Mental Health Issues in the Workplace: A Contact Intervention for the Reduction of Stigma at Work

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Abstract

One of the biggest priorities of organizations nowadays is to create an inclusive environment for all employees. The purpose of this study is to explore the role of contact in behavioral intention and attitudes towards employees with mental health issues and identify the role of empathy and self-confidence in these associations. In the current project, there were three conditions (*a*. role-play combined with induction of empathy and self-confidence, *b*. a plain role-play and *c.* a personal story). It was hypothesized that the conditions that included role-play (contact) would have significantly higher scores in the dependent variables. Also, empathy was expected that it would be correlated with contact, behavioral intention and attitude and then it would mediate the relationship between contact and the two dependent variables. Furthermore, self-confidence is being examined on the role of the moderator between contact and the dependent variables. In the Method, all the important information for the intervention is presented. The analysis disconfirmed the first hypothesis, with the third condition having only significant differences with the first condition regarding behavioral intention scores only. Also, regarding the second hypothesis, the only significant correlation was empathy with behavioral intention, which led to the fact that there was no significant mediation of empathy to the relationship between contact and the dependent variables. As for the moderator effect, significant results were found, with self-confidence moderating the relationship between contact and behavioral intention. For the relationship between contact and attitude, there were no significant results, but they were almost marginal. In the discussion section, an explanation of the results, further research, limitations, strengths and implications are presented.

Keywords: stigma, mental health issues, empathy, self-confidence, moderation

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Mental Health Issues in the Workplace: A Contact Intervention for the Reduction of Stigma at Work

It is a fact that one of the biggest concerns of organization nowadays, is the increase of the diversity and inclusion of people with diverse characteristics in the workplace. Many campaigns have been implemented through the years, various social groups have been active towards these goals and many initiatives have been proposed to the workplaces for achieving them. Some important steps have been made in order to increase diversity of difference and non-dominant groups in the workplace, but as for inclusion and belongingness, more effort should be placed on that, as many groups are still excluded (Greenwood & Anas, 2024; Ferdman & Deane, 2014).

Mental Health Issues in the Workplace

One group that is not included in the workplace is the people with mental health issues (MHI). World Health Organization (WHO), even tried to increase inclusion for the specific group, by implementing an Action Plan targeting this MHI, but still, the numbers show that they are treated unfairly (Gronholm et al., 2017). In more detail, MHI is defined by the WHO as a negative aspect of mental health that does not lead to clinical cases of low functionality at work, but a symptomatology that makes the person capable of working (WHO, 2019). In other words, there is a presence of functionality, but not mental and psychological well-being (Kelloway et al., 2022). People who have MHI, are considered to be those that experience mild-intense symptoms of poor mental health with a range of symptomatology from stress-related symptoms up to depressive ones, aggression and others (Lazarus & Folkam. 1984). Some symptoms might be mild-moderate such as tiredness, insomnia, mild stress, and low emotional control, but it could

include more intense symptoms such as depressive episodes, panic attacks, burn out and others (Greenwood & Anas, 2024). The statistics shows that even if the prevalence of the MHI at work is more than 65% in the workforce, still people with this characteristic face exclusion at work (Greenwood & Anas, 2024). The biggest reason behind this fact, is the presence of stigma in the workplace, as due to this, people get discriminated and do not get actively involved in working life (Clement et al., 2015). Almost 50% of the individuals who have tried to disclose to other coworkers that they were experiencing MHI during 2021, felt that they received positive results after doing this, which is the same percentage that was reported for 2019, as well, showing no improvement (Greenwood & Anas, 2021). Drawn information from previous research in the field of mental illnesses, in a study of 202 individuals with mental illness, 93% of the respondents reported that they were expecting to receive discrimination in the workplace, while 87% had already experienced one or more incidences, proving that indeed this is the reality inside the organizations (Farrelly et al, 2014). This is something that is being seen across the life-cycle of the employee in the organization, as 1/3 of the individuals who have MHI do not pass into the next stage of the selection process, but at the same time when they are inside the organizations, less opportunities are being given to them (Hipes et al., 2016; Matousian & Otto, 2023). These show that the problem persists even though the efforts to diminish stigma. Hence, it is imperative to find ways to reduce the stigma for this group of individuals in order to increase inclusion in the workplace (Ferdman & Deane, 2014). For this, attitude change and increased behavior intention should be cultivated, in order to be able to have culture changes in the organization with significant results on inclusion (Emmers et al., 2019). Without identifying though, the elements that

are needed in the intervention to be successful, no effective practices can be implemented in the organizations (Booth et al., 2002). This study aims to explore the elements that could enhance the reduction of stigma in the workplace, which involves the power of contact with someone with MHI, the role of empathetic feelings and the role of self-confidence to approach someone. Before analyzing though their effect on reducing stigma, it is important to understand the prevalence of mental health issues at work, define stigmatization and evaluate its costs.

Prevalence

In the last few decades, it has been observed that more and more people experience poor mental health symptoms at work. The modern world has been affected by various social and political changes, which increased the feelings of ambiguity, uncertainty fear and other negative feelings (Greenwood & Anas, 2021). Especially after COVID-19 era, there was an increase of 50% in irritability, 38% in sleeping problems, 53% in negative emotions like sadness and more than 50% of emotional exhaustion (Elfein, 2020). Some factors behind these changes could be the restrictions that were imposed to avoid the spread of the virus, the isolation that individuals had to experience from physical contact, the socioeconomical insecurity and the unknown future (Greenwood & Anas, 2021). At the same time, societal disturbance such as the "*Black Lives Matter*" movement, the increased violence towards non-dominant groups such as women, LGBT+ community, racial minorities etc., the political unrest and wars, might be important stressors for individuals (Greenwood & Anas, 2021). Literature argues that there is a spiral increase of occupational stress and poor mental health, which can be linked to long-hour shifts, the modern busy culture of 24/07, the low organizational

support and the limited presence of resources, the poor management practices, ambiguity of job roles, the technological advancements in the workplace and other stressors (Harrey et al., 2017; Fotinatos-Ventouratos & Cooper, 2015).

These effects are more vivid also to younger generations, like Gen Z and Millennials, which are the new workforce of the companies, as there is an increase in prevalence (Brouwers, 2020). The researchers stated in their report that more than 80% of the Gen Z workforce and 68% Millennials have pointing out that they have left a position due to MHI. These numbers, shows that it covers a very big portion of the current workforce in 2024, and it is a new reality that is not discussed that much as it should. Apart from this group, leaders and high executives are affected as well, as they have higher risk of experiencing MHI due to the increased responsibilities, but it something that is hidden under their fear to express themselves due to stigma reasons (Greenwood & Anas, 2021). The prevalence of the MHI, shows how much contact people have during their working life with people with MHI, without even knowing it, as most of the times is not even visible to others (Follmer & Jones, 2017).

Stigma and Stereotype Content Model

Even though the prevalence is that high, stigma still persists in the workplace (Follmer & Jones, 2017). Stigma is an outcome that stems from stereotypes that someone might carry (Gapinski et al., 2007). Stereotypes are category-based attitudes that are mostly implicit and they refer to a connection of an attribute/characteristic with a specific identity and it can be generalized to the whole group that has this identity (Dovidio, 2010; Gapinski et al., 2017). Stereotypes can be either positive or negative (Fiske et al., 2002) and they can be generalized in other groups that share parts of the specific characteristics,

spreading a stereotype with a spillover effect, to other non-dominant groups as well (Follmer & Jones, 2017). For this reason, we see stereotypes that are targeted to mental disorders, spreading into the group of people with MHI, who might share, at some extend, some common symptomatology (Follmer & Jones, 2017). For example, when a person observes someone who shows intense symptoms of stress, might think unconsciously of anxiety disorders. In other words, it expected for a person with stress related symptoms to behave like someone that has an anxiety disorder (Fiske et al., 2002). However, many people are not aware that they are biased and they hold these types of beliefs, which shows that this process in unconscious and difficult to change (Gapinski et al., 2007). Based on this perception, it is imperative to explore stigma for MHI at work, as it still understudied and overseen. For this reason, part of the literature that will be presented in the following sections might include studies that have taken place in samples having a mental disorder, but it is expected to have similar results for people that experience MHI at work, as well (Greenwood & Anas, 2021). A model that explains the mechanisms of stereotyping and discrimination, which can be applied in the case of employees with MHI, is the *Stereotype Content Model* by Fiske and other colleagues (2002). They explain that there are two dimensions behind stereotyping, with first being *Warmth* (the feelings of friendliness towards someone that holds a specific characteristic) and the second one the *Competence* (the efficacy, independence and competitiveness that this person can show). Once someone interacts with a person that belongs to a specific group, they "judge" their attributes based on these two factors (Fiske et al., 2002). The specific researchers explain that in case a person perceives a group as high in competence and high in warmth, then most probably they would be willing to approach someone,

provide assistance (helping behavior), have the drive to interact with them and have positive feelings towards them. When someone perceives someone as low in competence and low in warmth, avoidant behavior is expressed, with low intention to help, with negative feelings towards this group and even discriminatory behavior with active marginalization. They also explain that when there is high competence, but low warmth, the person is welcomed because of their abilities and skills, involving them to many different tasks in the workplace, but there are feelings of envy and possible microaggressions. Lastly, when there is the opposite, people might feel pity for someone, as they perceive them as not having the ability to perform but they care about them. People with MHI, generally belong to the categories in which there is low competence, and there is a debate in the literature regarding the warmth. Some scholars suggests that there is an agreement that the symptomatology is perceived as barrier to success in the workplace, but they experience high warmth as they feel pity of their situation and they wish to help (Corrigan, 2000). Though, it seems that the stronger opinion is that, indeed, there is low competence, but also low warmth, as there is an observed avoidant behavior in the workplaces which is met in this category (Fiske et al., 2002). Individuals might do not find it easy for them to talk about MHI or they might do not know how to handle symptomatology, hence they feel stressed around it, leading to low warmth (Angermeyer et al., 2004). Therefore, when someone meets an employee with MHI they might associate this person that holds this characteristic automatically (implicitly), without being even aware, with a stereotype that they do not have the competence to do the work (Angermeyer et al., 2004). At the same time, they might feel uncomfortable around them, due to intense symptomatology, and this can lead to discriminatory actions, like not

giving a promotion, or hire the person etc. (Gapinski et al., 2007; Tsang et al., 2007). Discrimination can be either formal (firing someone, do not give a promotion and others) or informal (microaggressions, avoidance etc.) and it can be manifested within the working life with overt or not observable behaviors (Jones et al., 2013). This is also depicted in the survey of Greenwood and Stein (2021), who wrote that 91% of the employees believed that there was enough support of the organization for people with MHI and they required action towards the reduction of exclusion. Also, Follmer & Jones (2017) in their study, supported this notion and explained that that employees with depression can be perceived as low in competence and warmth, because of increased anxiety when a person is near to them, stemming for safety concerns and social compatibility considerations. They might struggle to form easily relationships with others; hence this diminishes the friendly emotions of the employees for them (Follmer & Jones, 2017). The effect is even bigger when they can observe the symptoms and they are visible to everyone (Biggs et al., 2010). Additional to these, organizations do not wish to include them in significant responsibilities and they avoid showing outside the organization that there is presence of MHI at work, in order to evade being commented as having a "bad image" (Hand & Tryssenaar, 2006). Hence, for the scope of this study, the focus has been made in both warmth and competence, as it seems that these two are low in the modern workplaces.

Taking into consideration all the above, it is evident that these studies on stigma leads to low behavioral intention in general, with avoidant behavior (Corrigan, 2000) and also there is a prevalence of negative attitudes in the workplace for people with MHI (Corrigan, 2000). Consequently, these are the two main variables that would allow me to

measure stigma and explore the different elements that could enhance them. Before though focusing only to these to variables, it is important to point out some significant outcomes of stigma, in order to understand why this topic is important.

Organizational and Individual Cost

The increase of MHI and stigma at work, comes with significant costs, both for the individual and the organization. Regarding the organizational impact, employees with depression cost to the US economy annually more than $210 billion, which partially is being paid by companies (Michie & Williams, 2003). Additional costs should be considered for all the medical expenses that follow the physical illness related to poor mental health (Greenberg et al., 2015; Steel et al., 2014). Another relevant cost is stemmed from the absenteeism or the presenteeism of the employees who suffer from poor mental health issues, who either cannot go to work due to intense symptomatology or they put pressure to themselves to be present at work, even if they do not feel ok, leading to higher absenteeism in the long run, with even more serious symptomatology-both physically and psychologically (Fotinatos-Ventouratos et al., 2023; Razzouk, 2017). Employees with MHI in a study revealed that they would not go to work if mentally/psychologically were not ok, in order to avoid any discriminatory behavior towards them (Schulze & Angermeyer, 2003). Razzouk (2017) noted that the cost for an organization in UK for absenteeism at work, could reach up to $1.7 million dollars, which will be doubled up until 2030. Apart from the above, this is correlated also with lower productivity at work, low motivation, low engagement and lower innovation inside the organizations (Gignac et al., 2021; Kelloway et al., 2022; Trautmann et al., 2016). Last but not least, due to the high prevalence of individual stigma (personal level), people tend

to expand these views in the processes/policies of the organization and they construct procedures that they are might not inclusive or do not facilitate the reduction of stigma, because they build them based on the stigmatized attitudes they have, leading to a structural stigma as well (organizational level) (Hatzenbuehler, 2016).

As far as the individual outcomes are concerned, health problems have been linked with stigma at work, such as cardiovascular issues, gastrointestinal symptomatology, higher problems, insomnia, ulcers or even cancer (Ferdman & Deane, 2014). Also, in extreme cases, data have shown that people who have suffered from stigma at work, have higher probabilities to live less years, as the quality of life is diminished (Ferdman & Deane, 2014; Livingston & Boyd, 2010). Furthermore, people with MHI do not seek therapy and they avoid using the mental health services of the organization when they exist, as they are afraid that they will be stigmatized by using them, which is something that delays the therapeutic process and the alleviation of the symptomatology (Carolan & de Visser, 2018; Vogel et al., 2007). In an analysis review by Clement and his colleagues (2015) on stigma of 144 studies with overall 90,189 participants, it was found that stigma was the 4th most serious reason why someone did not seek therapy. More than 50% of the individuals with major depression in Europe and USA, do not follow a treatment, in order to avoid discrimination (Barret et al., 2008) Self-stigma, is also a byproduct of long-term discrimination, in which the individual internalizes the stigma and they give up on searching for therapy (Vogel et al., 2007). Psychologically speaking, lower self-esteem, loneliness, stress and burn out are outcomes that are experienced from most of the stigmatized individuals (Gray et al., 2019; Livingston & Boyd, 2010). Employees might face increased emotional exhaustion at

work and illness, when they try to mask the symptoms in order to not to receive negative comments from other employees and avoid any further stigmatization (Pescosolido et al. 2010). At the same time, discrimination at work restricts the opportunities of an employee with MHI and pose an obstacle to their career advancement (Hudson, et al., 2021; Hoedeman, 2012). People that have a mental disorder are less likely to be hired even compared with people with serious physical illness, such as cancer (Corrigan et al., 2001), which might be an indicator that a similar effect could be present also for people with MHI. Last but not least, financially speaking, when employees with MHI recover and return back to work, their annual earnings are decreased by 10% (Briand et al., 2007).

