *Benevolence* subscale were found to be associated with academic *qualification*, where a higher qualification was related to stronger benevolent, and therefore more positive, sentiments. Respondents who had only achieved a matric were the least benevolent ($\bar{x}$ = 37.75; *SD* = 2.87) while those with a post-doctorate were the most ($\bar{x}$ = 45.25; *SD* = 4.92), and therefore had more positive attitudes towards the mentally ill ($F = 2.192$; $df = 7$; $p = 0.034$).

Respondents with a higher, locally attained, qualification therefore tended to be more positively orientated towards the mentally ill than other subgroups, although HR practitioners registered at middle levels (i.e., Candidates) had more positive attitudes than those at other levels of registration.

Respondents' views about dealing with employee mental health issues at ***work*** were correlated with group mean scores on the four CAMI subscales and showed that beliefs about the *need* to be able to deal with employee mental health issues at work were associated with benevolence,

social restrictiveness and CMHI mean scores. Those who agreed strongly with the need to be able to deal with mental health issues had the highest mean score of all respondents on the *Benevolence* subscale ($\bar{x}$ = 42.17; *SD* = 4.16), while those who strongly disagreed scored the lowest ($\bar{x}$ = 39.04; *SD* = 4.99) and were therefore more negatively orientated towards the mentally ill (F = 4.537; df = 4; p = 0.001). Respondents who agreed strongly with this need also had the highest mean score on the *CMHI* subscale ($\bar{x}$ = 37.76; *SD* = 5.74) in contrast to those who strongly disagreed scoring the lowest ($\bar{x}$ = 34.38; *SD* = 5.04) and thus being the most negatively orientated regarding this concept (F = 3.032; df = 4; p = 0.018). Those who most firmly believed in the need to be able to deal with employee mental health issues had the lowest average score on the *Social Restrictiveness* subscale ($\bar{x}$ = 21.03; *SD* = 4.91), while those who strongly disagreed with this need had the highest mean score ($\bar{x}$ = 23.60; *SD* = 4.78) and were therefore more negatively orientated towards the mentally ill (F = 3.859; df = 4; p = 0.004).

An agreement with the need to be able to deal with employee mental health issues may therefore be associated with more positive attitudes towards the mentally ill.

In **summary**, HR practitioners who participated in this survey appeared to hold mainly positive attitudes towards the mentally ill in terms of their group mean scores on the four subscales of the CAMI. However, univariate analysis of frequencies revealed subtle negative attitudes as measured by the individual items within each of the four subscales. Although not in the majority, fair amounts of respondents appeared to adhere to the danger/fear myth of mental illness, to endorse the belief that the mentally ill are not suitable for responsible, decision-making or protector roles, and that both the mentally ill and their care facilities should be kept away from "normal" communities.

Analysis of variance and correlation analysis showed that negative sentiments were positively related to each other and inversely related to more positive sentiments. Furthermore, that group mean scores on the CAMI were associated with demographic and work variables including level of registration, academic qualification and believing that there existed a need for HR practitioners to be able to deal with employee mental health issues at work.

4.7 Summary

This chapter described the research findings of the survey investigating HR practitioners' attitudes towards the mentally ill and their mental health literacy. A response rate of 31% was achieved, with respondents roughly evenly distributed across the three vignettes included as part

of the survey questionnaire. Respondents resembled the study population, that is, the SABPP, in terms of their demographic and work characteristics.

The majority of respondents could not recognise mental illness, and faired poorly at identifying the different mental illnesses, especially panic disorder. Most respondents favoured psychosocial stress and intrapsychic factors as causes of mental illness, and believed that psychological and lifestyle treatment strategies would be helpful for the behaviour in the vignette they were presented with. Medical treatment strategies were most often viewed as harmful, or as neither helpful nor harmful.

At first glance, the majority of respondents had mainly positive attitudes towards the mentally ill as measured by the CAMI. However, when looking at individual items within each subscale of the CAMI, subtle negative attitudes were found, particularly relating to the fear/danger and responsibilities myths of mental illness.

The following chapter reports on the conclusions and recommendations to be made based on these research findings. Feedback is given on each of the assumptions made at the onset of the study, and this is brought into context of the research questions and ultimately the research problem. The study limitations are outlined, and recommendations are made for further research.

Chapter 5

"One never notices what has been done; one can only see what remains to be done"
Marie Curie (1867-1934)

CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This study set out to investigate and describe as accurately as possible the mental health literacy and attitudes of HR practitioners in South Africa. It was also concerned with investigating whether mental health literacy levels differ for different mental illnesses, and whether any associations exist between HR practitioner demographic and work variables, and their mental health literacy and attitudes. A sample survey was therefore conducted of SABPP members, to which a 31% response rate was achieved. Respondents resembled actual SABPP membership figures regarding their demographic and work characteristics, enabling inferences to be made to the study population.

This chapter discusses the study results in relation to the research objectives as stated at the onset of the study. The main findings are highlighted and used to respond to the research questions and related assumptions. The ultimate aim is to provide feedback to the research problem, and in the light of this, recommendations for HR training and practice are made. Study limitations are outlined, and areas for further research are listed.

5.2 Discussion of main findings

The main findings of this study were that (1) HR practitioners, as represented by respondents, are not literate in mental health and that (2) even though at first glance they generally hold positive attitudes, some nonetheless do hold subtle negative attitudes towards the mentally ill.

5.2.1 Mental health literacy

Mental health literacy refers to the knowledge and beliefs about mental illness that aid in the recognition, management and prevention of mental illnesses. Given the reality of mental illness in the workplace, coupled with the challenges of the new world of work, this study argued that HR practitioners should be mental health literate. Research questions were therefore asked pertaining to HR practitioners' knowledge and beliefs about mental illness that would facilitate their effectively managing mental illness in the workplace. The assumptions were made that respondents to this study would not be able to recognise mental illness or identify different

disorders and that they would lack knowledge regarding the risk factors and causes of mental illness as well as the most appropriate treatment strategies. Three vignettes were used to compare knowledge and beliefs about different mental disorders. The vignettes described one condition each, being depression, panic disorder, or alcohol abuse.

The HR practitioners in this study **faired poorly on all measures of mental health literacy**. This conclusion was made based on the following main findings:

(a) only 6.8% ***recognised*** the behaviour in the vignette as a definite mental illness, even though each vignette satisfied DSM-IV diagnostic criteria.

(b) more than one half of the respondents with an alcohol abuse or a panic disorder vignette believed that the described behaviour was a normal response.

(c) only 34% could correctly ***name*** the diagnosis described in the vignette, with only 6.6% being able to correctly identify panic disorder.

(d) the majority believed that psychosocial stress was the most likely ***cause*** of the described behaviour, with only 29.3% agreeing that biological factors could have played a role.

(e) psychosocial stress was rated most frequently as the cause for the depression and panic disorder vignettes, while those responding to the alcohol abuse vignette most frequently agreed with intrapsychic causal factors. It is well accepted that all three conditions surveyed in this study are caused by a combination of biological and psychosocial factors (Charney et al., 1999; Kaplan & Sadock, 1997).

(f) the overwhelming majority rated psychological and lifestyle ***treatment strategies*** as helpful for the person in the vignette, irrespective of the described diagnosis. Medical treatments were most frequently rated as harmful, or as being neither helpful nor harmful.

(g) the only medical treatment strategy rated as helpful by the majority of respondents was antidepressants, and only in the case of the depression vignette. However, it is well accepted that a combination of medication (most often antidepressants) and psychotherapy is the most appropriate treatment for depression and panic disorder (Stahl, 2000; Stein & Hollander, 2003). Medication is also helpful for alcohol abuse,

including the associated mood and anxiety disorders that are often co-morbid with this condition (de Miranda & Wilson, 2001; Kaplan & Sadock, 1997).

(h) admission to a psychiatric ward and electro-convulsive therapy (ECT) were rated as harmful for all three described conditions. However, ECT is a safe and extremely effective treatment for severe depression, especially when other treatments have not been effective or are not suitable for the concerned patient (APA, 1990; Coffey et al., 1984). Furthermore, treatment in a ward may be necessary and useful in treating all three conditions, especially in severe cases or to initiate and monitor treatment (Kaplan & Sadock, 1997; Liu & Liew, 2003; Schuster, 2003).

The mental health literacy of HR practitioners was found to be **associated with certain demographic and work variables**. Respondents with higher *academic qualifications* were slightly better at recognising mental illness and identifying different disorders than those with lower qualifications. An important finding was that those with many *years of HR experience* faired poorly at recognising mental illness, especially if they also had lower qualifications. This obviously holds implications for the education and re-training of HR practitioners who have been in the field for some time. Respondents registered at higher *levels* with the SABPP were slightly better informed about the risk factors and causes of mental illness, but only in relation to the role of biological factors and to the extent that they did not disagree that these factors could have played a role, as was the case with those at lower levels of registration. However, HR practitioners with higher *academic qualifications* were less literate regarding the risk factors, causes and best treatment strategies for mental illness than those who were less qualified. It is therefore clear that even those with higher academic qualifications have gaps in their mental health knowledge. This requires urgent steps to improve the mental health literacy of **all HR practitioners**, especially given the finding that respondents who were less literate regarding the risk factors and causes of mental illness also tended *never to refer* employees to company health facilities. Given the significant prevalence and costs of mental illness to industry, and that mental illness can be effectively treated, the field of HRM can no longer ignore mental illness in its training and education curricula.

The mental health literacy findings of this study find support for **other studies** conducted both locally and abroad. Community surveys in Australia and the United Kingdom report that the general public are poor at recognising and identifying mental illness (Fisher & Goldney, 2003; Goldney et al., 2001; Jorm et al., 1997a; Jorm, 2000; Wolff et al., 1996a). It is perhaps a poor reflection on the training of HR practitioners in South Africa that corresponding results were achieved with this survey of the "people specialists" in the business world as were obtained with

surveys of the lay public. Respondents to surveys in Germany, Australia, the United States and South Africa most frequently believed that psychosocial stress and environmental factors or a weak character would lead to mental illness, with very few agreeing that biological factors may have played a role in the aetiology of these conditions (Angermeyer & Matschinger, 1994; Hugo et al., in press; Jorm, 2000; Stahl, 2000). Even though the majority of respondents to this study did not believe that a weak character could have caused the behaviour in the vignette they were presented with, their beliefs about other risk factors and causes of mental illness duplicated findings reported by other studies. Furthermore, results from this study confirm the findings of surveys in Germany, Australia, the United Kingdom, and South Africa where members of the general public most frequently believed that lifestyle and psychological treatment strategies would be useful for mental illness, and most often felt that medical treatments would be harmful (Angermeyer & Matschinger, 1994; Angermeyer et al., 1993; Fisher & Goldney, 2003; Goldney et al., 2001; Hugo et al., in press; Jorm et al., 1997a, 1997c; Jorm, 2000; Priest et al., 1996).