The Role of Contact

There are various interventions in the workplace that have targeted the minimization of bias, stereotypes and stigma, either via increasing knowledge or with a goal of behavioral/attitude change (Corrigan et al., 2001). While there are numerous of practices that are effective, one element that has impressive results and long-term effects in the bibliography is the presence of personal contact with someone that experiences MHI (Gronholm et al., 2017; Stokoe, 2011), with literature suggesting that contact has a significant impact on increasing behavioral intention and improving attitudes. Based on *Allport's Intergroup Contact Theory* (Allport, 1954), the close physical contact can alter stereotypical thinking and minimize bias, as when someone has a positive experience with another person through direct contact, can see changes in behavior and attitudes. In other words, the gap between the ingroup and the outgroup is reduced during the interaction and the stigma is also reduced (Allport 1954). Tropp and Pettigrew (2008) in a

meta-analysis of 515 studies regarding bias expressed that the presence of contact in the literature was a predictor of lower bias, showing an alignment with previous research.

Based on various theories of stigma, the behavioral intention and attitudes are both part of a big model that consists of three factors (knowledge, attitude, behavior) that are all intercorrelated (Svensson & Hansson, 2014). This means that once one of the factors change, the other follows. A vast majority of literature has explored the relationship between behavioral intention and attitudes toward people with MHI (Thornicroft, 2007). More specifically, while the attitude scores are getting more positive, the behavioral intention scores simultaneously increases and the opposite (Hinshaw & Cicchetti, 2000). This is also observed in the meta-analysis of Hanish and the rest of the team (2016), in which they reported that there was a spillover effect of outcomes, meaning that many studies were targeting one or two aspects of stigma and there was an effect to the third variable as well. For instance, some scholars targeted knowledge and attitudes, but they saw an effect also on behavioral change (Maffit et al., 2014). Also, in a role play intervention targeting attitudes and behavior, there was a spillover effect of knowledge increase as well (Krameddine et al., 2013). Another study by Jorm & Oh (2009) showed that when somebody holds negative attitudes towards a group of people, they are more likely to avoid interacting with them and score high in social distancing and the opposite. Hence, if contact is correlated with one of the two variables, still an effect is expected in both variables.

However, the researchers have pointed out that the use of role-plays as a way to create contact should be further explored, as especially contact in the workplace for MHI, is extremely limited in the scholars. Also, the most effective structure that would allow

the maximum effect of role-plays to be seen, is the use of scenarios that are tailored to the job role of the individuals, in order for them to understand the relevance with their everyday working life and be able to recreate the behavior (Gronholm et al., 2017), which is also a practice that is missing in the literature. For this reason, the intervention of this study, which will include the presence of contact as a variable in the design in order to show the effects of it on behavioral intention and attitude change, will take place via using tailored scenarios for the employees, so that we could account for long-term effects as well. In addition, the most important in terms of contact, is to find out the role of additional variables that would influence their impact in stigmatized attitudes and behavior, hence this will be the focus of the rest of the study as there not enough data on this (Tropp & Pettigrew, 2008). Further literature showing the relationship between contact and the dependent variables are presented below.

Contact and Behavioral Intention

One of the most crucial impacts, is that other employees do not wish to come into contact with people who suffers from MHI, and especially this is depicted in the research related to mental disorders (Pescolido et al., 2010). Thus, a significant part of the manifestation of stigma is Behavioral Intention, which is also one variable of this study, defined as the tendency of the individual to approach someone with MHI. Studies have shown that the presence of contact can increase the intention of someone to work together with a person that has MHI (Hansson & Markstrom, 2014; Pinfold et al., 2003). Another study showed that when a person comes into contact with diversity in an environment that is safe for them, then there is absence of stress, fear and threat, this could be a good experience that would lead to future intention to re-do an activity/behavior, because the

consequences in the initial behavior were positive (Blascovich et al., 2001). Moreover, contact interventions have been also linked to behavioral intention, as contact allows the individual to observe the difference closely, and get exposed to new images and experiences, understanding that this might be a positive experience, rather than negative and wish to do it again, showing future behavioral intention (Hansson & Markstrom, 2014). In a more detail, a study of 640 participants showed that this is one of the most effectives way to increase the willingness to approach someone again in the future (Alexander & Link, 2003), indicating more long-term effects than other approaches of stigma reduction. Also, a study about depression, showed that 47% of the employees who completed a survey, reported that they would not like to work with someone who might have depressive symptoms and 30% of them that they would feel uncomfortable to interact with them (Pescolido et al., 2010).

However, in the study of Pinfold and his colleagues (2005), the role of contact was explored and they found significant results in children, but not in the adult population in terms of behavioral change, which is the next step of behavioral intention. This study though, did not disconfirm that contact is not effective, but rather than highlighted the need to identify the additional variable that might affect this relationship. Also, Svensson & Hansson (2014) in an analysis reviewed argued that the behavioral intention is not constantly significant across the literature, which means that it requires further research, in order to get more safe results. However, if we compare attitudes and behavioral intention, this variable is the one that is more easily affected and it can alter significantly while using a variety of interventions (Svensson & Hansson, 2014).

As a result, the first hypothesis of the study is that the presence of contact will have an impact on behavioral intention towards employees with MHI, with the scores being significantly higher in the conditions with the role-play activity than those in the condition with no contact.

Contact and Attitudes

The presence of contact seams to change also the attitudes of the individuals. Research had been conducted either by using role-play interventions or with theatrical plays (Corrigan et al., 2001; Hansson & Markstrom, 2014; Pinfold et al., 2003; Tolomiczenko et al., 2001) and they have found changes in the attitude, even if it was difficult for them to get results. Corrigan and his colleagues (2001) conducted a study in which there was a discussion with someone who had poor mental health and they realized through the conversation that the symptoms can be controlled by them, improving their attitudes about the whole non-dominant group that the person belonged to. At the same time, a meta-analysis of 37 contact-based interventions for attitude change, showed that one of the most significant predictors of attitude change was the presence of contact (Knaak et al., 2014).

Despite the above, there are studies that had focused on attitude change via role playing, but no results were found on stigmatized attitudes (Krameddine et al., 2013), which was something that should be researched in the future and especially with the role of emotions, as they might have blocked the process (Krameddine et al., 2013). There are additional articles that have not found any significant results (Nishiuchi et al., 2007) and they explained that this might be the outcome due to the use of generic content in the training, not tailored to the individual's knowledge and level (Hanish et al., 2016). Hence

further research should conduct an intervention that would be tailored to the individual and see if there are any changes. As follows, this is also a reason why this paper uses tailored role-play interventions.

It should be noted that even though attitude change is very difficult to be achieved, still there are scholars that have shown that contact can have a significant effect on it (Svensson & Hansson, 2014). Based on the above, it is also hypothesized that the presence of contact will have an impact on attitudes towards employees MHI, with the scores being significantly higher in the conditions with the role-play activity than those in the condition with no contact.

The role of Empathy

One variable that has been connected in the literature with the presence of contact and the reduction of stigma (increase of behavioral intention and better attitudes) is Empathy. Empathy is defined as the affective response of an individual when they observe the experiences of someone else (Davis, 1983). It should be noted that in the current research empathy is the empathetic concern (as there are different types of empathy), which is the one that is being researched from the rest of the literature and it focused only to the emotions that are being elicited, after observing someone's challenges or negative situation (Batson, 1997). Harth and her colleagues (2008), argued that this type of empathy is positively correlated with behavioral intention and attitude change. There is also research that has shown correlation of empathy with both behavioral intention and better attitudes, as well as experimental designs that try to find a deeper connection (Gapinski et al., 2007; Hayes et al, 2014; Vescio et al., 2003). Oliver and his colleagues (2012), after showing YouTube videos with empathetic content, discovered

that in this condition, the attitudes got better and the behavioral intention was significantly increased. Also, research has shown that while someone is in contact with a person with MHI and have a positive experience while is this happening, attitude change can take place (McKeever, 2014; Vescio et al., 2003). Other studies on empathy have shown a strong correlation with attitudes (Decety et al., 2010; Egbert & Parrot, 2003; Preston & de Waal, 2002) and others with behavioral intention (Vescio et al., 2003, Oliver et al., 2012), strengthening this notion.

At the same time, literature suggests that contact is correlated with empathetic feelings, as well (Krameddine et al., 2013; Potts et al., 2022). When someone comes into contact with a person of a non-dominant group, results have shown from the completion of affective questionnaires or empathy scales that they co-exist and empathy is even higher in the cases of more personal contact (Faigin & Stein, 2008). In a study design that had no contact, low contact and high contact, was found that in the corresponding conditions, the same pattern was met for empathy scores, without manipulating it (Faigin & Stein, 2008).

Contrary to the results above, is the study of Gloor and Puhl (2016), in which they tried to induce empathy with first person narratives or to ask participants to write by "taking other's perspective" (meaning like being the other person) to report the challenges someone that is obese might face. They found that even if the empathy was induced (especially in the self-narrative condition), no significant results were extracted from the analysis regarding attitudes and social distance (which is a term that is used interchangeably sometimes with behavioral intention), but rather than an increase of phobia towards this group. An explanation for these results, might be that the content that

was used could unintentionally strengthen negative stereotypes, by lowering the competence of the individuals while trying to increase the warmth (pity) (Daníelsdóttir et al., 2010). Another explanation might be that the empathy would not lead on its own to reduction of stigma, but it should be accompanied with other variables as well, as it might have a secondary role (Batson & Ahmad, 2009). If all the studies that are analyzed in this section is taken into consideration, the contact might be considered the variable that is missing, hence the empathy could have a role that would support this relationship.

Taking into consideration all the above, it is hypothesized in the current study that the empathy will be positively correlated with better attitudes and higher behavioral intention. Also, the presence of contact will be associated with high scores on empathetic feelings.

All the above, showed the connection of empathy with the variables, but further evidence from bibliography can help explore the role of empathy in this relationship between contact and the dependent variables, in case it is actually related with variables. A good start is the Allport's Intergroup Contact Theory (Allport, 1954), that states that the role of emotional arousal is the reason why change in stigma is taken place. It was imperative for him to understand what emotions could play a role there, and further research had shown that empathy is one of the most significant (Batson, 2009; Pettigrew & Tropp, 2008). Also, based on the Empathy-Attitude Model (Batson, 1997), the role of emotion is the most powerful variable that affects the attitude change, while increasing at the same time this effect to other groups as well, that share similar characteristics. This proves the power of emotions and the impact that is depicted in the literature. If we expand these theories and put them in the context of contact, it could show that empathy

might have a mediation effect. The study of Faigin and Stein (2008) depicted that there is a strong impact of contact on attitude change and behavioral intention, which was stronger for the condition in which there was a role-play, rather than the rest that the contact was online or even absent. What they observed was that the participants who were recruited for the condition with the role-play, had also increased emotional arousal, with the items related to empathy even higher. Their suggestion was to have future research explore the role of empathy which is a variable that seems to affect the relationship and maybe try to identify its role. Based on Weiner's work (1980), they argued that when empathy is increased in people, they tend to have a more helping approach towards other (Faigin & Stein, 2008), which might show that this variable might explain the relationship between the contact and the variables of interest. Hayes and her colleagues (2004), who studied burnout, illustrated in their study that empathy could be the explanation between the relationship of the presence of contact and reduction of stigma, hence the role of mediation should be given to this variable. Potts and his colleagues (2022), conducted the first study that examined this variable as a mediator and found significant results. In addition, Batson and the rest of the team (2002) conducted a contact intervention with a discussion with convicted men from drug usage and the individuals had increased behavioral intention afterwards, with better attitudes and heightened empathetic feelings simultaneously. Aligned with these results, is the research project of Pettigrew & Tropp (2008), who explained half of the relationship between the presence of contact and attitude change by inserting in their analysis the empathy as predictor. In order to explain this effect, they argued that this could be a possible mediation effect that needs to be tested in future further with this role, as

empathy might allow the individual to understand the other's position, feelings and thoughts and reduce the distance between their ingroup and their outgroup by reducing negative emotions. Empathy could be a variable that would make the person "*get on the other's shoes*" and by it is presence, during a contact the person might try to hinder negative attitudes, restricting blame to the whole group for each condition (Batson & Ahmand, 2009; Pettigrew & Tropp, 2008). Another explanation was given by Bartsch and others (2016), which said that when someone has feelings of empathy, they start reflecting more on their experience and the information they receive, hence they might be more open to an attitude/behavioral change, while they come into contact with a person with MHI. This could potentially be an explanation of a mediation effect that explain how this relationship is created (Hecht et al., 2021). Last but not, an interesting study about virtual reality (VR), showed that in case the individuals had completed a task with VR (which is a simulation of a real contact) had higher empathy than the rest of the groups that did not, and it was also accompanied by better attitudes, showing maybe that the role of empathy is there (Karami et al., 2021).

In terms of a biological explanation, research from neuropsychology has shown that when someone comes into contact with a person, mirror neurons try to match the emotions and the physiology of the other person, hence this change in attitudes and behavioral intention after contact, could be attributed to the empathetic feelings that are created through the interaction from biological reasons, make it a good explanation for this relationship to exists (Leverson & Ruef, 1992).

Summarizing, part of this study is to cover that gap, and examining the role of empathy further and add more evidence on the role of empathy, that is not constant

throughout the literature and there is limited data for the role of empathy. From the findings included on this literature review, it can be suggested that this variable explains how the presence of contact changes behavioral intention and attitudes, acting as a mediator. Therefore, it is also hypothesized that the empathy will mediate the relationship between the presence of contact and the two dependent variables (behavioral intention and attitudes)

The Role of Self-Confidence

A small part of the literature explored the role of self-efficacy into the relationship between behavioral intention and attitudes and argued that this might be an element that needs further research as well (Svensson & Hansson, 2014), as it seems that it has an important role in the contact designs. It should be noted though, that in some research this was defined as self-confidence, which is also used with this term in the current paper, because Hanish et his colleagues (2016) stated that self-efficacy is a more complex construct, while self- confidence on approaching someone again, seems to be encompass more variables that have been mentioned in the literature regarding confidence.

In order to explain the role of this variable, the theory of Bandura called Social Cognitive Theory is used firstly (1977). For Bandura, self-efficacy is the perception of the individual about themselves in order to do something effectively, having trust into their abilities, attributes and skills (Bandura, 1977). Based on this theory self-efficacy is key aspect that determines how people think, act and behave in a society. Regarding attitudes, if they have high self-efficacy, they are more comfortable with challenging things and situations, hence they are more open to change a stereotype and critically evaluate it, leading to a reduction on stigma (Devries et al., 1988).

At the same time, regarding behavioral change and intention, when someone has high self-efficacy/confidence, the chances of approaching someone are higher, as the person feels good for their skills to perform this exercise (Cohen, 1992). This motivation that would be created from the trust of the self (self-confidence), might enhance the observable behavior and receive a greater effect (Svensson & Hansson, 2014). Furthermore, research has shown that people who had positive experience during an interaction and has increased self-confidence, they were more intended to re-engage in this behavior later in life, as they felt sure about their skills to do it (Hanish et al., 2016). On this point, important insights can be drawn by the Social Cognitive Theory, as Bandura explains that the role of positive experience and positive outcomes is important in order to strengthen a behavior, as due to experiential learning, people learn and explore the world by understanding the consequences of a behavior (Sheeran et al., 2016). One of the most significant positive results for the self, is that the confidence is heightened and the outcomes is achieved due to self's actions (Conner & Norman., 2015).

Others studies that support this, included the notion of feedback after the role-play to increase behavioral intention, which could increase the self-efficacy/confidence simultaneously. Indeed, these groups showed high levels of behavioral intention and have good attitudes, after the intervention. This element has been overseen from the literature and these designs though and needs further research to understand its impact on the dependent variables. Feedback is also a way to increase the confidence to yourself, as you understand what you are doing ok and what should change in order to have positive results and replicate again a behavior (Conner & Norman, 2015). Generally, there are significant interventions that linked the role of contact with behavioral intention, and they

found as well that self-efficacy was also high (Conner & Norman, 2015; Gollwitzer, 199; McEachan et al., 2011), building on the above argumentation, depicted aligned results. Others, although they have not explored it directly, they made some noted for future research. For example, it is observed that in Krameddin's and his colleagues' study (2013) in the police department, which was a study with significant results, at the end of the design the police officers were receiving feedback in order to correct a behavior or enhance it, which could have increased potentially the self-efficacy of the individual to approach someone with mental illness as well. The police officers had significantly higher behavioral intention, but the role of self-efficacy or confidence was not explored, in order to have more data. Bandura argues that once you have more information about your skills, it is more possible to see also better results in behavior (Bandura, 1977). Verbal persuasion is a very powerful tool in order to increase self-efficacy/confidence, especially when this is accompanies with a positive experience and emotions (DeVries et al., 2008). The self-confidence in that case is heightened and great results can be observed. Last but not least, Usmani and others (2022), revealed in their results that self-confidence in a contact intervention was related with high behavioral intention, after the participation of 608 individuals, which according to data science is a significant sample size to make the results even more credible.

Overall, in the literature there were designs that after the role-play, which they had an effect of attitude change and/or behavioral intention, including strategies that would enhance the self-efficacy, allowing the researchers to see the effect of the self-efficacy. Also, Sheeran and others (2016), found a causal effect of self-efficacy to attitude change as well, exploring further their relationship, stating that the role of self-

efficacy might hide other effects as well (Sheeran et al., 2016). In addition, exploring the part of the literature regarding teaching, data showed that while teachers were coming into contact and having increased self-efficacy, they had better attitudes towards non-dominant groups (Hofman & Kilimo, 2014). This might also be explained by the fact that self-efficacy could have allowed them to be more open to different and be able to pay attention to new information, in order to use it consciously towards producing cognitive change (Layser et al., 2011). Other findings suggests that those teachers who had high self-efficacy, simultaneously showed more inclusive mindset when they came into contact with students in a classroom setting (Chacón, 2005). Finally, the above findings on contact literature, in relation to attitudes the role of self-efficacy / confidence can be explained partially also by using the Theory of Planned Behavior (Ajzen, 1991). Based on this theory, behavioral control (which is one of the three components apart from attitude and subjective norm), refers to the perception regarding the ability of the individual to control their behavior based on the difficulty of the task, which can be paralyzed with the self-efficacy (Emmers et al., 2019). This model suggests that when you have high behavioral control (like self-confidence) it is more likely to have behavioral change and attitude change as well (Ajzen, 1991).

The above scholars though, suggested that for further research the role of self-confidence should be explored further in terms of contact, as it is not very clear. (Sheeran et al., 2016). Literature has explored in various ways self-efficacy/confidence, as a secondary variable, but after the constant analysis of the literature review, the current study will set the role of a moderator in the variable of self-confidence, as it can be

implied that when it is present, in can enhance the relationship between contact and the dependent variables (behavioral intention and attitudes).

Further input is needed, hence taken all the above into consideration, it is hypothesized that self-confidence to approach an employee with MHI, will moderate the relationship between contact and the dependent variables.

The Present Study

The present study is an intervention that has as a goal to increase the inclusion of people with MHI in the workplace. As there is high prevalence of stigma in the workplace, the scope was to utilize the role of contact in order to reduce it (targeting behavioral intention and attitudes, which are the manifestation of stigma) (Corrigan et al., 2001; Gronholm et al., 2017; Tropp & Pettigrew, 2008) and explore also the role of additional variables in these relationships. This will cover the luck of evidence that exists in the literature in MHI, as most of the literature is towards mental disorders and the simpler forms of symptomatology is overseen, while it seems that stigma is present in the workplace, accompanied by the high prevalence (Greenwood & Anas, 2021) even in these cases. As these symptoms are very often met in the new generation of the new workforce, it is important to know what is going in the Greek cohort in terms of stigma and also realize that the presence of stigma is in organization's everyday life (Greenwood & Anas, 2021). Additionally, the contact will be implemented via the use of tailored role-plays, avoiding any general content that is not relevant with position of the participant, as there was a need for more personalized intervention (Gronholm et al., 2017). This is one of the few interventions that have conducted job analysis in each position in order to create tailored scenarios and increase empathy induction (Igartua & Barrios, 2012), while

giving to the intervention a higher face validity. Related to that is that an additional goal was to create a workplace intervention that would provide the safe space for employees who are not familiar with MHI, to come into contact with difference and create in a controlled situation their first positive experience.

In a more detail, this paper would like to enhance the contact theories that suggests that it can change stigma and understand the role of the empathy and the self-confidence on this. By combining the theory of Stereotype Content Model (Fiske et al., 2002) that explores the notion of competence and warmth in stereotypes and bias, and by relying on Allport's Intergroup Contact Model (Allport, 1954), this paper utilizes the methodology of role plays in order to create three condition that would examine the role of contact, the effect on behavioral intention and attitudes and would shed light on the role of empathy and self-confidence, my manipulating their induction. At greater detail, the first condition will have a role-play intervention (contact), though which empathy and self-confidence will be induced from the role-player. In the second condition, only a role play will be taken place, without any emotional arousal or increase of self-confidence I order to understand the effect of contact on its own and then a third condition is included, that would not have any contact present, but just a self-narrative story to induce feelings of empathy. For my design, empathy will have the role of mediator, as it can be implied from the literature review that it explains the relationship between contact and the dependent variables and self-confidence to approach someone will hold the role of a moderator, as it can be interfered from the literature that it strengthens the relationship and very limited research have been conducted in order to explore that or even almost non (Sheeran et al., 2016). As a result, putting together the main relationship of contact

and the reduction of stigma, and enriching it by adding in the picture a mediator and a moderator. Hence, the five hypotheses of the study are the following:

H1: Participants in the contact conditions (role play) (condition 1 & 2) will demonstrate significantly better scores on attitude towards employees with mental health issues in the workplace, and behavioral intention to approach an employee with mental health issues, compared to those who do not undergo the intervention with the contact, with condition sowing significantly better results than all of them.

H2: It is hypothesized that empathy will be positively correlated with behavioral intention and with better attitudes towards employees with mental health issues. It is also expected for higher scores to be related with the presence of contact.

H3: It is hypothesized that empathy will mediate the relationship between contact and the two dependent variables (Behavioral Intention and the Attitudes).

H4: It is hypothesized that self-confidence will moderate the relationship between contact and the two dependent variables (Behavioral Intention and the Attitudes).

Method

Participants

The participants of the current study consisted of adult individuals (N = 46) that were employed in companies in Greece in the private sector, ranging from the age of 18 – 62 (M = 31.26, SD = 8.38), with most of the population being into the late 20s – early 30s

(see table 1 and table 2). More specifically, the 61% of the whole sample were female participants (n = 28), and the rest of the 39% were male participants (n = 18) (see table 3). As in the intervention there were three conditions, in the first condition there were n = 17 individuals, in the second one n = 13 individuals and in the third one n = 16 individuals (see figure 1), with almost equal distribution of male and female participants in each one. From this sample, regarding the previous contact they had with people with MHI (*Mode* = 2, *SD* = 0.73) (see table 1), the 32.6% (n = 15), had experienced personally MHI, the 52.2% (n = 24) had a close family member or friend, the 13% (n = 6) had an acquaintance and 2.2% (n = 1) had no previous contact with somebody, while they were aware they are having MHI (see table 4). Furthermore, there was an exclusion criterion, in terms of comprehension, speaking and writing ability in English, assessed with three 7-likert point scales for each one (*M*= 6.09, *SD*= 0.67) (see table 1), with minimum score of one and maximum score of seven, and a cut-off point for retaining the data for valid purposes to be above four. For this reason, a total of four additional participants were not included in the total sample size, as they had lower than the passing threshold. Also, the participants were working in humanistic job roles in organizations, such as Consultants, HR professionals and trainers, as the scope of the paper was to explore solely the stigma in this field. For this reason, a purposive-convenient non-probability sampling method was used in order to recruit participants, making sure that they would meet the criteria of job industry and they would be willing also to participate in the current study. In order to contact the participants, I asked the professionals that I know that they work in this field and I asked for their job role in our initial communication, for an official confirmation. The recruitment happened via communication with the individuals that already had

contact with during the day for collaboration for other projects, informing them about the research project that is taking place and kindly asked them if they wish to participate, hence the participation was completely voluntary. There was not any reward or punishment/penalty related to their participation.

In addition, an informed consent was given to them prior to the beginning of the intervention, in order to read about their rights and the process (see Appendices A and B). They did not have to sign or provide any contact details, apart from ticking the box that they wish to participate, after having understood all the relevant sections. The Institutional Review Board-IRB Committee of the Deree – The American College of Greece, had already approved the project, as no harm was expected for the participants (see Appendix C).

Materials

In this section, both the materials that were used for the intervention during the role play or for the narrative and the scales that were used in order to measure the variables, will be described.

Scripts of Role Play, Induction of Empathy and Increase of Self-Efficacy

The materials that were used in this intervention, were designed with attention to detail and after extensive research. Regarding the scenarios used during the role plays for both conditions, it should be noted that they were tailored to the job roles of the individuals and prior to the intervention, a job analysis was conducted, in order to create examples of daily working life, projects that could be taken on etc, so that they would be realistic from them. Based on Gronholm and his colleagues (2017), in order for the individuals to use an information for future reference and reproduce a behavior, they

should have an experience that simulates as much as possible the everyday life and have meaning to them. Hence, after analyzing the role, I was replacing on the template the scenario that it was created, the information that was related with the context of the working environment, the daily tasks, the working relationships and other aspects. Also, another point that should be mentioned for the development of the scenarios is that they had a concrete goal each time, which was common to both of them, with very specific directions both from the script and the administrator, as based on Allport's Intergroup Contact Theory (1954) when the interaction has a clear structure, with no ambiguity and common goals, is more effective and the effect of anxiety will not intervene with the results.

For the first condition, that has as a goal to induce empathy and self – confidence, the development of the scenarios was complex (for an example of a scenario for the role player for the positions of an HR Consultant see Appendix D). First of all, it should be noted that these scenarios should show the competence of the individual as in all the conditions, but the most important is the elicitation of empathetic feelings and the increase of self-confidence of the individual, while portraying a symptomatology of stress/anxiety-related symptoms or depressive symptoms. This would allow the participant to come into contact with the most prevalent symptomatology of the workplace, without showing a clinical/non-functional symptomatology of the person and it does not require any familiarity with the mental health disorders (Knaak et al., 2014 Galinsky et al., 2008). The basic symptomatology was reported from previous literature that had used vignettes for similar projects in their design, but additional work-related symptoms were added with a collaboration of a Coach/Consultant/Psychotherapist who

was an expert on organizational psychology and disorders, in order to make it more realistic and avoid also any intense symptomatology. Then, the symptomatology and the examples that were used, were reviewed an expert I/O psychologist on DEI, in order to make sure that they do not carry any biases or they do not produce discriminated attitudes. Simultaneously, examples of testimonials of other people that had shared their stories were used, in order to enhance the details in the real examples that were included in the scenario. All this process, helped to create a standard template with constant symptomatology (covering a big umbrella), with two stories that can be altered based on the job description of the individual. Simultaneously, in order to induce empathy, through the role-play stories, the challenges that a person with MHI might face in the workplace were reported, as based on the literature hearing the challenges but showing at the same time competence can enhance significantly the positive empathetic feelings of the individual (Corrigan et al., 2001). Furthermore, the role-player had the same level job role in order to avoid any relationships of power that could affect the results (Gronholm et al., 2017), but also to increase the induction of empathy, as research shows that when participants have the same demographics or status, can have increased empathetic feelings for the other person (Igartua & Barrios, 2012). Batson and others (1981) created an experiment that participants saw someone that would be electrocuted, and when they had similar status, participants were more willing to take their spot, demonstrating higher empathy. Last but not least, for the increase of self-efficacy, the role-player had as instruction to provide feedback such as thanking the participant when they were doing nice questions or they felt heard, in order to reinforce this behavior and create positive emotions the person. As for the participants, the scenarios that they were given, explained

that the scope of the meeting with a colleague with a mental health that shares the same position, and their task was to explore the thoughts and experiences of the individual, without being requested to try to assist the person, as the role-player wish just to be heard and talk to someone (see Appendix E).