The results of this study therefore show that HR practitioners in South Africa are possibly no more literate in mental illness than are members of the general public as reported by studies conducted both abroad and locally. Although this study was conducted from a quantitative research paradigm, **comments made by respondents** in the feedback section of the questionnaire (see Appendix C) provide supportive qualitative data. From these comments, it would appear that some HR practitioners recognise their ***lack of knowledge and training*** in mental illness:

"HR Practitioners generally have too little training and experience in dealing with employees with mental health problems."

"It may be that the majority of HR practitioners are not competent enough in the fields of psychology or psychiatry to provide 100% competent constructive answers in this research."

"Thank you for the opportunity. It was not easy to answer the questions as I am not an expert in this field. Good luck with your research."

"None. Not adequately qualified in this area to comment."

"Some medical medicine terminology not understood - I am not a medical person, therefore these are my personal thoughts on the issue and may be inaccurate - my feelings rather than knowledge are expressed."

Other respondents commented on the ***need*** for addressing mental illness in the workplace, and that both research and training in this area is required. Most, however, saw this from a mental health point of view, indicating a ***lack of awareness*** of the reality of mental illness:

"Very comprehensive. Good luck - this topic needs urgent attention!"

"Intermittent mental illness, such as panic attacks (debilitating) are often difficult to manage in the workplace."

"My experience with mental illness is limited. In the few cases that I have dealt with I have arranged for professional counselling for the person - which has helped."

"This kind of research is essential. However, it is also important to focus on the positive side of things affecting all of us, i.e. mental health as opposed to mental illness. Practical guidelines are needed for the HR practitioner and line manager."

Some comments clearly showed a ***lack of understanding*** of the nature of mental illness, and ***ignorance*** about the aetiology and best treatments for these conditions. Other respondents made comments that may suggest that they do not believe that HR practitioners should deal with mental illness at work, but that the ***responsibility*** lies with other groups such as family:

"... Danger of 'overanalysis' at times when caring may be all that is needed for a period in time. More deep rooted manifestations need professional assistance."

"I believe that the mind is all powerful and we need to first work on being in control of our behaviour."

"Importance of life skills training to help people cope, support in the workplace to facilitate re-entry and assimilation, support and counselling for family, support people and work superiors."

"Mental health and its importance must be emphasised from primary school. The importance of building positive self-esteem cannot be over emphasised. Television must be utilised to help with programmes to assist SA."

"Families must be quick to identify signs that probably need medical attention and act responsibly."

Many comments were received about the role of ***stress-related factors*** in the mental health of employees. This underscores the finding that respondents favoured psychosocial stress as a risk factor and cause of mental illness. Again, the lack of knowledge regarding the aetiology of mental illness is emphasised. Moreover, it would appear that many respondents simply used the concept of "stress", rather than being able to use specific concepts of mental illness. Although there is useful literature on the biology of stress (e.g., Charney et al., 1999; Heuser & Lammen, 2003; Miczek, Tornatzky & van Erp, 1996), medicine and psychology now offer specific diagnoses of mental disorders (APA, 1994; WHO, 2001b):

"Stress amongst Caucasians. Spiritualism amongst indigenous Africans."

"Stress related factors are playing a major role in mental health of employees."

"Stress and stress related factors caused by work pressure now involve social support structures and lack of insight into psychological [mental illness] as reflected by society, is a major issue of social isolation."

"Stress at work - which is more related to reacting targets, poor management and victimisation."

5.2.2 Mental health attitudes

Negative attitudes towards the mentally ill impact on the costs and burden of mental illness in that they deter appropriate help-seeking behaviour and hinder adherence with prescribed treatments. Furthermore, given that the HR practitioner should be concerned with promoting mental health in the workplace and effectively managing mental illness, this study argued that a positive orientation towards the mentally ill is required. A research question was therefore posed asking about the orientation of HR practitioners in South Africa towards the mentally ill. The assumption was made that HR practitioners have negative attitudes towards the mentally ill as measured by the four subscales of the CAMI. That is, they score high on the Authoritarianism and Social Restrictiveness subscales and low on the Benevolence and CMHI subscales.

A cursory review of results showed that HR practitioners who acted as respondents to this study generally held positive attitudes towards the mentally ill. This was evidenced by group mean scores on all four subscales of the CAMI. The possibility of **response sets** needs to be acknowledged though, as this often occurs with attitude surveys (de Vaus, 1996). The design of

the CAMI is geared at countering *acquiescent response sets*, where respondents agree with all statements irrespective of their true attitude (Taylor & Dear, 1981). However, the possibility of *social desirability response sets* also exists, where respondents respond in a manner that they believe will place them in a good light with the researcher. The CAMI's use of multiple items to measure each underlying concept of mental health attitudes may assist in reducing the chances of obtaining social desirability response sets. Nonetheless, cognisance should be taken of the possibility of these response sets when looking at initial results.

On closer inspection of the study results, however, **subtle negative attitudes** were evident. This conclusion was based on the following main findings:

(a) almost a third of the respondents agreed with authoritarianism statements which imply that the public needs to be ***protected*** from the mentally ill and that mentally ill patients should be ***hospitalised***. However, the mentally ill are not significantly more violent than the rest of society and indeed, are more likely to be the victims of crime than to be criminals (APA, 1997; Harnois & Gabriel, 2000; WHO, 2001b). The shift away from institutionalised care to community-based care is motivated by the fact that community-based services can improve the outcome and quality of life for many mental patients. Moreover, this is more cost-effective, respectful of human rights, can aid early intervention and limit the stigma of mental illness (WHO, 2001b).

(b) these respondents also tended to believe that the mentally ill are ***noticeably different*** from so-called normal people and that they need to be ***disciplined and controlled*** like young children. However, advances in psychiatry and psychology have improved the outcome for many of the mentally ill, both in terms of the side effects of treatments and in facilitating their return to being normally functioning persons (US Department of Health & Human Services, 1999; WHO, 2001b). Workplace studies have also shown that on return to work, the mentally ill are better than average in attendance and punctuality and as good or even better than other employees in motivation, quality of work and work tenure (Harnois & Gabriel, 2000). Furthermore, a study by the National Institute of Mental Health (NIMH) in the United States found no significant differences in productivity between mental patients who had been treated and rehabilitated and their demographic equivalents (Weiner, Akabas & Sommer, 1973).

(c) although not in the majority, a fair amount of respondents agreed with the benevolence sentiment that the mentally ill are a ***burden to society***. However, the WHO's Project Atlas, which analyses information on mental health resources in 191 WHO Member

States (representing 99.3% of the world's population), reports that the care of the mentally ill is globally characterised by severe shortages and neglect (WHO, 2001c, p.1). Data from developed and developing countries shows that 41% have no mental health policy; 25% have no mental health legislation; 28% have no separate budget for mental health and 37% have no community care facilities for the mentally ill (WHO, 2001c, p. 1). Furthermore, a third of all countries spend less than 1% of their national health budgets on treating mental conditions, even though the WHO recommends an allocation of between 5 and 10% (Pincock, 2002, p. 1).

(d) these respondents tended to feel that ***less tax money*** should be spent on the mentally ill, that it was ***not necessary*** for society to be more ***tolerant*** of the mentally ill, nor was it society's responsibility to provide the ***best possible care*** for the mentally ill. It is well recognised, however, that the care of the mentally ill traditionally lacks resources and has not been prioritised within national policies or budgets, although this is sorely needed in South Africa as in most countries across the globe (Emsley, 2001; WHO, 2001b, 2001c).

(e) close to a third of the respondents reacted to social restrictiveness statements in a manner that implies that they believe the mentally ill should ***not be given decision-making responsibilities*** or be responsible for the wellbeing of the defenceless. With appropriate treatment, however, many of the mentally ill can resume normal functioning and responsible lives (APA, 1997; Harnois & Gabriel, 2000; WHO, 2001a, 2001b).

(f) a further quarter of the respondents expressed ***fear and danger*** sentiments by admitting that they did not want to live next door to the mentally ill and that they believed the mentally ill are more of a danger than most people suppose. Again, it needs to be stated that contrary to the common myth, the mentally ill are not more dangerous than other members of society. This popular myth is often fuelled by ignorance and negative portrayals in the media (Harnois & Gabriel, 2000; WHO, 2001b).

(g) roughly a quarter of the respondents showed negative attitudes on the CMHI subscale in terms of believing that having mental patients live in or come into residential areas to receive care would be ***dangerous*** to local residents. A further fifth of all respondents admitted that they feared the mentally ill and were ***frightened*** to think about the mentally ill living in residential areas.

These results clearly show that **HR practitioners do hold subtle negative attitudes** towards the mentally ill. The most frequently expressed negative attitudes related to the **common myth** that the mentally ill are violent or dangerous, and thus need to be feared and isolated from the rest of society. Other negative attitudes shown by this group of respondents relate to beliefs that the mentally ill are irresponsible, childlike, and a burden to society. These are also commonly believed mistruths, which, like the danger/fear myth are based on ignorance and a lack of accurate information (APA, 1997; Harnois & Gabriel, 2000; WHO, 2001b; Wolff et al., 1996a, 1996b). Education and training of HR practitioners is therefore required to address these commonly held misconceptions and myths.

Respondents' attitudes towards the mentally ill were found to be **associated with certain demographic and work variables**. Those who had achieved a higher *academic qualification*, particularly from a local *institution*, tended to be more positively orientated towards the mentally ill than other respondents. One explanation for locally trained HR practitioners holding more positive attitudes may be that those who received international higher qualifications more often did so from business-orientated schools, as opposed to following courses within the human sciences. Nonetheless, it would appear that level of education plays a role in determining attitudes towards the mentally ill. An interesting finding was that Candidate Practitioners held more positive attitudes than respondents registered at other *levels* with the SABPP. This holds obvious implications for the education and training of both lower and higher level HR practitioners. Respondents who felt that a *need* existed for them to be able to deal with mental health issues at work tended to have more positive attitudes towards the mentally ill. This suggests that a crucial element in mental health training would be to create an awareness of the need to be able to deal with employee mental health issues.