In terms of the second condition that had as a goal to create a contact situation with no emotional arousal and no increase of self-confidence, scenarios were created that would keep the emotions of the individual neutral and would have as a target only to open a conversation regarding job-related tasks. At the same time, they were demonstrating competence and the role player had a scenario that had in bullet points all the tasks they should discuss, after their modification for the current role, for a structured plan (see Appendix F for an example of a Senior Manager in Executive Search and Selection in a Big Four company). The participants received the scenario in order to have in hand the task for the role play, which mentioned the scope of the meeting, the theme of the discussion, the task and the information that this person has mental health issues, which should not be the focus of the discussion (see Appendix G).

Regarding the narrative in the third condition, the same scenarios (and procedure for their development) that were used in the first condition were followed (depending also the case, as this was also adjusted to the job description of the participant). The difference was that it was written like a personal story in the first person, which based on bibliography, it is the most effective way to see results on the induction of empathy (Gloor & Puhl, 2016) (see Appendix H for an HR Consultant role).

Behavioral Intention in the Workplace

The Behavioral Intention to approach people with MHI in the workplace is the first dependent variable that is part of the stigma. This variable was measured with the use of the Behavioral Intention Scale for Students (BIS-S) towards people with intellectual disability (Brown et al., 2011), after making the necessary modifications to adjust the scale for targeting MHI, specifically to the workplace. The modifications were related with replacing the phrase intellectual disability with MHI and add some word related to the organization (eg. colleague instead of student, corporate event instead of trip). Regarding the previous scale, the internal consistency that is reported in the literature is more than 0.90 and it has a very good overall validity (Siperstein et al., 2007), without any subscales present. The adjustments that were made did not change the nature of the items, and it is portrayed also in the current Cronbach a of this study which is α = .92 (see table 5), which will be further explored in a future study for its detailed psychometric properties. The current scale is named as Behavioral Intention in the workplace (BIW-MHI) and it measures the tendency of the individual to want to approach someone with MHI in an organization. An example of an item is "*Discuss with a colleague with mental health issues during work-break or lunch*". The scale consists of 12 positive item and the individual needs to report based on the 5-point Likert Scale, how much willing are they to do the action that each statement describes, ranging from 1 "*not at all willing*" to 5 "*I am very willing*". The maximum score is 60 and the lower score is 12, as the overall score is extracted from the sum of the responses. The higher the score of an individual, the more intention to approach someone with MHI in the workplace, which means less manifestation of stigma, and the opposite (see Appendix I).

Attitudes in the Workplace

The second dependent variable that refers to stigma, is the Attitudes towards people with MHI in the workplace. This is measured with modified scale of the shortened version of the Community Attitudes Towards Mental Illness (CAMI), by Taylor and Dear (1981) which has been adjusted by me in order to measure attitudes especially for MHI and not for mental illness, as well as targeted to the workplace, rather than the whole community. For this reason, the phrases mental illness was replaced with MHI, and words such as community, society patient and relevant wording was replaced with organization, workplace, colleague and others. The meaning of the items did not change significantly, hence no big differences in terms of reliability and validity were expected. In the existing literature, the CAMI scale has Cronbach α above 0.90 and good overall validity (Matousian & Otto, 2023). For this adjusted scale the current *Cronbach a* was $\alpha = 0.91$ (see table 6), but the psychometric properties of the current scale will be explored further in further research. The adjusted scale by me is called *Attitudes towards employees with MHI in the workplace (ATE-MHI)* and it measures how positive are the attitudes of participants, depending on how much they agree or not with statements related to the four factors/subscales of authoritarianism (items 2-6, 27), benevolence (items 7-13), social restrictiveness (items 14-20, 26) and community mental health ideology (items 22-25). In a more detail the first one refers to the perception that individuals with MHI are people with lower status, requiring coercive handling (e.g. "*One of the main causes of mental health issues is a lack of self-discipline and willpower*"), while the second one refers to the sympathetic perception towards this group, based on religious or humanistic rules (e.g. "*People with mental health issues*

don't deserve our sympathy") (Taylor & Dear, 1981). The social restrictiveness reflects the beliefs that MHI could be a threat to the organization/community (e.g. "*Employees with mental health issues are far less of a danger than most people suppose"*) and the last factor includes the statements that are relevant with the support given to the employees with MHI, as well as the institutional belongingness that should be present (e.g. "*The best therapy for many people with mental health issues is to be part of the working life of an organization*") (Taylor & Dear, 1981). The initial version had 40 items, but the shorten scale was used with 27 items (Matousian & Otto, 2023). However, during the analysis there were three problematic items that were excluded, as wither they were not clear and produced confusion to the participants when we were referring to MHI instead of mental health illness (item 20) or the wording was not good and it was not and it could be interpreted with mor than one ways (item 3 and 8), hence overall the modified version consisted of 24 items. From these items, the items 1,2,10,11,12,13,14,15,16,17,24,25 and 27 are reversed items, and the rest were positive ones. As this is a 5-point Likert scale, ranging from 1 "*I strongly disagree*" up to 5 "*I strongly agree*" by calculating the sum someone can extract the overall score of each participant, with the minimum being 24 and the maximum 120. Thus, in order to show good attitudes, someone needs to score higher in this scale, while negative attitudes are depicted via low scores (see Appendix J).

Scale for Empathy

In order to measure empathy and test the empathy induction before and after the intervention, a 7-point Likert scale was used, created by Batson and her colleagues (1997), measuring specifically affective empathy. It is ranging from 1 "*I do not experience this feeling at all*" up to 7 "*I feel this feeling extremely*", and individuals had

to report how much they experience each feeling by rating 6 positive items (six feelings) for people with MHI. In a more detail, the higher someone scores in the scale, the more empathetic feelings they have and the opposite, with the maximum score being 42 and the minimum score being 7. An example of an emotion that they need to rate is sympathy. It should be noted though, that in order to make sure that the differences of each emotion are understandable to the Greek population (as most of them were not native speakers), a definition in English was added with an explanation of each one. The Cronbach that was exported after the data collection for this study was α = .88, which shown very good internal consistency and it is in agreements with previous research, which is even highher (Furnham & Sjokvist, 2017) (see Appendix K).

Item for Self-Confidence

The self-confidence to approach someone with MHI in the workplace was assessed with a 1-item questions asking "*How confident do you feel in coming into contact at work with someone that has mental health issues?*" (Usmani et al., 2022), which measured the degree of confidence of the participant to come into contact with a colleague at work, who experiences MHI. The participants had to rate the item from 1 "*Not at all confident*" to 5 "*extremely confident*", with the higher score meaning higher self-confidence and the opposite (see Appendix L).

Demographics Questionnaire

A Demographic Questionnaire was administered with 7 questions. There was one nominal question for Gender, one item for the age (numerical) and one item in order to measure the degree of contact that someone might already have up until now (ordinal variable), from "*a*" being the closest contact which is the self, up to "*d*" which reflected

no contact. The latter item was used in order to account for the effect of familiarity with MHI in the analysis of the results and strengthen the effect, as based on Gronholm and his colleagues (2017) stated that familiarity in a research design should be measured in order to make sure that the effect that we see is not an outcome of this characteristic, but from the manipulation that the researchers have done, because this was a problem in previous research. Furthermore, in order to test participants' understanding in English, a 7-Likert scale was used in order to measure English ability, measuring understanding, reading and comprehension skills, with "*1*" meaning "*almost none*" and "*7*" "*native speaker ability*". This item worked in the design as an exclusion criterion, as those who have an average lower than 4, they were excluded from the study, because this would mean that the barrier of language might have affected the responses. Hence, the higher the score, the better the English ability and the opposite. Finally, there was question with two options, asking if they answered the questionnaire serious or the researchers should throw away the data, in order to validate an confirm their participation (see Appendix M).

Design

The current intervention has a mixed design of both between and withing–subjects design. In a more detail, there were three different conditions, attempting to measure the differences on the scores of two dependent variables between the three groups, but also exploring the differences in the measurements before and after the intervention of each group. As this is a study targeting the role of contact in the reduction of stigma, the independent variable is the *presence of Contact*. This is defined as the physical face-to-face interaction (discussion) with a role-player, embodying a colleague who suffers from MHI. The contact was taken place via the role-play in the first and the second condition.

Also, the outcome that was measured was stigma, which was expected to be reduced, and it was measured via the use of two dependent variables; the *Behavioral Intention* to approach someone with MHI in the workplace and the *Attitudes* towards people with MHI in the workplace. The first one is operational defined as the tendency that expresses someone in order to come into contact and approach someone that has MHI in the workplace and the latter one is operationally defined as the degree to which someone has positive attitudes for people that has MHI in the workplace, measured by the scales that are presented in the *Materials* section. Also, the variable *Empathy,* which refers to the degree someone experiences feelings related to empathy that were measured with six specific emotions, was explored under the role of mediator, as based on the literature review in the introduction, it is considered to be an explanation of how the presence of contact could lead to better scores in BIW and AW. The last variable is the *Self-Confidence* to approach someone with mental health, perceived as moderator (which is solely related with the confidence that someone might have on their self in order to come into contact (interaction) with someone with MHI, because as it already explained in the introduction, it could strengthen the effect of this relationship, when it is present.

In the next paragraphs the design three conditions are presented, with the two of include a contact with a colleague (role-player) with MHI at work, with the difference that the first one will have the induction of empathetic feelings and the increase of self-efficacy, while on the seconds these are not manipulated. In the third condition, no contact is present and there is only the induction of empathy through a narrative.

First Condition

In the first condition of the intervention, the participants had to come into contact with a role-player, as like being one of their colleagues in the same position and they needed to explore the role-player's daily working life, feelings and thoughts in the workplace. The role-player faced symptoms at work such as those that exists in depression and the ones that are present in anxiety disorders, but without labeling any disorder, as the focus was on general symptomatology that do not interfere with the functionality of the individual to be part of the working life. The participants had as a task to make questions in order to deep dive into the experiences of the role-player and while they were asking questions, two of the variables were manipulated by the role-player. More specifically, the role-player tried to elicit empathetic feelings to the participants, by describing vividly the challenges they have faced and expressing the symptoms via the body language and the expressions. At the same time, the role player was providing feedback to the participants when they heard questions that would make them feel comfortable opening up and they showed concern, in order to increase further the self-confidence of the individuals, by confirming that this actions in helpful and brings positive results and emotions. More details on the content are presented in the *Materials* section, with detailed explanation of each choice. It should be noted also, that through these stories the role-player was demonstrating her high competence, in order not to enhance the stereotype of low competence of people with MHI. Hence, this condition is a representation of the interaction of all the variables, by creating a situation of contact, while increasing the empathy and the self-confidence of the participants, in order to test

later the effect on the dependent variables. Before and after the role-play, the scales were administered for completion.

Second Condition

In the second condition, again the element of contact was present, but without the elicitation of empathy and the manipulation of self-confidence. Hence, it was a role-play discussion again with a colleague, but the difference was that their task was to hear what their colleague had done up until now (and what they will do) on a project related to their every-day work and give an honest feedback and advice on how to proceed. The scope of the meeting is that they are same-level employees and the colleague wish to hear an opinion from someone on the team. The participants knows that the person has MHI, but the topic of discussion was only on the job (which is something that is clear in the instructions as well). During the interaction, the person shows high competence, as the role-player present very detailed and effective steps in the project and she does not try to elicit any emotions, hence they engage in a neutral job-related discussion. This condition, provides data in order to understand the impact of the presence on the dependent variables, without the interfering of the mediator and the moderator and it was expected that it would reveal less significant results in changing the stigma than the first condition, but higher change than the third condition with no contact, proving that this is crucial to exist in order to see the effect.

Third Condition

In the third condition, the participants had to read a story (personal narrative) about someone that experiences MHI in the work place, writing about their feelings, thoughts and experiences, that let to challenges for her, while simultaneously showing

examples of competence. This had as a goal to elicit empathy to the participants, while showing competence in the workplace, but without having any personal contact with any role player. This would allow to understand the role of contact further, using this group as a control one. It should be noted, that the same text was used also for the stories of the role plays, in order to keep consistency of the material, to avoid any noise in the data from the differences. The rest of the design was the same, with the completion of the scales before and after the narrative. It was expected that in this condition, little change or even no change would be made to the behavioral intention and the Attitudes, as the contact was not present and the Self-Confidence was not manipulated either, apart from the empathy induction that could have a small effect. If there was a significant higher change in the two dependent variables, this might mean that the empathy has the key role to the reduction of stigma and maybe the element of empathy during a contact is what brings mainly the effect and not the presence of contact per se. At the same time, maybe the role of Self-Confidence is not that strong, if the first condition does not have a stronger effect in the reduction of stigma and other variables should be explored as moderators.

Procedure

The intervention had taken place in the premises of the employee (in a booked room in the company) or in the premises of the ACG, in case of Deree students. The procedure was different for each condition, with common elements that are analyzed.

Prior to the Intervention

In the current study, there were two significant roles that should be mentioned before stating the process; an administrator and a role-player (in the first and second

condition). In a more detail, there were two different administrators for the whole project, as the one should accompanied me when I was the role player (trained organizational psychologist, with certificate on conducting role-plays), otherwise I was acting as an administrator. This allowed me to be always present in the intervention with different roles, I order to make sure that there are no difficult questions that cannot be answered and the intervention is running smoothly. In addition, there were also two role-players, one being me as the researcher and the second one was a professional female actor (with more than 10 years of experience), as the role-player should not be related to the participants, as his might interfere with the effect that is measured, hence in cases in which I had a familiar participant, another woman role-player should participate. In order for this procedure to be effective, a 2-hour training was conducted prior to that to both the administrator and the role-player, so that the process is standardized, along with demonstration of the whole project. In this way, it was reassured that the beginning of the intervention and would be successful with a common flow for all and avoid any noise in the data.