The mental health attitude findings of this study correspond with results from both **local and international studies**. Surveys of the general public, families of mental patients, and various professional groups have shown that the mentally ill are often viewed as dangerous, unpredictable, weak, and foolish (Green et al., 1987; Jorm et al., 1999; Mbanga et al., 2002; Taylor & Dear, 1981; Wessels et al., 1998; Wolff et al., 1996a). The finding that higher education is associated with positive attitudes also finds support from other studies (Taylor & Dear, 1981; Wessels et al., 1998; Wolff et al., 1996a), although there are some that report contradicting results (Green at al., 1987).

The results of this study show that HR practitioners hold subtle negative attitudes towards the mentally ill regarding all four concepts assessed with the CAMI, even though group mean scores suggest general positive attitudes. This conclusion is underlined by some of the

comments made by respondents within the feedback section of the study questionnaire. Many of these comments relate to the ***danger/fear myth***, the belief that the mentally ill are ***weak*** by nature and somehow responsible for their condition, and are a burden to society:

"Yes I wished you had included a definition of mental illness - some mentally ill people are not a menace to society while others are dangerous. So my answers are not always balanced."

"Please emphasize the element of own responsibility for your choices and not to blame it on all other roleplayers or circumstances."

"Yes, do not try to feed the mental by burdening business, the state should accept responsibility - we pay tax, tax, tax."

Other comments acknowledged the ***role of attitudes and stigma*** in help-seeking behaviour. Some respondents also commented on the ***stereotypes and prejudice*** the mentally ill have to contend with:

"Normally EAP works best if provided by an external expert as employees don't easily approach a full time other employee with personal issues even if the other employee is skilled, qualified to assist."

"Mental Health is sorely neglected in industry. This is merely the result of society's prejudice; stereotypical perceptions."

"Mental health should be given more primacy to achievements. Mental illness unfortunately is still defined from a 'mad' point of view, and the worst sufferer is the one who is invisible and denying he/she is under stress. This 'invisible' sufferer is the one who is likely to die or be sick from other things, e.g., aches, pains, etc."

5.3 Report back on study objectives and the research problem

This study set out to investigate and describe the mental health literacy and attitudes of HR practitioners in South Africa. It was found that HR practitioners, as represented by members of the SABPP who responded to this survey, are **not literate regarding mental illness** and hold **subtle negative attitudes** towards the mentally ill.

The mental health literacy of HR practitioners differs for **different mental disorders**. HR practitioners tend to be better able to recognise and identify conditions that are traditionally covered by HR training institutions (i.e., mood disorders and substance abuse) but fair poorly when confronted with mental illnesses not traditionally included in training curricula (i.e., anxiety disorders). Moreover, they are generally not literate regarding the aetiology and treatment of mental illness, irrespective of the condition confronted with.

The mental health literacy and attitudes of HR practitioners was found to be associated with certain **demographic and work variables**. Those with higher academic qualifications tend to be more literate in mental health matters than their lesser qualified peers, although this only holds true for recognising and identifying mental illness. Higher level of registration with the SABPP is also associated with better mental health literacy, yet this only applies to knowledge about some of the risk factors and causes of mental illness. HR practitioners with many years of experience in the field tend to be illiterate regarding the risk factors and causes of mental illness. Those with higher academic qualifications and those who acknowledge the need to be able to deal with employee mental health issues tend to hold more positive attitudes towards the mentally ill than other HR practitioners. Middle level members of the SABPP also have more positive attitudes than those registered at higher or lower levels. HR practitioners of all levels of qualification and registration therefore have gaps in knowledge and orientation regarding mental illness and therefore require education and training. This appears to be especially relevant to those who have been in the field for many years. Extensive education and re-training may be required for this group.

Therefore, to respond to the **research problem** of what human resource practitioners in South Africa feel, think and know about mental illness and the mentally ill, this study replies that they lack knowledge and hold subtle negative attitudes towards the mentally ill.

5.4 Recommendations

Based on an extensive review of the literature and the results of this study, the following recommendations are made in respect of the HR field in general, HR practitioners already in practice, and students at HR training institutions.

5.4.1 The HR field

(a) The human resources discipline should recognise the reality of mental illness in the workplace. These conditions are highly prevalent and costly, however, effective treatments do exist and most workers with a mental disorder can return to normal, or even better, work functioning.

(b) Mental illness, and not only mental health, should be acknowledged as a factor deserving attention within the realm of employee health and wellbeing.

(c) Including mental illness within employee wellness policies, programmes and structures will contribute towards the general HR aim of the most effective utilisation of HR and to containing HR-related costs.

(d) Addressing mental illness and promoting mental health should therefore be included within the current re-design of the HR function.

(e) Mental health literacy should be set as one of the required competencies of HR practitioners.

(f) Vague concepts of "stress" need to be replaced with specific aetiology and treatment ideas, and with knowledge of cost-efficacy studies.

(g) Professional bodies such as the SABPP and the IPM should therefore include mental health literacy within their qualification and expertise standards, as well as provide regular accredited training sessions to update the knowledge of HR practitioners.

(h) Mental illness (and not only mental health or emotional health) policies and practices should be designed and implemented. These should be considered necessary and future HR practices of equivalent stature as, for example, managing intellectual capital and total quality management.

(i) The HR field should encourage a culture of understanding and acceptance of mental illness in the workplace. Only then can mental illness programmes be effective and the mentally ill be allowed to reach optimal performance, albeit after treatment and rehabilitation or through being free of the stigma of mental illness.

5.4.2 HR practitioners in practice

(a) HR practitioners should be made aware of the reality of mental illness in the workplace. This should include highlighting the prevalence of mental disorders amongst the working population, as well as the costs and impact of these conditions on business.

(b) HR practitioners should be made aware of the need for them to be able to deal with employee mental health issues, as this falls within their role of attending to wellness in the workplace.

(c) Training programmes should be designed and implemented to educate HR practitioners in recognising mental illness and identifying different illnesses.

(d) Training should also include information on the risk factors and causes of mental illness as well as the best treatment strategies available.

(e) These programmes should highlight the fact that mental illness can be effectively treated and that the mentally ill can return to work as valuable, productive and motivated employees if correctly handled.

(f) HR practitioners should be educated about the costs of untreated or inappropriately treated mental illness and realise the benefits both in terms of employee costs, productivity and relations, of appropriate treatment strategies.

(g) Training should also be provided in the referral process, and HR practitioners should be made aware of work and benefits of company-based health facilities as well as those in the immediate environment.

(h) HR practitioners should be made aware of their own attitudes towards the mentally ill, and how this may impact on those who suffer from a mental illness.

(i) Strategies to address negative attitudes towards the mentally should be designed and implemented. These include providing accurate information on mental illness, the mentally ill, treatment strategies, and dispelling common myths and misconceptions.

(j) Follow-up and evaluation sessions should be held to monitor the progress and impact of these awareness, education and training programmes.

(k) Feedback should be given to individual HR practitioners regarding their mental health literacy and attitudes, and the opportunity for re-training should be provided.

(l) Train-the-trainer programmes should be designed and implemented to enable HR practitioners to institute company-wide mental health literacy and attitude programmes.

The best venue for this may be through already established company wellness or employee assistance programmes.

(m) Training programmes directed specifically at management should be designed and implemented. The aim of these programmes should be to get management to incorporate mental health and illness matters within strategic business policies and plans. The need and cost benefits of effectively managing mental illness in the workplace may serve as motivation in emphasising this to management.

(n) Company-wide screening programmes to identify and appropriately manage mental illness in the workplace should be instituted; much like cholesterol and other health screenings are conducted. Again, already established wellness or EAP's may be utilised for this purpose.

5.4.3 HR students

(a) Mental health literacy should be included within HR training curricula.

(b) This may be in the form of specific mental health modules, or incorporated within health and safety courses. If the latter route is taken, it should be ensured that students are adequately trained in mental illness and not just mental health issues.

(c) Attention should be given to the signs and symptoms of the major mental disorders, the risk factors and causes of mental illness, as well as the best treatment strategies for these conditions.

(d) Students should be made to realise that mental health literacy is one of the essential components to being a HR practitioner, and that the knowledge they acquire through their training will be needed once practicing in the world of work.

(e) The prevalence of mental disorders within the workplace should therefore also be highlighted, and they should be informed about the enormous costs that these conditions hold to business unless adequately managed.

(f) Students should be made aware of their own attitudes towards the mentally ill, and accurate information should be provided within the curricula to dispel common myths and misconceptions.

(g) The training of HR students should include information on implementing and maintaining workplace mental health programmes, including the running of screenings for mental illness.

(h) HR students should understand the referral process and be made aware of the various health facilities and resources that are available and that can assist with employee mental health issues.

5.5 Limitations

This study achieved a response rate of 31% which equates to 15% of the SABPP members. An improved response rate would have been desirable. A further limitation to this study was that follow-up mailing to potential respondents was not possible. This may have improved the response rate.

The possibility of response sets exists with attitude and knowledge surveys. Even though the design of the study questionnaire was aimed at limiting response sets, it may be possible that some respondents, particularly with the attitudes section of the questionnaire, responded in a manner that did not give an accurate account of their personal beliefs or views.

The CAMI has not been specifically validated for South African populations. However, it has been used in attitude studies conducted in Germany, China and the United Kingdom, to name a few of the diverse populations, and been found to deliver results that closely correspond with the original data obtained by the Canadian studies (Angermeyer, Heiss, Kirschenhofer, Ladinser, Loffler, Schulze & Swiridoff, 2003; Sevigny, Yang, Zhang, Marleau, Yang, Su, Li, Xu, Wang & Wang, 1999; Wolff et al., 1996a; 1996b). Moreover, it has been employed with numerous studies of the South African general population and health professional groups, and been found to be understandable and to deliver results that correlate with studies undertaken abroad (Hugo et al., in press; Wessels et al., 1998; Wessels et al., 2000; Dirwayi, 2002).

5.6 Further research

(a) This study needs to be duplicated to confirm findings and to address the abovementioned limitations.