Beginning of the Intervention

First of all, during the meeting, a trained administrator was always there to meet the participants first, welcoming into the intervention and explaining the process. This included the preparation of the room for the intervention, the setting of the papers for the seamless execution, the handing out of the Informed Consent, a short standard description of what would be followed, the information that existed in the Informed Consent, the completion of the questionnaire in the English language, providing also a short description of what it is defined as “MHI”, explaining the task of the role-play in order to

be prepared for later or the fact that they will read a story about a colleague, being willing to answer any possible questions, inform the role player -if there was any based on the condition-, administer the second questionnaire and closing the intervention with the debriefing. After the welcoming of the individuals and after the reading of the Informed Consent, the administrator was explaining clearly that no signing of the documents with personal details should be made and in order to preserve the anonymity of the individuals. Then, the questionnaire was given to them and the administrator was sitting in a more distant area of the room, in order to make sure that the participants feel comfortable while filling the questionnaire, but at the same time being in the sight, so that they could reach easily for any questions. Then, the participant was required to put a 4-digit code with numbers and letters in the questionnaire, ending with the number "*A*" (indicating the first completion), so that the researcher could pair the two questionnaires after the intervention and compare the pre and post scores. At this point, the researcher was given to the participant an envelope with already completed questionnaires to put inside wherever they wish their questionnaire, because it is a good practice in order to avoid knowing the code of the participant and reassure the participant that their responses could be stored somewhere that does not distinguish this participant from others (eg in the very beginning of the envelope, being the first one).

Role Play Interaction / Story

For the next steps, the administrator summarized handed out the scenario for the role play with instructions about the task or the story that they should read, depending on the condition. The administrator emphasized in the first condition, even though it was written that their task was just to explore the feelings, emotions and experiences of the

individual, rather than try and assist them, so that they make sure that they will do the prompt questions that would lead to a simple discussion on mental health, allowing the person to be heard and do not make it more difficult for the participant, creating feelings of stress or awkwardness. As for the second condition, the administrator pointed out that the individual had issues with mental health but the scope of the meeting between the two is job-related and they should ask discuss about a work project for feedback the role player wish to receive from a colleague. In both situations, in order to make it more realistic, the administrator clarified that the colleague (the role-player) had requested to have this meeting in between the job, as she trusted their opinion. Through this, the administrator wanted to express that they should not expect to have a discussion on mental health and it would not be the main topic of the interaction, so that the elicitation of any emotions would be diminished (eg empathy or stress). In the third condition, the administrator explained only that they should read the story at their own pace and that s/he will be at their disposal for any questions or clarifications, sitting again far from the participant but on their sight. Meanwhile, in the rest of the conditions, the administrator was leaving the room and was asked for the role player who was sitting outside the room to enter. This happened, in order to make the participant free to express themselves during the role play and in order to enhance this, before leaving s/he informed the participants about it, saying that through the role play, no data are collected, hence they will step out of the room in order to make them feel more comfortable. This was an important step for the methodology, as it was a reassurance for the individuals that they would be themselves and do not try to act in a specific way, focusing only to the interaction. This should be a reflective time for the person; hence their whole attention

should be there free from any negative possible feeling stemming from observation of the administrator.

Once the role player was in, in the first condition, they shitted in a chair, starting with thanking the participant for their time to hear what they have to say even though the job is very tight, in order to create a realistic situation, similar with one in the workplace. Then, the role-player expressed the reason why they wish to talk with them, showing their trust and started explaining that lately she does not feel well. During the whole conversation, the role-player was following the scenario that was given beforehand, remembering all the challenges that were included in there, with examples that was fitting the job role of the participant, so that they could see the relevance with their real life and make it realistic. Throughout the interaction, the role player was making pauses in order to allow the participant to ask questions, had vivid body language and expressions, analyzing the two examples that were stated in the scenario, step-by-step in between the questions that the participants were making. From this process, the challenges of the individuals could induce empathy to the participant. Simultaneously, by saying phrases such as "*Thank you for this question, this is very helpful to feel more comfortable talking with you*", "*Thank you for hearing me, this so important that you are doing now for me*", "*I wish all the colleagues in the team to approach me like you did*", the role-player tried to increase the SC of the participant, by providing feedback targeting positively participant's emotions. It should be noted, in case there was a comment that was questioning the person's ability to work, their productivity etc, the role-player was answering in a way that could show their competence and the positive results, without though trying to be assertive in order to allow the individual to express themselves and

feel respected. After the role-player had shared almost all of the examples that she had to share, the role-player was closing the role-play smoothly saying that they need to go back to work as she has a meeting and she was leaving the room, informing the administrator to enter again and proceed with the second questionnaire.

Regarding the second intervention, almost the same process was taking place, but the only change is that the role-player and the participant had a conversation about work, with the participant ending their part by saying wither that what the role-play has done was excellent or proposing some minor changes. Then, the role play got back to work and the administrator returned to the room for the second completion of the questionnaire.

Closing the Intervention

At this point, the administrator would ask for the feedback of the participant, in order to make sure that they feel ok and they are comfortable. Then, the administrator gave the questionnaire again, while explaining that they should reply as honest as possible, without trying to guess what the researcher was expecting, as there are different conditions for this in the study, exploring different elements each time, hence having as expectation that different aspects might change based on the element or and some others might be expected to remain the same. This eliminated a little any demand characteristics effect, as they indeed find it very helpful in order to avoid leading the questionnaire. This phrase created the thought to the individuals, that they should not for instance increase their scores, because their assumptions were reduced. In case of the third condition, again the same order was being given prior to the second completion.

Once they completed the questionnaire, along with the demographics form, they entered again their 4-digit number with the letter "*B*" at the end, indicating the second

completion and they put the questionnaire in the folder that was shared before, in a random order. Finally, the administrator called the role-player back (in case of the first and second condition) and they shared the debriefing form (see Appendix N) with the participants, while verbally describing the study for further understanding.

Concluding, the duration of the first and second conditions were one hour for each one, which included 20-30 minutes for the double completion of the questionnaire, approximately 15-20 minutes for the role-play and the rest was allocated for the further process. As for the third condition, the overall time that was needed was approximately more or less 40 minutes, as apart from the double completion of the questionnaire, 15 minutes were provided in order to read the story, leaving some spare time again for the rest of the process. The data were gathered mainly the two first weeks of July of 2024, throughout the day based on the availability of the participant.

Results

In order to conduct the analysis, the SPSS software was used, with the extension of the Process v.4. The first of the analysis at the SPSS was the demographics of the individuals and I run the Kolmogorov Smirnoff test for the three conditions, in order to make sure that there is normality of the sample. Then, I run the Cronbach a of the scales, reassuring the presence on internal reliability (see Materials section of Method for each scale). As the test revealed that there was normality in the data, I continued with the analyses to test my hypothesis.

Condition, Behavioral Intention and Attitudes

For the first hypothesis a one-way ANOVA analysis was conducted. The behavioral intention towards employees with MHI, was measured in the following

"contact" conditions: First Condition (contact with induction/manipulation) (*M* = 48, *SD* = 9.02), Second Condition (contact without induction/manipulation) (*M* = 53.77, *SD* = 6.56), and Third Condition (story/personal narrative, no contact) (*M* = 54.75, *SD* = 54.75). The application of the ANOVA showed that type of contact had a significant effect on the behavioral intention F (2,45) = 4.02, p =.025 (see table 7-9). In particular, the post hoc comparisons with Bonferroni correction revealed that in the condition with no contact (Condition 3), the scores for behavioral intention were significantly higher than Condition 1 (contact and induction/manipulation), p = 0.34 (see table 9). This indicated that individuals who had read the story had significantly higher tendency to approach individuals with MHI in the workplace, than those who had come into close contact with a person who has MHI, while the empathy and the self-confidence inductions were present. Also, in the rest of the comparisons, no significant results were obtained, indicating no significant differences between the scores.

Also, the attitudes towards employees with MHI, was measured in the following "contact" conditions: First Condition (contact with induction/manipulation) (*M* = 96.76 *SD* = 9.11), Second Condition (contact without induction/manipulation) (*M* = 96.85, *SD* = 19.67), and Third Condition (story/personal narrative, no contact) (*M* = 105.38, *SD* = 7.29). The application of the one-way ANOVA showed that the type of condition had no significant effect on the attitudes, F (2,45) = 2.43, p =.099 (see table 7-8). These results indicates that there were no differences in scores in the three conditions in terms of attitude towards employees with MHI.

Empathy, Behavioral Intention, Attitudes and Type of Condition

In order to test the second hypothesis two Pearson correlation coefficient analysis were executed, in order to test the relationship between empathy (M =31.54, SD = 6.12) and behavioral intention (M = 51.98, SD = 7.80), as well as empathy (M =31.54, SD = 6.12) and attitudes (M = 99.78, SD = 12.94). The analysis regarding the first pair, revealed that there was a positive significant correlation between the variables, r (44) = .58, p <.001 (see table 10-11). This means that the higher the empathetic scores, the higher the behavioral intention scores, while the lower the empathetic scores, the lower the behavioral intention of the individuals to approach an employee with MHI in the workplace. As far as the second variables (attitudes), the Pearson correlation coefficient analysis revealed no significant relationship between the empathy scores and the attitudes scores, r (44) = .48, p = .130 (see table 11).

Part of the second hypothesis was to test the association between the type of condition (Mdn = 2.0, SD = .86) and empathy (M = 31.54, SD = 6.12), hence a Spearman correlation coefficient analysis was conducted in order to examine it. The analysis revealed no significant association between the variables, r (44) = .21, p = .17 (see table 12).

Mediation Effect (Empathy)

For the third hypothesis, the model 4 of Process was used, in order to check if the empathy is a mediator of the relationship between the type of conditions (contact) and the dependent variables (behavioral intention and attitudes). As Empathy had no relationship with attitudes, it was not expected to have a mediation effect, but the analysis could provide with further insights that can be useful for the interpretation of the results.

Behavioral Intention

A mediation analysis was conducted with the use of Model 4, in order to examine if empathy mediates the relationship between the type of condition and behavioral intention, while controlling for familiarity (previous contact). As for the effect on empathy, the overall model was not significant, F (2, 43) = 1.09, p = .347). Regarding the effect of the type of condition on empathy, no significant results were found b = 1.56, t (43) = 1.46, p = .151, showing that there is no effect of the independent variable of type of contact on empathetic feelings. The only significant result was constant b = 29.24, t (43) = 9.27, p < .001. The model predicting behavioral intention was significant, F (3, 42) = 11.75, p < .001, explaining 45.64% of the variance in behavioral intention R^2 = .4564. In a more detail, the constant was significant, b = 30.13, t (42) = 5.66, p < .001, with type of condition having significant direct effect on behavioral intention b = 2.50, t(42) = 2.35, p = .024 and empathy as well b = 0.67, t (42) = 4.49, p < .001. This means that the two variables have an effect on behavioral intention. What it should be noted though is that the effect of familiarity (contact) on behavioral intention was significant, b = -2.62, t (42) = -2.15, p = .038, which indicated that high scores of familiarity predict low scores on behavioral intention. However, the effect of empathy on the relationship between the types of condition and behavioral intention was not significant. Thus, the analysis revealed that empathy did not have mediating effect on the relationship of the two variables. Concluding, the model revealed that type of contact has a significant effect on behavioral intention, but no through the presence of empathy.

Attitudes

A mediation analysis was conducted in order to examine the role of empathy as a mediator in the relationship between type of condition (contact) and attitudes, controlling familiarity with MHI (prior contact). As for the effect on empathy, the overall model predicting it from types of condition, familiarity was not significant, F (2, 43) = 1.09, p = .347). Regarding the effect of the type of condition on empathy, no significant results were found b = 1.56, t (43) = 1.46, p = .151, showing that there is no effect of the independent variable of type of contact on empathetic feelings. The only significant result was constant b = 29.24, t (43) = 9.27, p < .001. The model predicting attitudes, from empathy, type of condition and familiarity was not significant F (3, 42) = 2.36, p = .085. In a more detail, the constant was significant, b = 86.23, t (42) = 7.78, p < .001. Also, the effect of type of condition on attitude was not significant, b = 3.88, t (42) = 1.75, p = .088. Similarly, the effect of empathy on attitudes was not significant, b = 0.37, t (42) = 1.20, p = .236. Regarding the mediation effect, as it was logical based on the above, there was no significant results, of the role of empathy mediating the relationship between the type of condition and attitudes. The results show that the empathy did not mediate the relationship, as the hypothesis was expected to do it.

Moderation Effect (Self-Confidence)

For the fourth hypothesis, moderation analyses were conducted with the Model1 for the role of self-confidence as a moderator between the relationship of type of condition (contact) and the dependent variables (behavior intention and attitudes)

Behavioral Intention

In order to examine if there is a moderating effect of self-confidence on the relationship between the types of condition (contact) and behavioral intention, a moderator analysis using Model 1 in SPSS Process was conducted, controlling for the familiarity that someone might have already with mental health issues (previous close contact). The overall model was significant, F (4, 41) = 7.22, $p < .001$, explaining 41.34% of the variance in behavioral intention scores $R^2 = .4134$. As a main effect, the condition type (type of contact) had a significant positive effect on behavioral intention b = 24.71, t (41) = 2.68, p = .010. This result show that the type of condition that someone took part in had a significant impact on behavioral intention. Self-confidence also had a significant main effect on behavior intention, b = 13.99, t (41) = 3.39, p = .002. In detail, high levels of self-confidence were related with high levels of behavioral intention. Also, the output indicated that the interaction of type of condition/contact x self-confidence was significant, b = -4.55, SE = 2.03, p = .031, meaning that self-confidence is moderator between the relationship of types of condition (contact) with behavioral intention (see figure 2). With further exploration, at low levels of self-confidence (4.00), the effect of the type of condition on behavior intention was significant, b = 6.50, t (41) = 4.35, $p < .001$. At a moderate level of self-confidence (5.00), the effect of the type of condition on behavior intention was not significant, b = 1.95, t (41) = 1.28, p = .207. At a high level of self-confidence (5.00), the effect of type of condition on behavior intention was not significant, b = 1.95, t (41) = 1.28, p = .207. As a result, this shows that generally, the type of condition had an effect on behavioral intention, as well as self-confidence on behavioral intention, by acting as predictors. Building on this, there is an interaction

between the type of condition and the self-confidence, meaning that self-confidence moderates the relationship between type of condition and behavioral intention, with type of condition (contact) having a stronger effect on behavioral intention especially when there is low self-confidence.

Attitudes

Also, a Model 1 analysis was conducted in order to test the if there is a moderation effect of self-confidence to the relationship between contact (conditions) and attitudes, controlling again for familiarity. The overall model was significant, F (4, 41) = 2.67, p = .046, explaining 20.64% of the variance in attitude towards behavior R^2 = .2064. The results indicated that the interaction contact × self-confidence was not significance, but was almost very close, b = -7.83, SE = 3.92, t = -1.99, p = 0.052. The conditional effects of contact on attitudes at specific values of self-confidence were as follows: At self-confidence = 4.00, the effect of contact on attitude scores was significant, *Effect* = 8.68, SE = 2.89, t = 3.00, p < .001. At self-confidence = 5.00, the effect of contact on attitudes was not significant, *Effect* = 0.84, SE = 2.94, t = 0.2881, p = 0.77. These results indicate that the interaction could potentially be significant as it was almost close to that, meaning that the self-confidence could moderate the relationship between contact and attitudes. In detail, at higher levels of self-confidence (5.00), the effect of contact on attitudes was not significant, while in lower levels of self-confidence (4.00) it was significant, showing that self-confidence might be a moderator, moderating the relationship between contact (conditions) and attitude in lower levels of self-confidence.

Additional Analysis

After testing the hypotheses, additional analyses were executed in order to identify supplementary results that could be used for the explanation of the present study's outcomes or for their use of future research. Firstly, a Pearson correlation coefficient was conducted to see the relationship between behavioral intention (*M* = 51.98, *SD* = 7.80) and attitudes (*M* = 51.98, *SD* = 7.80). The analysis revealed a significant positive correlation r (44) = .485, p <.001 (see table 10-11). This finding implies that as the behavioral intention increases or decreases, the attitudes follow the same direction simultaneously. Then, the pre and post scores in each scale / items were analyzed for each condition with a Paired Samples t-test, in order to identify which variables had changed after the intervention. Some pairs were significant, some others revealed that no change took place (see table 13).

Moreover, it should be noted that further analysis was conducted in order to test the relationship between empathy (*M* =31.54, *SD* = 6.12) and self-confidence (*M* = 4.52, *SD* = .55) for future research, by conducting a Pearson correlation analysis and it as revealed that there was no significant relationship between the variables, *r* (44) = .13, *p* = .38 (see table 10-11). Also, further analyses were run in order to test differences in empathy scores and self-confidence scores, depending on the conditions of the participants, but the one-way ANOVA showed non-significant results as well, as for empathy the *p* = 0.28 and for self-confidence the *p* = .366 (see table 7-8 for the rest).

Last but not least, a Model 7 analysis was conducted, in order to test for further research if empathy is a moderator between type of condition (contact) and behavioral intention and it was found that there were significant results (*p* = .034) (see table X for the whole analysis).

Discussion

The present study is an intervention that focused on increasing the inclusion of people with MHI in the workplace. More and more people nowadays suffer from MHI at work, showing a symptomatology that does not refer to mental disorders or clinical cases, but rather than symptoms of poor psychological well-being, accompanied with functionality at work (Kelloway et al., 2022). This could include mild to more intense cases of MHI, such as strain, increased worry, emotional tiredness, insomnia, rare panic attacks, burnout and others, that are related either with stress-related symptoms or mood related ones (Greenwood & Anas, 2024). Fredman and Deane (2014) explained that this group is still being excluded inside the organizations and it is imperative to break that stigma and stop discrimination and stereotyping (Farrelly et al., 2014). Hence, a mixed-design intervention with three conditions, has been created to enhance this effort. The study focuses on the role of presence of contact in the reduction of stigma, by measuring behavioral intention towards employees with MHI in the workplace and attitudes towards employees with MHI. Taking into consideration that there is a gap in the literature on the additional variables that plays a role in this relationship, this paper examines the role of empathy and self-confidence to approach someone with mental health issues in the workplace, with the first one to be considered as mediator and the second one as moderator. Hence, in the first condition, the individuals had to conduct a role-play with a colleague who experiences MHI, while the role-player during the conversation tried to induce empathy and increase their self-confidence. The second condition included also a role-play, but the participants who were in this group they just had a conversation about job-related projects, with a colleague (role-payer) who experience MHI, but no discussion on this topic

is being made. The reason behind this, is that no increase of empathy or self-efficacy should be made, as these conditions explored the role of contact without the secondary variables. The third condition, included a narrative of an employee who experiences mental health issues and the participant has to read the story, without coming into contact with someone (no contact condition). The participants had to complete a questionnaire before and after the intervention, in order for the researcher to understand how do the behavioral intention and the attitudes (the dependent variables) are changing in each condition and if indeed there is a mediation and moderation effect. Hence, the hypothesis of this study was the following:

H1: Participants in the contact conditions (role play) (condition 1 & 2) will demonstrate significantly better scores on attitude towards employees with mental health issues in the workplace, and behavioral intention to approach an employee with mental health issues, compared to those who do not undergo the intervention with the contact, with condition sowing significantly better results than all of them.

H2: It is hypothesized that empathy will be positively correlated with behavioral intention and with better attitudes towards employees with mental health issues. It is also expected for higher scores to be related with the presence of contact.

H3: It is hypothesized that empathy will mediate the relationship between contact and the two dependent variables (Behavioral Intention and the Attitudes)

H4: It is hypothesized that self-confidence will moderate the relationship between contact and the two dependent variables (Behavioral Intention and the Attitudes)

Contact and Behavioral Intention

It is important to analyze the results of the hypothesis, by simultaneously explaining the view of previous literature and possible explanations of the current results. First of all, the first hypothesis has not been confirmed, for both the behavioral intention and the attitudes variables, which is contradictive to previous research. More specifically, beginning by the first variable which is behavioral intention, the present study has found significant results in terms of the differences in scores in behavioral intention based on the type of condition, but the unexpected was that the only difference was met between the condition 1 (role play with induction of empathy and self-confidence) and condition 3 (no contact, only empathy). Also, no significant differences were found in comparison with the other conditions. What is surprising though, is that the mean scores showed that the third condition had higher behavioral intention than the first condition, which was hypothesized in the beginning. This is also contradictory to the existing literature, which states that contact is one of the most significant predictors to behavioral intention and change (Gronholm et al., 2017; Stokoe, 2011). More specifically, it has been found that contact can lead to increased behavioral intention, while enhancing the possibilities to approach someone with same characteristics in the future (Hansson & Markstrom, 2014; Alecander & Link, 2003). This is explained with the Allport's Intergroup Theory of Contact (1954), in which it is argued that when there is positive experience during personal contact, the person distance between ingroup and outgroup diminishes and this reduces bias, which is something that has been argued by researchers as well (Blascovich et al., 2001). Moreover, another study that has used the method of theatrical play and discussions with people with MHI, in comparison with conditions with low or no contact at all, they found that there

was a significantly greater change on the scores of behavioral intentions in the contact condition (Faigin & Stein, 2008).

However, Pinfold and his colleagues (2005) in a study that they conducted, found that contact had a significant impact in the change of behavioral intention in children but not in the adult population, which is aligned with these results. They explained that there might be variables as well, that would interfere with this relationship which should be explored (Pinfold et al., 2005). Furthermore, Svensson & Hansson (2014), in an analysis review, argued that the behavioral intention is not constantly significant across the literature, and it should be studied the role of contact further. Therefore, contact might not be the most significant factor and other variables should be researched.

In order to explain the current results in my study, further analyses were conducted in the variables in order to identify any hidden patterns. Firstly, a Paired samples t-test was conducted in order to make sure that there was actually a behavioral change before and after the intervention in the condition, which was actually significant (see table 13). Then, the role of empathy was explored further, in order to try and explain the results from the effect of empathy. However, both conditions had the element of induction of empathy, consequently it was not logical to attribute the effect solely to this, as it would be expected, then, similar results to both conditions. Though, I run the analysis of a paired samples t-test, in order to make sure if the empathy has been significantly changed in both conditions after the intervention and revealed no significant differences before and after for both conditions, instead of the second one (see table 13), which was not though higher than the rest of the groups in their mean scores (see table 9). As a result, this might indicate that the effect should not be attributed to the role of empathy or the contact, but in a third variable

that is unknown. For instance, further research should replicate the same intervention with adding into the design, the measure of negative emotions such as stress, fear and others (Gronholm et al., 2017). Based on other studies, negative feelings, when they are present, hinder the effect of contact on reduction of stigma, as the person is overwhelmed by the negative emotions, which do not leave room for the brain to process the information that they receive and be more open to change the belief that already exists in the self (Bandura, 1977). In other words, in order to change a behavior, people need to be aware and have moderate amount of emotional arousal, in order cognitively to change an already established behavior or belief.

Another explanation of the results, could be the familiarity of the person with MHI, which is reflected in the 1 – item question that exists in the demographics questionnaire, asking how much prior contact the participants had with someone who have MHI, in order to account for prior experience with that. Research has shown that the more familiar someone is with MHI, the less stigma they might have (Batson et al., 2002). In this question, close contact is considered the self and a person from the family or close friend. In the analysis that was conducted for the third hypothesis, regarding the role of empathy as a mediator, I controlled for familiarity to enhance the results. However, in the mediation analysis it was revealed that the familiarity had a significant effect on behavioral intention, with the behavioral intention being decreased, while the familiarity was high. This finding is also contradicting with the literature (Batson et al., 2002; Corrigan et al., 2001, Fiske et al., 2002). In the current study, the first condition has more individuals who had close contact with someone with MHI (either the self of a close person), which could be an explanation of the current effect. For this reason, based on this finding, the results of the

behavioral intention could be expected to be lower in the first condition. The limitation of the small sample size (*N*=46) of the current study, might have interfered with this noise in the data and a bigger effect of familiarity could have been revealed.

Contact and Attitude

Regarding the attitude, in the current study, no significant results were found, as no differences in the scores were reported, disconfirming the current hypothesis. This is contradictive with the majority of the previous literature, that shows that there is actually an impact of contact on attitude change (Corrigan et al., 2001; Hansson & Markstrom, 2014; Pinfold et al., 2003; Tolomiczenko et al., 2001). In addition, Corrigan and his colleagues (2001), conducted a study that included a discussion with a person who has mental illness, and after the interventions the attitudes were improved significantly. The explanation of the results was that the participants understood through the discussion that people with mental health problems, can actually control their symptoms, which increased their perception about their competent. Fiske and her colleagues through the Stereotype Content Model, explains that people form stereotypes about a group based on two factors; competence (which is the efficacy of the person to complete a task) and warmth (which is the friendly emotions that are triggered). Therefore, this study proved that by increasing the perception that someone is competent, the stigma is reduced (Corrigan et al., 2001). In the current design this was always an important factor and all the stories or role plays were showing competence, but maybe part of the stories could hide negative stereotypes or low competent statements (Angermeyer at al., 2015). On top of that, this could also be the case for the story in the third condition, which was the same story as the ones that were used in the first condition. Simultaneously, as the role play is something experiential and it might

be different from person to person, its body language or facial expressions could have affected the results. The effort to keep the administration and the role-plays standardized was important, but there might be something that could have contributed in not showing competent. For instance, I can recall that in the first role-plays I was more lenient to answer questions about the items of the scale (which could have biased the responses of the participants) or I might unconsciously in other cases have shared additional information than I should, as they were not in the script, when I did not see the other person be empathetic, being affected by the effort to actually make a change. Even in the second condition, in which there was no effort to induce any emotions, I received as feedback that the fact that a person with MHI asks for feedback, it puts this person in a less competent position. Hence, this by itself could have enhanced a little bit the image of low competence, without expecting that (Follmer & Jones, 2017). Further research could have a measurement in order to gather data about the perception of the individual on the competence of employees with MHI before and after the intervention, so that more light shall be shed on what actually can change the belief about the presence of competence.

Another explanation for this result, could be the duration of the intervention. Studies argue that attitude change takes more time than behavioral change to happen (Corrigan et al., 2001). In a more detail, the length of the contact is key to the attitude change, as this is a cognitive process and it needs internal reflection, so that changes occur (Maffit et al., 2014). For this reason, long term interventions are suggested for future research or with longer interaction. For instance, in the case of the theatrical play and the discussion that were followed, the individuals were present for more than 1 hour, which is a much more time than 15-20 minutes of the current study (Faigin & Stein, 2008). This is

also a pattern that has been observed in other studies as well, that they might have not found significant results (Krameddine et al., 2013).

Empathy, Contact, Behavioral Intention and Attitudes

The second hypothesis was partially confirmed. It was hypothesized that empathy would be correlated with type of condition, behavioral Intention and attitudes, but the results revealed that there was no significant association between empathy with contact and attitudes, but only a positive one with behavioral intention (see table 11 and 12).

Firstly, it should be noted that research agrees with the significant results between empathy and behavioral intention (Gapinski et al., 2007; Hayes et al., 2014; Vescio et al., 2003). More specifically, a good study is the one that has been conducted by Oliver and his colleagues (2012), in which they requested from the participants to watch videos from Youtube with empathetic content, while having a control group with not this element inside. In the condition in which they watched a video that included empathetic content, there was an improvement in the attitudes of the individuals. Research has shown that empathic concern is a significant motivator for initiating helping behaviors, as they are willing to alleviate other's people challenges and provide their support (Corrigan, 2000). Finally, when people feel that they can understand the difference through empathy, the unfamiliar feelings are reduced, as well as social distance (Angermeyer et al., 2004).

Regarding the relationship between empathy and attitudes, the literature review suggests that there is a correlation between them, disagreeing with the results of this study (Egbert & Parrot, 2003; Gapinski et al., 2007; Oliver et al., 2012; Vescio et al., 2003). McKeever, 2014 explains that empathetic feelings provide to the participant a

positive experience, which could allow the person to be more open to change, including attitude change (Mc Keever, 2014).

Nevertheless, there is also a part of literature that agrees with the fact that empathy might be not related with attitude change. There is a study by Bruneau and Saxe (2012), which analyzed the concept of empathy and its relationship with change in perception, and they have found out that when people might come into contact with diversity, empathy might help them understand other's thoughts and feelings, but this does not necessarily mean that the attitudes will change as well, as the beliefs of an individuals are quite hard to change. The role of emotion is important, but maybe not enough in order to change the perception in such a short time (Bruneau and Saxe, 2012). Zaki & Cikara (2015) found also similar results with that, stressing out that attitudes in order to change, needs additional variables to be present and not only empathy. As a result, this should be an explanation for not founding significant results. Apart from that, Batson and the team (2002), found no association between attitude and empathy, which made them feel concerned regarding what is empathy and how it is measured. They suggested that there are different types of empathy and scales which have been developed, with different correlations in the literature. Generally, empathetic concern is being examined by most of the researchers, but probably the focus on the future research should be reflective thinking, which is a cognitive aspect related to empathy (Batson et al., 2002). In other words, it might be true that what is corelated with attitudes, is the reflective tendency of the individual to think of an information they heard, once the empathy is heightened, and not be the variable of interest per se (Batson et al., 2002).