(b) As this purpose of this study was descriptive in nature, further research is needed to find support for the reported results, to build on the research questions, and to adequately address the research problem.

(c) Further research should therefore include other HR populations, for example the IPM and the Psychological Society of South Africa.

(d) This study selected three mental disorders to assess the mental health literacy of the respondents. Other diagnoses may be used in further studies, including conditions within the mood (e.g., dysthymia, post-natal depression), anxiety (e.g., generalised anxiety disorder, social phobia) and substance abuse (e.g., cannabis, amphetamines) disorders, severe mental illness (e.g., bipolar mood disorder, schizophrenia), and other mental illnesses (e.g., personality, sleep, or eating disorders).

(e) Results from this study and other research may be compared with other population groups within the workplace, for example, management, supervisors, and union representatives.

(f) An extension of the mental health literacy topics covered by this research may include investigating beliefs about the natural course and long-term outcome of different mental disorders, as well as whether with respondents believe that others (e.g., management, colleagues) stigmatise and discriminate against the mentally ill.

(g) Research to design specific mental health literacy and attitudes interventions relevant to the South African workplace is needed in order to address gaps in knowledge and orientation.

(h) Explanatory research would be required to evaluate the impact/effectiveness of mental health literacy and attitudes interventions implemented in the workplace.

(i) It would be worthwhile to do research of various interventions and to determine which are the most effective given different work populations.

(j) Longitudinal studies may also be conducted to determine the long-term impact of mental health literacy and attitudes interventions and to ascertain which methods deliver the best long-term results for particular population groups.

5.7 Conclusion

The field of HRM in South Africa is faced by many challenges, including those posed by re-entry into the international community and the many transformation and development issues confronted in the workplace. Attending to the wellbeing of employees is one of the

acknowledged methods to attaining competiveness and thus survival in the new era of work. However, this study argues that the reality of mental illness in the workplace should be acknowledged and effectively managed, as ignoring these conditions holds enormous cost, productivity and work relations implications.

A lack of awareness, research and information currently exists within the HR field regarding mental illness, although mental health issues have traditionally received some attention. This raises questions about the mental health literacy and attitudes of HR practitioners towards mental illness and the mentally ill. This study found that HR practitioners in South Africa are not literate in mental illness and hold subtle negative attitudes towards the mentally ill. The challenge now to the HR field is to acknowledge that mental illnesses exist within the workplace, are costly, and affect the company bottom-line. As the "people specialists" within business, HR practitioners should be enabled to effectively manage mental illness in the workplace, just as they are required to be knowledgeable about other employee health matters that affect individual and company performance.

This study therefore recommends that urgent steps be taken to include mental illness as a factor that needs HR attention within the current re-design and search for key future competencies. HR practitioners should therefore be adequately trained in mental illness matters, and should be made aware of their personal attitudes and how these impact on managing mental illness in the workplace. Training and the provision of accurate information are necessary to address the current gaps in knowledge and negative orientations of HR practitioners regarding mental illness. Mental illness modules and courses should therefore be included in HR curricula, training and evaluation sessions. This should not only be considered the responsibility of tertiary education institutions, but should also be included in the training programmes of bodies such as the SABPP, IPM, and the like. Equipping HR practitioners to understand and effectively manage mental illness in the workplace will contribute towards HR's optimal utilisation of human resources to ultimately attain company strategic goals and be competitive in the global marketplace.

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APPENDIX A

Impact and consequences of stigma

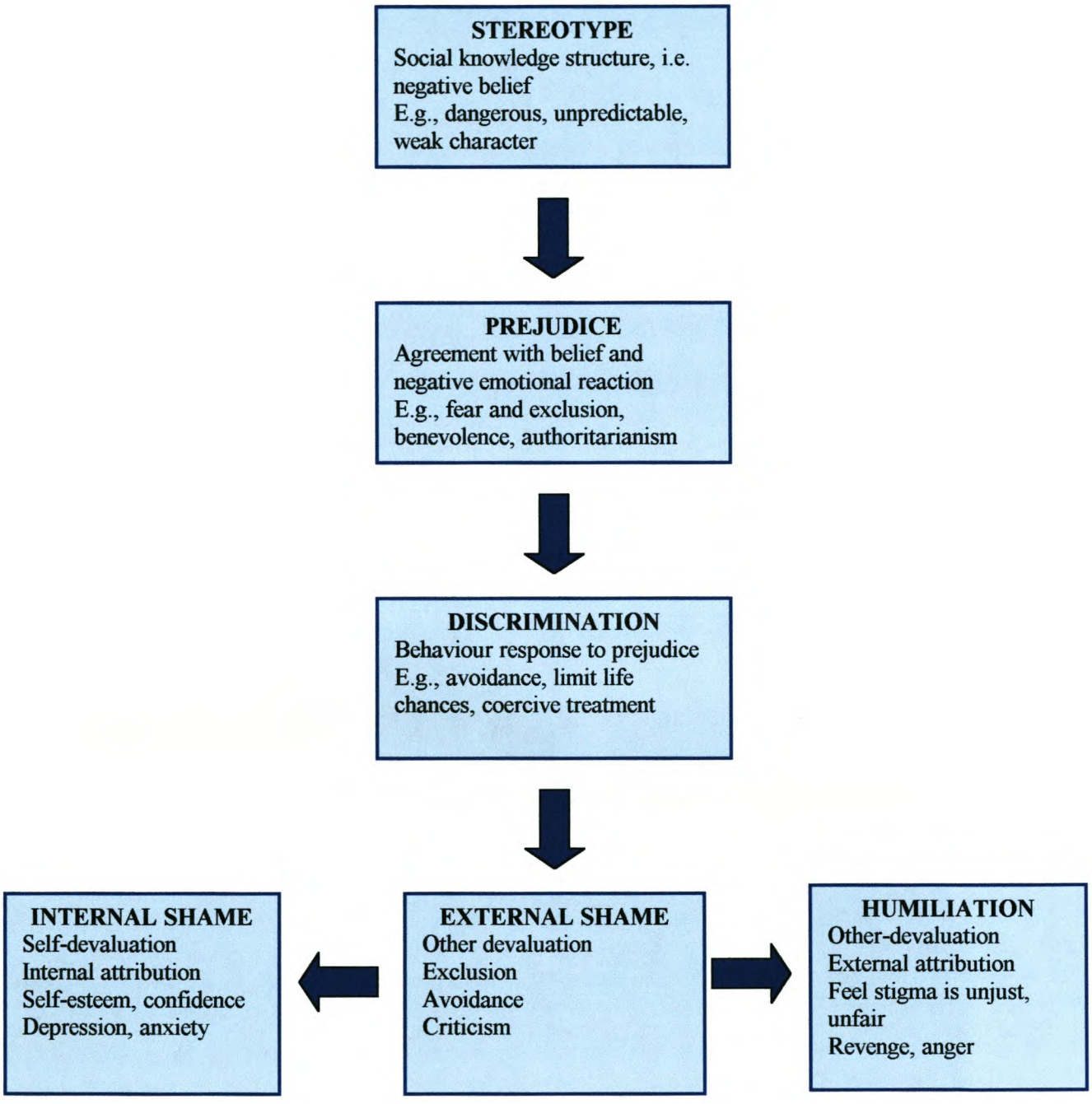

Figure 1 The impact and consequences of stigma

APPENDIX B

Selected South African resources for information on mental health/illness

MENTAL HEALTH/ILLNESS RESOURCES

South African Federation for Mental Health (SAFMH)
Private Bag X46
Braamfontein 2017
Tel: (011) 242-9600
Fax: (011) 725-5853
E-mail: safmh@sn.apc.org
Internet: www.safmh.org.za

Department of Health: Directorate Mental Health & Substance Abuse
Private Bag X828
Pretoria 0001
Tel: (012) 312-0489/3
Fax: (012) 323-1913
Internet: www.doh.gov.za

Mental Health Information Centre of South Africa (MHIC)
PO Box 19063
Tygerberg 7505
Tel: (021) 938-9229
Fax: (021) 931-4172
E-mail: mhic@sun.ac.za
Internet: www.mentalhealthsa.co.za

South African National Council on Alcoholism & Drug Disorders (SANCA)
PO Box 663
Auckland Park 2006
Tel: (011) 482-1070
Fax: (011) 482-7187
E-mail: sanca@sn.apc.org
Internet: www.wn.apc.org/sanca

Alcoholics Anonymous (AA)
PO Box 727
Goodwood 7459
Tel: (021) 592-5047
Fax: (021) 592-3159
Internet: www.alcoholicsanonymous.org

South African Depression & Anxiety Group (SADAG)
PO Box 652548
Benmore 2010
Tel: (011) 783-1474/6
Fax: (011) 884-7074
E-mail: anxiety@iafrica.com
Internet: www.anxiety.org.za

Schizophrenia Foundation of South Africa
PO Box 653164
Benmore 2010
Tel: (011) 484-9330/1
Fax: (011) 484-9332
E-mail: info@schizophrenia.co.za

APPENDIX C

Mental health literacy and attitudes survey questionnaire

A. DEMOGRAPHICS

The following set of questions is to find out more about you and your work. Please note that your responses are **confidential** and **anonymous** and cannot be traced back to you. Select **one response per question**, unless otherwise specified. Mark your response on the questionnaire by **circling** the number that corresponds with your reply.