As for the relationship between the presence of contact and empathy, there is a part of the literature that disagrees with these findings. Vescio and the rest of the team (2003), argue that these variables are associated, as during contact, due to the positive interactions, the presence of positive feelings like empathy is also there. Over and above that, other studies have found in their results a significant association or even a relationship of predictor and predicted outcome, with contact predicting the elicitation of empathy (Batson et al., 2002; Hayes et al., 2004). Still, Pettigrew and Tropp (2008) explained that if contact is not meaningful for the other person, empathy will not be elicited and no effect of positive emotions will be made. Additionally, Igartua and Barrios (2012), explained that even if contact can increase the emotions of empathy, it was observed that this effect was mainly for people that had similar demographics, status or characteristics. In this design, I matched the role-player's job role and status with the participant's one, in order to avoid this effect. However, the differences in the age (as the role-players were mostly younger than the participants), the difference in the gender (only female role-players and there were also male participants) or any other characteristic that someone perceive it as important might have interfered.

Mediation Effect – Empathy

Regarding the third hypothesis, there were no significant results of mediation of empathy on the relationship between contact and behavioral intention, as well as between contact and attitudes.

These results were expected, as no significant results were found between empathy and contact, as well as empathy and attitudes. In order to have a mediation effect, it is prerequisite for the mediator to be significantly associated with all of the

variables. However, research suggests that these variables have a relationship together and it seems like empathy explains the association between contact and the dependent variables (Potts et al., 2002). In addition, Batson and the rest of the team (2002) conducted a contact intervention with a discussion with convicted men from drug usage and the individuals had increased behavioral intention afterwards, with better attitudes and heightened empathetic feelings simultaneously. Also, Faigin and Stein (2008), realized that in the contact interventions the emotional affect of the individuals was heightened, even if they did not manipulate it, while in the rest of the conditions this effect was not reported. The last studies though, had not tested statistically the role of empathy in order to understand its role. Though, this side is strengthened with a biological basis as well, as neuropsychology research has found that when a person comes into contact with a person, tries matched their physic and emotions, hence the empathy is observed to be increased, which is translated later with higher behavioral intention and better attitudes (Leverson & Ruef, 1992).

Though, Batson & Ahmad (2009), illustrated in their research that empathy might have a different role than the ones that are explored in the literature, advising researchers to shift their attention (After conducting further analysis with the Model 1 of SPSS Process, it was revealed that the empathy moderated the relationship between contact and behavioral intention, which is new evidence in the literature (see table 14). Generally, the role of empathy is mostly approached as mediator and not moderator, leading to the conclusion that future studies should direct their research on this topic.

Moderation Effect – Self-Confidence

The third hypothesis was partially confirmed, as the self-confidence moderated the relationship between contact and behavioral intention. Also, there was no significant moderation effect on the relationship between contact and attitudes, but it was almost marginal. To be more accurate, regarding the first analysis, it was revealed that the type of condition had an effect on behavioral intention, as well as self-confidence on behavioral intention, by acting as predictors. Building on this, there was an interaction between the type of condition and the self-confidence, meaning that self-confidence moderated the relationship between type of condition and behavioral intention, with type of condition (contact) having a stronger effect on behavioral intention, especially when there was low self-confidence. In other words, when a person has low self-confidence, the effect of the contact could have stronger results on behavioral intention, which is key finding, if we consider employees who have already low self-confidence on approaching people with MHI in the workplace. Future interventions in companies can create role – play activities and theatrical plays, especially to those who does not feel comfortable with the approach, as it seems that there is very fruitful ground in terms of utilization.

Regarding the second moderation analysis, similar patterns were obtained, but it was marginally significant. The results indicated that the interaction could potentially be significant as it was almost close to that, meaning that the self-confidence could moderate the relationship between contact and attitudes. In detail, at higher levels of self-confidence (5.00), the effect of contact on attitudes was not significant, while in lower levels of self-confidence (4.00) it was significant, showing that self-confidence might be a moderator, moderating the relationship between contact (conditions) and attitude in lower levels of self-confidence, as it was the case for the previous moderation analysis. Subsequently,

future research, should explore additional variables that would influence this moderation effect in order to explore their interaction even further. In addition, bigger sample size should be included, as this might interfere with the clear significance of the moderation effect on the relationship between contact and attitudes.

These findings are aligned with the literature that suggests that self-efficacy/confidence, when is present, allow the individuals to be more open minded while they are in contact with diversity and unfamiliar groups, while at the same time motivate the individual to act on the behavior they wish (Hanish et al., 2016; Sheeran et al., 2016). Teachers when they had high self-efficacy, used more inclusive behaviors during teaching and at the same time they had better attitudes (Chacon, 2005). Hofman and Kilimo (2014), teachers demonstrate less biased attitudes when they have high self-efficacy/confidence, once they come into contact with non-dominant groups. At the same time, research designs that had as an element the feedback session and increased the self-confidence of the participants, they were more motivated to act on the behavior and they could replicate the behavior as well (Conner & Norman, 2015). Based on Social Cognitive Theory of Bandura (1977), it is explained that self-efficacy/confidence increases the motivation to act. At the same time, while participants become comfortable with challenging circumstances, they are more receptive to change their perception around a stereotype and critically evaluate it, leading to a reduction of stigma (Devries et al., 1988).

Limitations and Strengths and Further Research

This study has a lot of limitations and strengths that needs to be discussed. Regarding the limitations, it should be noted that it would be ideal to have more conditions and bigger sample for this study. In a more detail, the third condition could be divided in

two, with one reading a plain story with no emotions and the second one as it is, in order to be able to differentiate if part of the results are attributed to the presence of empathy or to the absence of contact. This study did not have any significant results on empathy induction, hence it did not affect my results, but it is a good suggestion for future research in order to avoid any noise in the data. Also, the sample size should be increased in order to have higher statistical power. Apart from that, the sample of this study was mainly individuals working in the consulting industry, so it would be ideal to open the recruitment umbrella and find explore differences that they might exist in stigma based on demographics. In this way, the results will be more generalizable (Wu et al., 2021).

Also, another limitation is the fact that the process that was followed in the role plays, might be different case by case, which could add noise to the results. What I would like to propose is a replication of the study with only specific symptomatology and not the whole range of the MHI, as there might be overwhelming for the individual to hear different symptomatology at once and create the opposite effect of what is expected.

Apart from that, the scales that were used for Behavioral Intention and Attitude towards employees with MHI, have been modified by me, with guidance from my academic advisor, therefore this is the first small pilot study to receive basic feedback, in order later on to adjust it, make changes and run a study in order to confirm the psychometric properties of the scales, which is one of the strengths of this study. At the same time, this could be a limitation as it is the first time that is being used in this form, but it was reassured that they have high internal consistency.

Another strength, is that the social desirability was diminished a lot with the phrase that we were saying to the individuals before completing the second questionnaire.

Further research should be also conducted in order to identify other variables that are having the role of moderators, but especially mediators. A good start is to explore other variables that are correlated with self-confidence and empathy and they are of similar construct, because researchers might find significant results. Also, the role of empathy should be researched further and I would propose to add the reflective evaluation thinking into the model between empathy, attitudes, behavioral intention, contact and self-confidence (Batson et al., 2022).

Implications

The findings of this study are very important for future interventions as its shows first of all the role of positive experience (Angermeyer et al., 2004). The negative impact that it was received from the familiarity control on behavioral intention, might show that employees hold negative stereotypes for MHI and they have perceived negatively previous experiences. This is only an assumption, but having interventions or trainings that would allow the employees to create positive experiences in a safe environment, minimizing the risk of the generation of negative results, could actually bring small changes to the organizations by reducing steadily the presence of stigma (Kent et al., 2016).

Also, trainings programs should be designed especially for those who have low self-confidence, including role-play exercises, as this could have increased positive effects on attitude change and behavioral change. Self-confidence is the key for many positive changes in the workplace and it should begiven more attention.

Conclusion

Concluding, this paper build on the research on stigma in the workplace for people with mental health issues. It is important to identify the variables that affect stigma and create more tailored intervention that would enhance inclusion. We should start discussing more about mental health in the workplace, and create allyships in order to start supporting each other.

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Table 1

Descriptive Statistics for Demographics

		Age	Gender	Contact	English
N	Valid	46	46	46	46
	Missing	0	0	0	0
Mean		31.26	1.61	1.8478	6.09
Median		29.00	2.00	2.0000	6.00
Mode		26	2	2.00	6
Std. Deviation		8.386	.493	.72930	.673

Table 2

Age Frequency Table

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	18	1	2.2	2.2	2.2
	20	1	2.2	2.2	4.3
	22	2	4.3	4.3	8.7
	24	1	2.2	2.2	10.9
	26	8	17.4	17.4	28.3
	27	5	10.9	10.9	39.1
	28	3	6.5	6.5	45.7
	29	3	6.5	6.5	52.2
	30	4	8.7	8.7	60.9
	31	2	4.3	4.3	65.2
	32	2	4.3	4.3	69.6
	33	3	6.5	6.5	76.1
	36	2	4.3	4.3	80.4
	37	1	2.2	2.2	82.6
	38	1	2.2	2.2	84.8
	39	1	2.2	2.2	87.0
	40	1	2.2	2.2	89.1
	41	1	2.2	2.2	91.3
	43	1	2.2	2.2	93.5
	44	1	2.2	2.2	95.7
	57	1	2.2	2.2	97.8
	62	1	2.2	2.2	100.0
	Total	46	100.0	100.0	

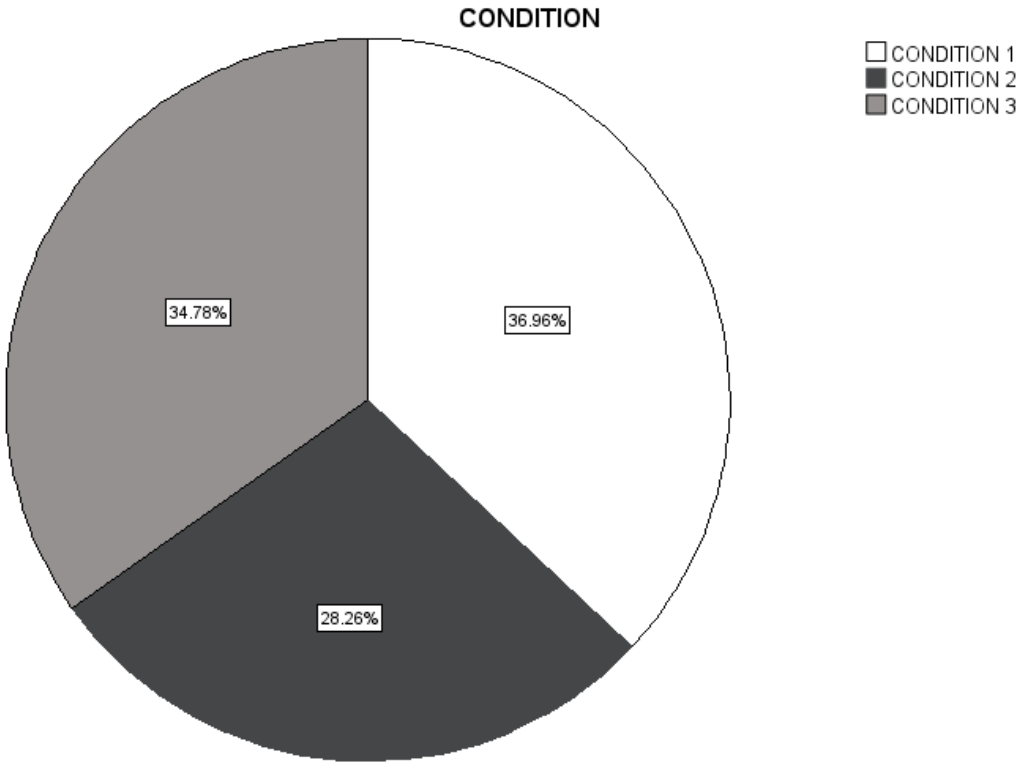
Table 3

Frequency Table for Gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	18	39.1	39.1	39.1
	Female	28	60.9	60.9	100.0
	Total	46	100.0	100.0	

Figure 1

Frequency Pie Chart for Participants in each Condition



Note: The percentage of participants that were allocated in each condition

Table 4

Frequency Table for Contact

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	self	15	32.6	32.6	32.6
	family/friends	24	52.2	52.2	84.8
	acquaintance	6	13.0	13.0	97.8
	noone	1	2.2	2.2	100.0
	Total	46	100.0	100.0	

Table 5

Cronbach's Alpha of the BIW scale

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.930	.925	12

Table 6

Cronbach's Alpha of the AW scale

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.906	.913	24

Table 7

Descriptive Statistics – One-Way ANOVA

		N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
						Lower Bound	Upper Bound		
BIB_t	CONDITION 1	17	48.0000	9.02081	2.18787	43.3619	52.6381	24.00	60.00
	CONDITION 2	13	53.7692	6.55939	1.81925	49.8054	57.7330	40.00	60.00
	CONDITION 3	16	54.7500	5.68624	1.42156	51.7200	57.7800	40.00	60.00
	Total	46	51.9783	7.79883	1.14987	49.6623	54.2942	24.00	60.00
AB_t	CONDITION 1	17	96.7647	9.10720	2.20882	92.0822	101.4472	75.00	113.00
	CONDITION 2	13	96.8462	19.67590	5.45711	84.9561	108.7362	40.00	116.00
	CONDITION 3	16	105.3750	7.29269	1.82317	101.4890	109.2610	90.00	115.00
	Total	46	99.7826	12.94246	1.90826	95.9392	103.6260	40.00	116.00
EB_t	CONDITION 1	17	31.4118	6.53891	1.58592	28.0498	34.7738	14.00	42.00
	CONDITION 2	13	31.5385	5.31688	1.47464	28.3255	34.7514	24.00	41.00
	CONDITION 3	16	34.5625	6.10976	1.52744	31.3068	37.8182	21.00	42.00
	Total	46	32.5435	6.11630	.90180	30.7272	34.3598	14.00	42.00
SEB_t	CONDITION 1	17	4.6471	.60634	.14706	4.3353	4.9588	3.00	5.00
	CONDITION 2	13	4.5385	.51887	.14391	4.2249	4.8520	4.00	5.00
	CONDITION 3	16	4.3750	.50000	.12500	4.1086	4.6414	4.00	5.00
	Total	46	4.5217	.54728	.08069	4.3592	4.6843	3.00	5.00