Example:
An apple is a type of fruit

① Yes
2 No

1. At which level are you currently registered with the SABPP?

1 Personnel Practitioner
2 Associate Practitioner
3 Candidate Practitioner
4 Candidate Associate Practitioner

2. In which category are you currently registered with the SABPP?
(Indicate as many as relevant)

1 Generalist
2 Specialist: Training & Development
3 Specialist: Industrial Relations
4 Specialist: Recruitment & Selection
5 Specialist: Personnel Services
6 Specialist: Education & Research
7 Specialist: Psychologiae
8 Specialist: Employee Assistance Programmes
9 Specialist: Assessment Centres
10 None of the above

3. How many years of experience do you have working in the HR field?

1 0 – 5 years
2 6 – 10 years
3 11 – 15 years
4 16 – 20 years
5 >20 years

4. What is your highest academic qualification?

1 Matric (Grade 12)
2 Diploma
3 Degree
4 Honours degree
5 Masters degree
6 Doctorate
7 Post-doctorate
8 Other _____

5. At which academic institution did you receive your most recent HR qualification?

_____

6. In which year did you receive your most recent HR qualification?

_____

7. How many people are employed by your organisation?

1 100 or less
2 101 – 400
3 401 – 700
4 701 – 1 000
5 1 000 or more

8. Please indicate which of the following facilities / professionals are available to employees at your work: ***(Indicate as many as relevant)***

1 Employee assistance / well-being programme
2 Psychologist
3 Social worker
4 Nursing sister and / or General practitioner
5 Outside contractor (Psychologist, Psychiatrist)
6 None of the above

9. How often do you refer employees to any of the above?

1 Never
2 Seldom
3 Occasionally
4 Frequently
5 Almost daily
6 Not applicable as none available

10. Do you feel adequately trained to deal with employee mental health issues at work?

1 Definitely yes
2 Somewhat yes
3 Unsure
4 Somewhat no
5 Definitely no

11. Do you feel there is a need for your being able to deal with employee mental health issues at work?

1 Definitely yes
2 Somewhat yes
3 Unsure
4 Somewhat no
5 Definitely no

12. Do you feel adequately supported by company policies and structures to deal with employee mental health issues at work?

1 Definitely yes
2 Somewhat yes
3 Unsure
4 Somewhat no
5 Definitely no

13. Do you feel adequately supported by top management to deal with mental health issues at work?

1 Definitely yes
2 Somewhat yes
3 Unsure
4 Somewhat no
5 Definitely no

B. VIEWS ABOUT MENTAL ILLNESS IN GENERAL

The following set of statements apply to your **personal view** of mental illness and of people who suffer from a mental illness. Please respond to **each statement** by **circling** the number most closely representing your view, where:

1 = strongly agree
2 = agree
3 = neutral
4 = disagree
5 = strongly disagree

	strongly agree	agree	neutral	disagree	strongly disagree
14. One of the main causes of mental illness is a lack of self-discipline and willpower	1	2	3	4	5
15. The best way to handle the mentally ill is to keep them behind locked doors	1	2	3	4	5
16. There is something about the mentally ill that makes it easy to tell them from normal people	1	2	3	4	5
17. As soon as a person shows signs of mental disturbance, he should be hospitalised	1	2	3	4	5
18. Mental patients need the same kind of control and discipline as a young child	1	2	3	4	5
19. Mental illness is an illness like any other	1	2	3	4	5
20. The mentally ill should not be treated as outcasts of society	1	2	3	4	5
21. Less emphasis should be placed on protecting the public from the mentally ill	1	2	3	4	5
22. Mental hospitals are an outdated means of treating the mentally ill	1	2	3	4	5
23. Virtually anyone can become mentally ill	1	2	3	4	5
24. The mentally ill have for too long been the subject of ridicule	1	2	3	4	5
25. More tax money should be spent on the care and treatment of the mentally ill	1	2	3	4	5
26. We need to adopt a far more tolerant attitude toward the mentally ill in our society	1	2	3	4	5
27. Our mental hospitals seem more like prisons than like places where the mentally ill can be cared for	1	2	3	4	5
28. We have a responsibility to provide the best possible care for the mentally ill	1	2	3	4	5
29. The mentally ill don't deserve our sympathy	1	2	3	4	5
30. The mentally ill are a burden on society	1	2	3	4	5
31. Increased spending on mental health services is a waste of tax money	1	2	3	4	5

	strongly agree	agree	neutral	disagree	strongly disagree
32. There are sufficient existing services for the mentally ill	1	2	3	4	5
33. It is best to avoid anyone who has mental problems	1	2	3	4	5
34. The mentally ill should not be given any responsibility	1	2	3	4	5
35. The mentally ill should be isolated from the rest of the community	1	2	3	4	5
36. A women would be foolish to marry a man who has suffered from mental illness, even though he seems fully recovered	1	2	3	4	5
37. I would not want to live next door to someone who has been mentally ill	1	2	3	4	5
38. Anyone with a history of mental problems should be excluded from taking public office	1	2	3	4	5
39. The mentally ill should not be denied their individual rights	1	2	3	4	5
40. Mental patients should be encouraged to assume the responsibilities of normal life	1	2	3	4	5
41. No one has the right to exclude the mentally ill from their neighbourhood	1	2	3	4	5
42. The mentally ill are far less of a danger than most people suppose	1	2	3	4	5
43. Most women who were once patients in a mental hospital can be trusted as babysitters	1	2	3	4	5
44. Residents should accept the location of mental health facilities in in their neighbourhood to serve the needs of the local community	1	2	3	4	5
45. The best therapy for many mental patients is to be part of a normal community	1	2	3	4	5
46. As far as possible, mental health services should be provided through community based facilities	1	2	3	4	5
47. Locating mental health services in residential neighbourhoods does not endanger local residents	1	2	3	4	5
48. Residents have nothing to fear from people coming into their neighbourhood to obtain mental health services	1	2	3	4	5
49. Mental health facilities should be kept out of residential neighbourhoods	1	2	3	4	5
50. Local residents have good reason to resist the location of mental health services in their neighbourhood	1	2	3	4	5
51. Having mental patients living within residential neighbourhoods might be good therapy but the risks to residents are too great	1	2	3	4	5
52. It is frightening to think of people with mental problems living in residential neighbourhoods	1	2	3	4	5
53. Locating mental health facilities in a residential area downgrades the neighbourhood	1	2	3	4	5

C. CASE STUDY

Brenda	Major depressive episode
Joe	Panic attack
Jeremy	Alcohol abuse

Please read the above case study and then indicate on the scale below **your view** of [**Name**]'s behaviour as described in the **case study**. Please respond to **each statement** by **circling** the number most closely representing your view, where:

1 = definitely yes
2 = probably yes
3 = unsure
4 = probably no
5 = definitely no

	definitely yes	probably yes	unsure	probably no	definitely no
54. [Name]'s behaviour is a normal response	1	2	3	4	5
55. [Name]'s behaviour is typical of a weak character	1	2	3	4	5
56. [Name]'s behaviour is typical of a mental illness	1	2	3	4	5
57. [Name]'s behaviour could be because of a general medical problem (e.g. an infection)	1	2	3	4	5

58. If this behaviour is typical of a diagnosable condition, it would be called: .....

Please indicate on the scale below your view of the possible **cause** of [Names]'s behaviour as described in the **case study**. Please respond to **each statement** by **circling** the number most closely representing your view, where:

1 = definitely yes
2 = probably yes
3 = unsure
4 = probably no
5 = definitely no

	definitely yes	probably yes	unsure	probably no	definitely no
59. Difficulties in partner or family relationship	1	2	3	4	5
60. Work difficulties	1	2	3	4	5
61. Stressful life event	1	2	3	4	5
62. Brain disease (e.g. "imbalance in chemicals")	1	2	3	4	5
63. Heredity / genetic factors	1	2	3	4	5
64. Constitutional (natural make-up or structure) weakness	1	2	3	4	5

	definitely yes	probably yes	probably unsure	probably no	definitely no
65. Lack of willpower	1	2	3	4	5
66. Expecting too much of oneself	1	2	3	4	5
67. Unconscious conflict	1	2	3	4	5
68. Growing up in a broken home	1	2	3	4	5
69. Lack of parental affection	1	2	3	4	5
70. Overprotective parents	1	2	3	4	5
71. Loss of traditional values in society	1	2	3	4	5
72. Decay of natural ways of life (modern lifestyle)	1	2	3	4	5
73. Exploitation of people in industrial society	1	2	3	4	5
74. Will of God	1	2	3	4	5
75. Witchcraft, possession by evil spirits	1	2	3	4	5
76. Signs of the zodiac	1	2	3	4	5

There are a range of different people, medicines and interventions that could possibly **help [Name]**. For each of the following **treatment strategies**, please indicate if you think they will be helpful, harmful, or neither, for [Name]. Please respond to **each statement** by **circling** the number most closely representing your view, where:

1 = Helpful
2 = Neither helpful nor harmful
3 = Harmful

	Helpful	Neither	Harmful
77. Counsellor	1	2	3
78. Social worker	1	2	3
79. Telephone counselling	1	2	3
80. Psychiatrist	1	2	3
81. Psychologist	1	2	3
82. Close family	1	2	3
83. Close friends	1	2	3
84. Naturopath	1	2	3
85. Vitamins	1	2	3
86. Pain relievers	1	2	3
87. Antidepressants	1	2	3

	Helpful	Neither	Harmful
88. Antibiotics	1	2	3
89. Sleeping pills	1	2	3
90. Antipsychotics	1	2	3
91. Tranquillisers	1	2	3
92. Physical activity	1	2	3
93. Get out more	1	2	3
94. Psychotherapy (talk therapy)	1	2	3
95. Hypnosis	1	2	3
96. Psychiatric ward (in hospital, clinic, etc.)	1	2	3
97. Electro-convulsive therapy (shock therapy)	1	2	3

THANK YOU FOR YOUR TIME AND CO-OPERATION !

FEEDBACK
Do you have any comments or feedback to make regarding this questionnaire? Are there any important issues or topics within the field of mental health you feel we have overlooked? If so, we would appreciate hearing from you.

RETURNING THIS QUESTIONNAIRE
Please mail your completed questionnaire within the supplied self-addressed envelope to reach us by [**Date**].
You may also fax the completed questionnaire to Charmaine Hugo at fax no: (021) 933 5790.
Alternatively, an electronic version is available at www.mentalhealthsa.co.za.
Select 'Research', followed by 'MHIC Survey' and then 'Survey01'.
Your password is mhicsurv01
If you have any queries or problems relating to this questionnaire, please call Charmaine Hugo at telephone (021) 938 9229.

APPENDIX D

Vignettes used within the survey questionnaire

VIGNETTES

Vignette 1: Major Depressive Episode

Brenda started feeling increasingly sad after her sister died in a motorcar accident. Of course, the whole family had been affected by this tragic loss, but Brenda's sadness seemed to last the longest. Some six months after her sister's death, she was still unable to keep thoughts about this loss out of her mind. She continuously questioned the value of life. She found that she had difficulty falling asleep, lost 10kg in weight, had very little energy, and she had trouble concentrating. At work, she found herself crying without reason.

Vignette 2: Panic Attack

Joe was driving to work one day when all of a sudden he experienced an intense sense of fear. His heart started to race, he felt short of breath, his hands were sweating, and his knees were trembling. He felt as though he was about to die, and his first thought was to stop the car and get out. He pulled over, opened the door, and stood at the side of the road. After about 10 minutes, he was more in control and decided to go to the hospital to make sure that he had not suffered a heart attack. After extensive physical tests he was pronounced to be in good general health and told to take it easy for a few days.

Vignette 3: Alcohol Abuse

Jeremy starting drinking heavily each weekend during his student days, when he was the life and soul of many parties. By the time he had graduated and married he was drinking on a daily basis. Although his wife insisted that he drank too much, Jeremy argued that he remained in control. Nevertheless, his work and appearance gradually deteriorated to the point that his supervisor at work began to suspect that he might be drinking on the job. A few months later he was involved in a serious car accident, where he wrote off two cars. The police who arrived at the scene of the accident insisted that his blood be taken for alcohol analysis. In view of the fact that his alcohol level far exceeded recommended levels, Jeremy was found negligent and his license repealed. Only at that point did he agree to seek help.

APPENDIX E

Cover letter to the survey questionnaire

28 October 2002

Dear Human Resource Practitioner

We need your help to address a concern that is costing South Africa billions of rands a year in healthcare and work-related costs. According to the World Health Organization's 2001 WHO Report, as many as 25% of the world's population will suffer from a mental problem sometime in their lives. We need to know how human resource officers, often the first to deal with mental health problems in the workplace, relate to this topic.

In cooperation with the Mental Health Information Centre of South Africa, The MRC Unit on Anxiety and Stress Disorders and the Dept of Industrial Psychology at the University of Stellenbosch, we are conducting a workplace survey of views about mental illness. Results from this study will help design interventions to more effectively manage mental health in the South African workplace. We can e-mail an **executive summary of results** to all those who respond to this survey. If you would like a copy, please forward us your e-mail address.

You have been randomly selected from the membership list of the South African Board for Personnel Practice to participate in this study. As we could not include all SABPP members in our survey, **your views and thoughts on the subject are very important.**

Enclosed is a questionnaire that includes:

- Questions about you, your work and workplace
- Your views about mental illness and the mentally ill in general
- A case study describing someone's behaviour
- Your views about the causes and treatment of the behaviour as described in the case study

Please take the time to complete the questionnaire and return it in the enclosed self-addressed stamped envelope. It would be very helpful to have your completed questionnaire returned to us by **15 December 2002.** You also have the option of completing and returning the questionnaire **electronically.** Please go to www.mentalhealthsa.co.za. Select 'Research' and 'MHIC Survey' and then 'Survey01'. The password for this questionnaire is: mhicsurv01.

Your responses are confidential and anonymous. No name or individual identifying information is required. If you have any questions or concerns, please feel free to call Charmaine Hugo at (021) 938 9229.

Yours sincerely,

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APPENDIX F

Critical values of the chi-square distribution

Table 1 Critical values of the chi-square distribution

Degrees of freedom (*df*)	**Chi-square at the 95% level of confidence ($\chi^2_{0.05}$)**	**Chi-square at the 99% level of confidence ($\chi^2_{0.01}$)**
1	3.841	6.635
2	5.991	9.210
3	7.815	11.345
4	9.488	13.277
5	11.070	15.086
6	12.592	16.812
7	14.067	18.475
8	15.507	20.090
9	16.919	21.666
10	18.307	23.209
11	19.675	24.725
12	21.026	26.217
13	22.362	27.688
14	23.685	29.141
15	24.996	30.578
16	26.296	32.000
17	27.587	33.409
18	28.869	34.805
19	30.144	36.191
20	31.410	37.566
21	32.671	38.932
22	33.924	40.289
23	35.172	41.638
24	36.415	42.980
25	37.652	44.314
26	38.885	45.642
27	40.113	46.963
28	41.337	48.278
29	42.557	49.588
30	43.773	50.892

(Rea & Parker, 1992, p.197)

APPENDIX G

Academic institutions where respondents had received their most recent HR qualification

Table 1 Academic institutions where respondents had received their most recent HR qualification

Institution	**Frequency**	**%**
University of the Witwatersrand Business School	4	1.1
Vaal Technikon	3	0.9
University of the Witwatersrand	13	3.7
University of Stellenbosch	23	**6.6**
University of South Africa	72	**20.6**
University of Pretoria	30	**8.6**
University of Port Elizabeth	13	3.7
University of the Free State	6	1.7
University of Fort Hare	4	1.1
University of Cape Town	16	4.6
Technikon of South Africa	17	4.9
Technikon of the Free State	5	1.4
University of Stellenbosch Business School	2	0.6
Rhodes University	3	0.9
Rand Afrikaans University	49	**14.0**
Pretoria Technikon	3	0.9
Potchefstroom University for Christian Higher Education	14	4.0
Port Elizabeth Technikon	3	0.9
University of Natal	8	2.3
Management College of Southern Africa	2	0.6
Institute for People Management	24	**6.9**
University of Cape Town Graduate School of Business	8	2.3
South African National Defence Force	1	0.3
Cape Town Technikon	5	1.4
ML Sowetan Technikon	1	0.3
University of the Western Cape	3	0.9
Vista University	2	0.6
Natal Technikon	3	0.9
International (UK, USA, EU)	12	3.4

APPENDIX H

Mental health literacy tables

Table 1 Frequencies of respondents' beliefs about the risk factors and causes of mental illness

Cause	DY %	PY %	U %	PN %	DN %
Difficulties in partner or family relationship	3.3	47.6	13.3	28.3	7.6
Work difficulties	6.3	49.2	9.5	28.0	7.1
Stressful life event	**23.9**	**59.2**	5.2	10.1	1.6
Brain disease	0.8	25.3	**22.1**	41.1	10.6
Heredity/genetic	1.9	30.7	**19.3**	38.9	9.2
Constitutional weakness	1.6	27.6	16.1	40.4	14.2
Lack of willpower	3.5	26.6	5.4	39.9	24.5
Expecting too much of oneself	2.4	46.5	12.2	29.6	9.2
Unconscious conflict	3.3	**55.2**	14.9	22.0	4.6
Growing up in a broken home	1.4	24.7	16.8	**48.6**	8.4
Lack of parental affection	0.8	23.6	18.2	**47.6**	9.8
Overprotective parents	1.1	22.6	18.8	**47.6**	10.1
Loss of traditional values in society	1.4	24.5	13.1	46.6	14.4
Decay of natural ways of life	3.5	28.3	15.8	37.6	14.7
Exploitation of people in industrial society	0.5	25.0	13.6	39.1	21.7
Will of God	2.7	9.0	9.8	23.4	**55.2**
Witchcraft, possession by evil spirits	0.5	3.5	8.7	21.2	**66.0**
Signs of the zodiac	1.6	1.9	10.1	16.0	**70.4**

Note. DY = definitely yes; PY = probably yes; U = unsure; PN = probably no; DN = definitely no

Table 2 Domains and corresponding original items measuring respondents' beliefs about the risk factors and causes of mental illness

Domain	**Item**
Psychosocial stress	Difficulties in partner or family relationship
	Work difficulties
	Stressful life event
Biological factors	Brain disease
	Heredity/genetic
	Constitutional weakness
Intrapsychic factors	Lack of willpower
	Expecting too much of oneself
	Unconscious conflict
Socialisation	Growing up in a broken home
	Lack of parental affection
	Overprotective parents
State of the society	Loss of traditional values in society
	Decay of natural ways of life
	Exploitation of people in industrial society
Supernatural powers	Will of God
	Witchcraft, possession by evil spirits
	Signs of the zodiac

Table 3 Beliefs about relationship problems causing depression, panic disorder, or alcohol abuse

	Depression	**Panic disorder**	**Alcohol abuse**
DY %	3.7	**1.5**	**5.2**
PY %	37.3	**57.7**	**47.4**
U %	9.7	16.8	13.4
PN %	36.6	19.0	29.9
DN %	12.7	5.1	4.1
$\chi^2 = 25.73$; $df = 8$; $p = 0.001$			

Table 4 Beliefs about work difficulties causing depression, panic disorder, or alcohol abuse

	Depression	**Panic disorder**	**Alcohol abuse**
DY %	6.0	8.8	3.1
PY %	26.9	**73.7**	45.4
U %	6.7	8.8	14.4
PN %	**45.5**	8.0	32.0
DN %	**14.9**	0.7	5.2
$\chi^2 = 91.99$; $df = 8$; $p < 0.0001$			

Table 5 Beliefs about a stressful life event causing depression, panic disorder, or alcohol abuse

	Depression	**Panic disorder**	**Alcohol abuse**
DY %	**51.5**	13.1	1.0
PY %	40.3	**78.8**	**57.7**
U %	0.7	2.9	14.4
PN %	5.2	5.1	23.7
DN %	2.2	0.0	3.1
$\chi^2 = 138.33$; $df = 8$; $p < 0.0001$			

Table 6 Beliefs about brain disease causing depression, panic disorder, or alcohol, abuse

	Depression	**Panic disorder**	**Alcohol abuse**
DY %	2.3	0.0	0.0
PY %	21.1	27.7	27.8
U %	16.5	**26.3**	**23.7**
PN %	**43.6**	**40.1**	**39.2**
DN %	**16.5**	5.8	9.3
$\chi^2 = 17.67$; $df = 8$; $p = 0.024$			

Table 7 Beliefs about heredity/genetic factors causing depression, panic disorder, or alcohol abuse

	Depression	**Panic disorder**	**Alcohol abuse**
DY %	3.7	0.0	2.1
PY %	27.6	32.1	33.0
U %	17.2	**21.2**	19.6
PN %	**36.6**	**42.3**	**37.1**
DN %	**14.9**	4.4	8.2
$\chi^2 = 15.19$; $df = 8$; $p = 0.055$*			

Note. * *Not significant at the 5% significance level*

Table 8 Beliefs about constitutional weakness causing depression, panic disorder, or alcohol abuse

	Depression	**Panic disorder**	**Alcohol abuse**
DY %	0.0	0.0	**6.3**
PY %	20.1	23.4	**44.2**
U %	13.4	18.2	16.8
PN %	**48.5**	**43.1**	25.3
DN %	**17.9**	**15.3**	7.4
$\chi^2 = 45.56$; $df = 8$; $p < 0.0001$			

Table 9 Beliefs about a lack of willpower causing depression, panic disorder, or alcohol, abuse

	Depression	**Panic disorder**	**Alcohol abuse**
DY %	0.7	0.0	**12.4**
PY %	17.2	18.2	**51.5**
U %	3.0	5.1	9.3
PN %	**47.8**	**44.5**	22.7
DN %	**31.3**	**32.1**	4.1
$\chi^2 = 96.40$; $df = 8$; $p < 0.0001$			

Table 10 Beliefs about high self-expectations causing depression, panic disorder, or alcohol abuse

	Depression	**Panic disorder**	**Alcohol abuse**
DY %	2.2	2.9	2.1
PY %	37.3	**56.9**	**44.3**
U %	8.2	12.4	17.5
PN %	**35.8**	21.9	32.0
DN %	**16.4**	5.8	4.1
$\chi^2 = 26.56$; $df = 8$; $p = 0.001$			

Table 11 Beliefs about unconscious conflict causing depression, panic disorder, or alcohol abuse

	Depression	**Panic disorder**	**Alcohol abuse**
DY %	2.2	6.6	0.0
PY %	**51.5**	**56.9**	**57.7**
U %	12.7	12.4	21.6
PN %	27.6	20.4	16.5
DN %	6.0	3.6	4.1
$\chi^2 = 16.94$; $df = 8$; $p = 0.031$			

Table 12 Beliefs about growing up in a broken home causing depression, panic disorder, or alcohol abuse

	Depression	**Panic disorder**	**Alcohol abuse**
DY %	0.7	1.5	2.1
PY %	23.1	23.4	28.9
U %	10.4	**21.2**	**19.6**
PN %	**51.5**	**48.9**	**44.3**
DN %	**14.2**	5.1	5.2
$\chi^2 = 15.74$; $df = 8$; $p = 0.046$			

Table 13 Beliefs about a lack of parental affection causing depression, panic disorder, or alcohol abuse

	Depression	**Panic disorder**	**Alcohol abuse**
DY %	0.7	0.7	1.0
PY %	20.1	19.7	**34.0**
U %	12.7	20.4	22.7
PN %	**52.2**	**50.4**	**37.1**
DN %	14.2	8.8	5.2
$\chi^2 = 17.76$; $df = 8$; $p = 0.023$			

Table 14 Beliefs about overprotective parents causing depression, panic disorder, or alcohol abuse

	Depression	**Panic disorder**	**Alcohol abuse**
DY %	0.7	1.5	1.0
PY %	18.7	16.8	**36.1**
U %	15.7	20.4	20.6
PN %	**50.7**	**54.0**	**34.0**
DN %	14.2	7.3	8.2
$\chi^2 = 21.02$; $df = 8$; $p = 0.007$			

Table 15 Beliefs about the loss of traditional values causing depression, panic disorder, or alcohol abuse

	Depression	**Panic disorder**	**Alcohol abuse**
DY %	0.0	0.0	5.2
PY %	18.7	21.3	**37.1**
U %	9.0	14.7	16.5
PN %	**53.7**	**48.5**	**34.0**
DN %	**18.7**	**15.4**	7.2
$\chi^2 = 35.63$; $df = 8$; $p < 0.0001$			

Table 16 Beliefs about the decays of natural ways of life causing depression, panic disorder, or alcohol abuse

	Depression	**Panic disorder**	**Alcohol abuse**
DY %	0.7	2.2	9.3
PY %	20.1	29.4	**38.1**
U %	14.2	19.1	13.4
PN %	**42.5**	**40.4**	26.8
DN %	**22.4**	8.8	12.4
$\chi^2 = 33.79$; $df = 8$; $p < 0.0001$			

Table 17 Beliefs about the exploitation of people in industrial society causing depression, panic disorder, or alcohol abuse

	Depression	**Panic disorder**	**Alcohol abuse**
DY %	0.0	0.0	2.1
PY %	14.9	**40.9**	16.5
U %	10.4	15.3	15.5
PN %	**47.8**	32.8	**36.1**
DN %	**26.9**	10.9	**29.9**
$\chi^2 = 45.27$; $df = 8$; $p < 0.0001$			

Table 18 Beliefs about the will of God causing depression, panic disorder, or alcohol abuse

	Depression	**Panic disorder**	**Alcohol abuse**
DY %	3.0	4.4	0.0
PY %	14.2	10.2	0.0
U %	8.2	14.6	5.2
PN %	28.4	24.1	15.5
DN %	**46.3**	**46.7**	**79.4**
$\chi^2 = 40.83$; $df = 8$; $p < 0.0001$			

Table 19 Beliefs about witchcraft or possession by evil spirits causing depression, panic disorder, or alcohol abuse

	Depression	**Panic disorder**	**Alcohol abuse**
DY %	0.0	0.0	2.1
PY %	1.5	6.6	2.1
U %	6.7	12.4	6.2
PN %	23.1	25.5	12.4
DN %	**68.7**	**55.5**	**77.3**
$\chi^2 = 24.17$; $df = 8$; $p = 0.002$			

Table 20 Beliefs about the signs of the zodiac causing depression, panic disorder, or alcohol abuse

	Depression	**Panic disorder**	**Alcohol abuse**
DY %	3.0	1.5	0.0
PY %	3.0	1.5	1.0
U %	6.0	**14.6**	9.3
PN %	13.4	21.9	11.3
DN %	**74.6**	**60.6**	**78.4**
$\chi^2 = 17.49$; $df = 8$; $p = 0.025$			

Table 21 Frequencies of respondents' beliefs about different treatment strategies for mental illness

Treatment strategy	**Helpful %**	**Neither %**	**Harmful %**
Counsellor	**95.4**	3.8	0.8
Social worker	76.6	22.6	0.8
Telephone counselling	62.0	34.0	4.1
Psychiatrist	78.0	16.3	5.7
Psychologist	**92.7**	6.3	1.1
Close family	**81.5**	17.7	0.8
Close friends	78.8	20.4	0.8
Naturopath	28.7	**63.9**	7.4
Vitamins	41.1	**53.4**	5.4
Pain relievers	9.5	**51.8**	38.7
Antidepressants	43.8	32.3	23.9
Antibiotics	10.1	48.0	42.0
Sleeping pills	12.0	36.7	**51.4**
Antipsychotics	8.7	**51.4**	39.9
Tranquillisers	24.2	34.8	41.0
Physical activity	**83.2**	14.4	2.4
Get out more	**65.7**	29.7	4.6
Psychotherapy	**86.7**	11.4	1.9
Hypnosis	44.0	47.3	8.7
Psychiatric ward	19.4	34.4	**46.2**
Electro-convulsive therapy	9.6	27.6	**62.8**

Table 22 Beliefs about treatment strategies for mental illness: subscales and corresponding items

Subscale	**Item**
Psychological	Counsellor
	Social worker
	Telephone counselling
	Psychiatrist
	Psychologist
	Psychotherapy (talk therapy)
	Hypnosis
Medical	Pain relievers
	Antidepressants
	Antibiotics
	Sleeping pills
	Antipsychotics
	Tranquillisers
	Psychiatric ward
	Electro-convulsive therapy (shock therapy)
Lifestyle	Close family
	Close friends
	Naturopath
	Vitamins
	Physical activity
	Get out more

Table 23 Beliefs about psychological treatment strategies for depression, panic disorder, or alcohol abuse

Counsellor	**Depression**	**Panic disorder**	**Alcohol abuse**
Helpful %	**96.3**	**93.4**	**96.9**
Neither %	3.7	5.1	2.1
Harmful %	0.0	1.5	1.0
$\chi^2 = 3.33$; $df = 4$; $p = 0.505$*			
Social worker	**Depression**	**Panic disorder**	**Alcohol abuse**
Helpful %	73.1	75.2	83.5
Neither %	24.6	24.8	16.5
Harmful %	2.2	0.0	0.0
$\chi^2 = 8.23$; $df = 4$; $p = 0.083$*			
Telephone counselling	**Depression**	**Panic disorder**	**Alcohol abuse**
Helpful %	58.2	67.2	59.8
Neither %	37.3	27.7	38.1
Harmful %	4.5	5.1	2.1
$\chi^2 = 4.86$; $df = 4$; $p = 0.302$*			
Psychiatrist	**Depression**	**Panic disorder**	**Alcohol abuse**
Helpful %	78.4	78.1	77.3
Neither %	15.7	15.3	18.6
Harmful %	6.0	6.6	4.1
$\chi^2 = 1.04$; $df = 4$; $p = 0.903$*			
Psychologist	**Depression**	**Panic disorder**	**Alcohol abuse**
Helpful %	**94.0**	**89.1**	**95.9**
Neither %	6.0	9.5	2.1
Harmful %	0.0	1.5	2.1
$\chi^2 = 7.85$; $df = 4$; $p = 0.097$*			
Psychotherapy	**Depression**	**Panic disorder**	**Alcohol abuse**
Helpful %	**94.0**	**80.3**	85.6
Neither %	6.0	15.3	13.4
Harmful %	0.0	4.4	1.0
$\chi^2 = 14.51$; $df = 4$; $p = 0.006$			

Note. * *Not significant at the 5% significance level*

Table 23 (continued)

Hypnosis	**Depression**	**Panic disorder**	**Alcohol abuse**
Helpful %	41.8	43.1	48.5
Neither %	**52.2**	43.1	46.4
Harmful %	6.0	13.9	5.2
$\chi^2 = 8.60$; $df = 4$; $p = 0.072$*			

Note. * *Not significant at the 5% significance level*

Table 24 Beliefs about medical treatment strategies for depression, panic disorder, or alcohol abuse

Pain relievers	**Depression**	**Panic disorder**	**Alcohol abuse**
Helpful %	8.2	14.0	5.2
Neither %	**54.5**	**55.9**	42.3
Harmful %	37.3	30.1	**52.6**
$\chi^2 = 14.80$; $df = 4$; $p = 0.005$			
Antidepressants	**Depression**	**Panic disorder**	**Alcohol abuse**
Helpful %	**55.2**	**42.3**	29.9
Neither %	27.6	**35.8**	34.0
Harmful %	17.2	21.9	36.1
$\chi^2 = 18.65$; $df = 4$; $p = 0.001$			
Antibiotics	**Depression**	**Panic disorder**	**Alcohol abuse**
Helpful %	6.8	14.6	8.2
Neither %	41.4	46.7	**58.8**
Harmful %	**51.9**	38.7	33.0
$\chi^2 = 13.49$; $df = 4$; $p = 0.009$			
Sleeping pills	**Depression**	**Panic disorder**	**Alcohol abuse**
Helpful %	13.4	13.1	8.2
Neither %	31.3	**47.4**	28.9
Harmful %	**55.2**	39.4	**62.9**
$\chi^2 = 15.21$; $df = 4$; $p = 0.004$			
Antipsychotics	**Depression**	**Panic disorder**	**Alcohol abuse**
Helpful %	2.2	13.2	11.5
Neither %	**52.2**	**58.1**	40.6
Harmful %	45.5	28.7	**47.9**
$\chi^2 = 20.71$; $df = 4$; $p < 0.0001$			
Tranquillisers	**Depression**	**Panic disorder**	**Alcohol abuse**
Helpful %	20.1	**35.8**	13.4
Neither %	35.1	**36.5**	32.0
Harmful %	**44.8**	27.7	**54.6**
$\chi^2 = 24.24$; $df = 4$; $p < 0.0001$			

Table 24 (continued)

Psychiatric ward	**Depression**	**Panic disorder**	**Alcohol abuse**
Helpful %	16.4	14.8	29.9
Neither %	37.3	40.0	22.7
Harmful %	**46.3**	**45.2**	**47.4**
$\chi^2 = 13.08$; $df = 4$; $p = 0.011$			
Electro-convulsive therapy	**Depression**	**Panic disorder**	**Alcohol abuse**
Helpful %	12.0	**9.5**	**6.3**
Neither %	18.8	29.2	37.5
Harmful %	**69.2**	**61.3**	**56.3**
$\chi^2 = 10.78$; $df = 4$; $p = 0.029$			

Table 25 Beliefs about lifestyle treatment strategies for depression, panic disorder, or alcohol abuse

Close family	**Depression**	**Panic Disorder**	**Alcohol abuse**
Helpful %	**87.3**	**73.7**	84.4
Neither %	12.7	24.1	15.6
Harmful %	0.0	2.2	0.0
$\chi^2 = 12.00$; $df = 4$; $p = 0.017$			
Close friends	**Depression**	**Panic disorder**	**Alcohol abuse**
Helpful %	**87.3**	**67.2**	83.5
Neither %	12.7	30.7	16.5
Harmful %	0.0	2.2	0.0
$\chi^2 = 20.63$; $df = 4$; $p < 0.0001$			
Naturopath	**Depression**	**Panic disorder**	**Alcohol abuse**
Helpful %	30.6	31.6	21.9
Neither %	60.4	60.9	72.9
Harmful %	9.0	7.5	5.2
$\chi^2 = 4.83$; $df = 4$; $p = 0.305$*			
Vitamins	**Depression**	**Panic disorder**	**Alcohol abuse**
Helpful %	42.5	45.3	33.3
Neither %	50.0	48.9	64.6
Harmful %	7.5	5.8	2.1
$\chi^2 = 8.14$; $df = 4$; $p = 0.087$*			
Physical activity	**Depression**	**Panic disorder**	**Alcohol abuse**
Helpful %	86.6	81.8	80.4
Neither %	11.9	16.1	15.5
Harmful %	1.5	2.2	4.1
$\chi^2 = 2.86$; $df = 4$; $p = 0.582$*			
Get out more	**Depression**	**Panic disorder**	**Alcohol abuse**
Helpful %	**80.5**	**56.9**	57.7
Neither %	16.5	38.7	35.1
Harmful %	3.0	4.4	**7.2**
$\chi^2 = 21.54$; $df = 4$; $p < 0.0001$			

Note. * *Not significant at the 5% significance level*

APPENDIX I

CAMI tables

Table 1 Response descriptives on the Authoritarianism subscale of the CAMI

Item	SA %	A %	N %	D %	SD %	Mean (SD)
One of the main causes of mental illness is a lack of self-discipline and willpower	4.9	10.6	7.9	47.7	28.9	3.85 (1.10)
The best way to handle the mentally ill is to keep them behind locked doors	0.8	1.4	0.3	**22.0**	**75.5**	**4.70** (0.63)
There is something about the mentally ill that makes it easy to tell them apart from normal people	2.7	14.8	5.2	52.5	24.9	3.82 (1.05)
As soon as a person shows signs of mental disturbance, he should be hospitalised	1.6	7.9	6.0	**51.4**	**33.2**	**4.07** (0.92)
Mental patients need the same kind of control and discipline as a young child	3.6	12.6	8.5	48.1	27.3	3.83 (1.07)
Mental illness is an illness like any other	31.3	46.5	4.9	14.1	3.3	2.12 (1.10)
The mentally ill should not be treated as outcasts of society	55.7	31.5	1.1	3.8	7.9	**1.77** (1.17)
Less emphasis should be placed on protecting the public from the mentally ill	16.3	41.3	13.3	**21.5**	**7.6**	2.63 (1.20)
Mental hospitals are outdated means of treating the mentally ill	12.0	35.6	22.0	**25.8**	**4.6**	2.76 (1.10)
Virtually anyone can become mentally ill	37.2	54.6	2.7	4.9	0.5	**1.77** (0.77)

Note. SA = strongly agree; A = agree; N = neutral; D = disagree; SD = strongly disagree. (SD) = standard deviation

Table 2 Response descriptives on the Benevolence subscale of the CAMI

Item	SA %	A %	N %	D %	SD %	Mean (SD)
The mentally ill have for too long been the subject of ridicule	26.8	59.0	8.5	3.0	2.7	1.96 (0.85)
More tax money should be spent on the care and treatment of the mentally ill	**23.1**	**59.5**	10.9	4.1	2.4	2.03 (0.85)
We need to adopt a far more tolerant attitude toward the mentally ill in our society	**35.3**	**59.0**	3.3	1.6	0.8	**1.74** (0.68)
Our mental hospitals seem more like prisons than like places where the mentally ill can be cared for	21.2	54.9	16.8	5.7	1.4	2.11 (0.85)
We have a responsibility to provide the best possible care for the mentally ill	**33.7**	**55.2**	4.1	2.4	4.6	**1.89** (0.94)
The mentally ill don't deserve our sympathy	0.5	6.5	4.6	39.4	48.9	**4.30** (0.87)
The mentally ill are a burden on society	**1.1**	**12.3**	8.2	39.5	39.0	4.03 (1.03)
Increased spending on mental health services is a waste of tax money	0.3	2.7	4.3	50.5	42.1	**4.32** (0.71)
There are sufficient existing services for the mentally ill	1.4	4.1	11.1	63.0	20.4	3.97 (0.78)
It is best to avoid someone who has mental problems	0.8	1.4	2.7	59.0	36.1	4.28 (0.66)

Note. SA = strongly agree; A = agree; N = neutral; D = disagree; SD = strongly disagree. (SD) = standard deviation

Table 3 Response descriptives on the Social Restrictiveness subscale of the CAMI

Item	SA %	A %	N %	D %	SD %	Mean (SD)
The mentally ill should not be given any responsibility	1.6	8.7	7.3	**59.0**	**23.4**	3.94 (0.89)
The mentally ill should be isolated from the rest of the community	1.1	2.2	3.0	53.7	40.1	**4.29** (0.73)
A women would be foolish to marry a man who has suffered from mental illness, even though he seems fully recovered	1.9	9.8	10.6	53.4	24.3	3.88 (0.95)
I would not want to live next door to someone who has been mentally ill	**4.3**	**19.6**	9.2	40.8	26.1	3.65 (1.19)
Anyone with a history of mental problems should be excluded from taking public office	**6.0**	**23.1**	13.6	38.3	19.0	3.41 (1.20)
The mentally ill should not be denied their individual rights	37.1	46.0	3.0	8.7	5.2	**1.99** (1.10)
Mental patients should be encouraged to assume the responsibilities of normal life	**34.2**	**57.9**	3.0	3.5	1.4	**1.80** (0.77)
No one has the right to exclude the mentally ill from their neighbourhood	**36.1**	**52.7**	3.5	7.1	0.5	**1.83** (0.84)
The mentally ill are far less of a danger than most people suppose	11.7	47.6	15.2	**22.8**	**2.7**	2.57 (1.05)
Most women who were once patients in a mental hospital can be trusted as babysitters	4.3	31.0	32.6	**25.5**	**6.5**	2.99 (1.00)

Note. SA = strongly agree; A = agree; N = neutral; D = disagree; SD = strongly disagree. (SD) = standard deviation

Table 4 Response descriptives on the CMHI subscale of the CAMI

Item	SA %	A %	N %	D %	SD %	Mean (SD)
Residents should accept the location of MH facilities in their neighbourhoods to serve the needs of the local community	14.9	66.3	10.6	6.8	1.4	2.13 (0.80)
The best therapy for many mental patients is to be part of a normal community	**21.7**	**67.4**	7.1	3.3	0.5	**1.93** (0.68)
As far as possible, MH services should be provided through community based facilities	**20.9**	**67.4**	5.7	5.2	0.8	**1.98** (0.74)
Locating MH services in residential neighbourhoods does not endanger local residents	13.0	55.4	12.8	**14.7**	**4.1**	2.41 (1.02)
Residents have nothing to fear from people coming into their neighbourhoods to obtain MH services	13.9	53.7	10.1	**18.5**	**3.8**	2.45 (1.06)
MH facilities should be kept out of residential neighbourhoods	2.4	13.0	12.0	54.9	17.7	**3.72** (0.98)
Local residents have good reason to resist the location of MH services in their neighbourhood	1.1	13.6	12.3	54.5	18.5	**3.76** (0.95)
Having mental patients living within residential neighbourhoods might be good therapy but the risks to residents are too great	**3.5**	**22.8**	14.9	49.5	9.2	3.38 (1.04)
It is frightening to think of people with mental problems living in residential neighbourhoods	**3.0**	**16.6**	9.5	55.2	15.8	3.64 (1.03)
Locating MH facilities in a residential area downgrades the neighbourhood	**4.9**	**24.2**	19.0	38.6	13.3	3.31 (1.12)

Note. SA = strongly agree; A = agree; N = neutral; D = disagree; SD = strongly disagree; (SD) = standard deviation; MH = mental health