Note: BIBt = second completion of the Behavioral Intention scale,
ABt= second completion of the Attitude scale,
EB = second completion of the Empathy scale,
SEB = second completion of the Self-Confidence item

Table 8

ANOVA Table

		Sum of Squares	df	Mean Square	F	Sig.
BIB_t	Between Groups	433.671	2	216.835	4.048	.025
	Within Groups	2303.308	43	53.565		
	Total	2736.978	45			
AB_t	Between Groups	767.325	2	383.662	2.437	.099
	Within Groups	6770.501	43	157.454		
	Total	7537.826	45			
EB_t	Between Groups	100.127	2	50.064	1.360	.268
	Within Groups	1583.286	43	36.821		
	Total	1683.413	45			
SEB_t	Between Groups	.615	2	.308	1.028	.366
	Within Groups	12.863	43	.299		
	Total	13.478	45			

Note: BIBt = second completion of the Behavioral Intention scale,
ABt= second completion of the Attitude scale,
EB = second completion of the Empathy scale,
SEB = second completion of the Self-Confidence item

Table 9

Comparisons – ANOVA

Dependent Variable	(I) COND	(J) COND	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
						Lower Bound	Upper Bound
BIB_t	CONDITION 1	CONDITION 2	-5.76923	2.69654	.114	-12.4870	.9485
		CONDITION 3	-6.75000*	2.54926	.034	-13.1009	-.3991
	CONDITION 2	CONDITION 1	5.76923	2.69654	.114	-.9485	12.4870
		CONDITION 3	-.98077	2.73281	1.000	-7.7889	5.8274
	CONDITION 3	CONDITION 1	6.75000*	2.54926	.034	.3991	13.1009
		CONDITION 2	.98077	2.73281	1.000	-5.8274	7.7889
AB_t	CONDITION 1	CONDITION 2	-.08145	4.62318	1.000	-11.5990	11.4361
		CONDITION 3	-8.61029	4.37068	.166	-19.4988	2.2782
	CONDITION 2	CONDITION 1	.08145	4.62318	1.000	-11.4361	11.5990
		CONDITION 3	-8.52885	4.68537	.227	-20.2013	3.1436
	CONDITION 3	CONDITION 1	8.61029	4.37068	.166	-2.2782	19.4988
		CONDITION 2	8.52885	4.68537	.227	-3.1436	20.2013
EB_t	CONDITION 1	CONDITION 2	-.12670	2.23568	1.000	-5.6964	5.4430
		CONDITION 3	-3.15074	2.11358	.430	-8.4162	2.1147
	CONDITION 2	CONDITION 1	.12670	2.23568	1.000	-5.4430	5.6964
		CONDITION 3	-3.02404	2.26575	.567	-8.6686	2.6205
	CONDITION 3	CONDITION 1	3.15074	2.11358	.430	-2.1147	8.4162

		CONDITION 2	3.02404	2.26575	.567	-2.6205	8.6686
SEB_t	CONDITION 1	CONDITION 2	.10860	.20151	1.000	-.3934	.6106
		CONDITION 3	.27206	.19051	.481	-.2025	.7467
	CONDITION 2	CONDITION 1	-.10860	.20151	1.000	-.6106	.3934
		CONDITION 3	.16346	.20422	1.000	-.3453	.6722
	CONDITION 3	CONDITION 1	-.27206	.19051	.481	-.7467	.2025
		CONDITION 2	-.16346	.20422	1.000	-.6722	.3453

*. The mean difference is significant at the 0.05 level.

Note: BIBt = second completion of the Behavioral Intention scale,
ABt= second completion of the Attitude scale,
EB = second completion of the Empathy scale,
SEB = second completion of the Self-Confidence item

Table 10

Descriptive Statistics – Variables, Scales

	Mean	Std. Deviation	Median	N
BIB_t	51.9783	7.79883		46
AB_t	99.7826	12.94246		46
EB_t	32.5435	6.11630		46
SEB_t	4.5217	.54728		46
Contact	-	.85607	2	

Table 11

Correlation Analysis – Pearson

		BIB_t	AB_t	EB_t	SEB_t
BIB_t	Pearson Correlation	1	.485**	.577**	.320*
	Sig. (2-tailed)		<.001	<.001	.030
	N	46	46	46	46
AB_t	Pearson Correlation	.485**	1	.227	.079
	Sig. (2-tailed)	<.001		.130	.601
	N	46	46	46	46
EB_t	Pearson Correlation	.577**	.227	1	.132
	Sig. (2-tailed)	<.001	.130		.380
	N	46	46	46	46
SEB_t	Pearson Correlation	.320*	.079	.132	1
	Sig. (2-tailed)	.030	.601	.380	
	N	46	46	46	46

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

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

Table 12

Correlation Analysis – Spearman

			COND	EB_t	SEB_t
Spearman's rho	COND	Correlation Coefficient	1.000	.206	-.250
		Sig. (2-tailed)	.	.169	.094
		N	46	46	46
	EB_t	Correlation Coefficient	.206	1.000	.027
		Sig. (2-tailed)	.169	.	.858
		N	46	46	46
	SEB_t	Correlation Coefficient	-.250	.027	1.000
		Sig. (2-tailed)	.094	.858	.
		N	46	46	46

Figure 2

Moderation Effect of Self-Confidence

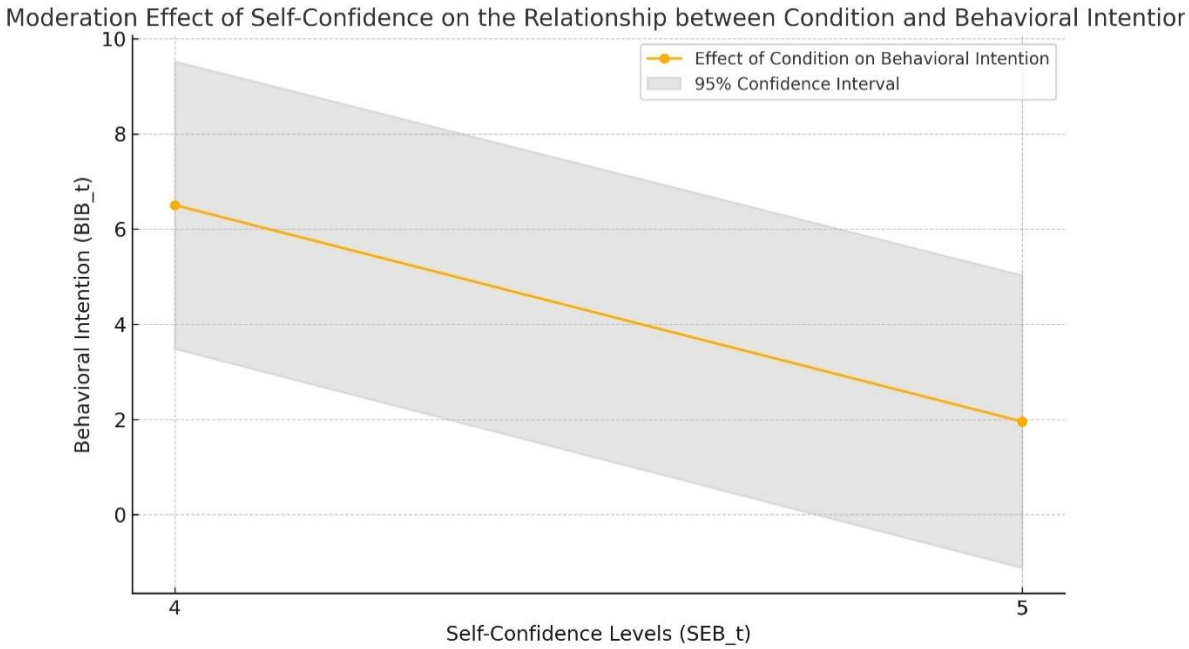


Table 13

Paired samples t-test

		Paired Differences					t	df	Significance	
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				One-Sided p	Two-Sided p
					Lower	Upper				
Pair 1	COND1BIA – COND1BIB	-3.29412	3.49580	.84786	-5.09149	-1.49675	-3.885	16	<.001	.001
Pair 2	COND1A – COND1AB	-2.29412	6.63103	1.60826	-5.70348	1.11524	-1.426	16	.086	.173
Pair 3	COND1EA – COND1EB	-1.82353	3.72886	.90438	-3.74073	.09367	-2.016	16	.030	.061
Pair 4	COND1SEA – CONDSEAB	-.52941	.71743	.17400	-.89828	-.16054	-3.043	16	.004	.008
Pair 5	COND2BIA – COND2BIB2	-2.76923	2.86222	.79384	-4.49885	-1.03961	-3.488	12	.002	.004
Pair 6	COND2A – COND2AB	-5.61538	6.86220	1.90323	-9.76217	-1.46860	-2.950	12	.006	.012
Pair 7	COND2E – COND2EB	-1.00000	1.91485	.53109	-2.15713	.15713	-1.883	12	.042	.084
Pair 8	COND2SEA – COND2SEB	-.38462	.50637	.14044	-.69061	-.07862	-2.739	12	.009	.018
Pair 9	COND3BIA – COND3BIB	-2.56250	3.91525	.97881	-4.64879	-.47621	-2.618	15	.010	.019
Pair 10	COND3A – COND3AB	-.18750	3.27045	.81761	-1.93020	1.55520	-.229	15	.411	.822
Pair 11	COND3E – COND3EB	-.68750	1.70171	.42543	-1.59428	.21928	-1.616	15	.063	.127

Note: BIA & B = Behavioral Intention scale pre & post
AA & B= Attitude scale pre & post
EA &B = Empathy scale pre & post
SEA &B = Self-Confidence item pre & post

Table 14

Empathy – Moderator Effect

OUTCOME VARIABLE: BIB_t						
Model Summary						
R	R-sq	MSE	F	df1	df2	p
.7165	.5133	32.4894	10.8106	4.0000	41.0000	.0000
Model						
	coeff	se	t	p	LLCI	ULCI
constant	8.0713	11.2889	.7150	.4787	-14.7273	30.8699
COND	14.1287	5.4083	2.6124	.0125	3.2062	25.0512
EB_t	1.3490	.3419	3.9454	.0003	.6585	2.0395
Int_1	-.3516	.1606	-2.1898	.0343	-.6759	-.0273
Contact	-2.6595	1.1679	-2.2771	.0281	-5.0181	-.3008

Int_1 : COND x EB_t					
Test(s) of highest order unconditional interaction(s):					
	R2-chng	F	df1	df2	p
X*W	.0569	4.7952	1.0000	41.0000	.0343

Focal predict: COND (X)						
Mod var: EB_t (W)						
Conditional effects of the focal predictor at values of the moderator(s):						
EB_t	Effect	se	t	p	LLCI	ULCI
27.0000	4.6355	1.4113	3.2847	.0021	1.7854	7.4857
32.0000	2.8775	1.0337	2.7836	.0081	.7898	4.9652
39.4800	.2476	1.4472	.1711	.8650	-2.6752	3.1703

Appendix A

Informed Consent Form for Condition 1 & 2 (role-plays)

Informed Consent Form

Purpose:
The purpose of this study is to explore the different elements that, based on the literature, could enhance the inclusion of the individuals with MHI in the workplace. This study is part of a thesis project for the Organizational Psychology Master's Program at Deree – The American College of Greece.

Procedure:
The whole procedure lasts approximately 40 minutes. If you agree to be in this study, you will be asked to do the following:

1. Complete a questionnaire
2. Read a Story
3. Provide demographic information

Benefits/Risks to Participant:
By participating in this study, you will get more familiar with MHI in the workplace. Also, you will have the chance to participate in an intervention of a research project and you will contribute to the research community. No known risks are associated with this study.

Voluntary Nature of the Study:
Your participation in this study is entirely voluntary. Refusal to participate (or discontinue participation) will involve no penalty or loss of benefits to which you are otherwise entitled. You may also deny to answer a specific question, if you do not wish to, and retain your participation to the study. You may also stop at any time during the study.

Data Collected:
Data collected is confidential and anonymous and will only be viewed and used by the researcher. It will be stored in locked desk, in personal premises of the researcher or stored

in a laptop secured with a password. Data collected will be destroyed after 1 year and will not be used for future research. Results will be reported only in the aggregate.

Contacts and Questions:
After the conduction of the intervention, you may address any questions to the administrator of the intervention or the researcher. More specifically, if you have questions after your participation has finished, you may contact the researcher Nefeli Pavlaki at her personal e-mail (N.Pavlaki@acg.edu) and/or the supervisor of the study Dr. Olivia Kyriakidou (okyriakidou@acg.edu).

Hereby freely agree to take part in the study described right above, by ticking the corresponding box. By doing that, you are indicating that you have read and understood the information provided above, that you are over 18 and that you willingly agree to participate and that you are not waiving any legal claims.

☐ I confirm that I have read the above text, and I have understood the purposes and procedures of the study, as well as my willingness to participate.

Date:

Appendix B

Informed Consent for Condition 3 (story)

Informed Consent Form

Purpose:
The purpose of this study is to explore the different elements that, based on the literature, could enhance the inclusion of the individuals with MHI in the workplace. This study is part of a thesis project for the Organizational Psychology Master's Program at Deree – The American College of Greece.

Procedure:
The whole procedure lasts approximately 40 minutes. If you agree to be in this study, you will be asked to do the following:

1. Provide demographic information
2. Read a story
3. Complete a questionnaire

Benefits/Risks to Participant:
By participating in this study, you will get more familiar with MHI in the workplace. Also, you will have the chance to participate in an intervention of a research project and you will contribute to the research community. No known risks are associated with this study.

Voluntary Nature of the Study:
Your participation in this study is entirely voluntary. Refusal to participate (or discontinue participation) will involve no penalty or loss of benefits to which you are otherwise entitled. You may also deny to answer a specific question, if you do not wish to, and retain your participation to the study. You may also stop at any time during the study.

Data Collected:
Data collected is confidential and anonymous and will only be viewed and used by the researcher. It will be stored in locked desk, in personal premises of the researcher or stored in a laptop secured with a password. Data collected will be destroyed after 1 year and will

not be used for future research. Results will be reported only in the aggregate.

Contacts and Questions:
After the conduction of the intervention, you may address any questions to the administrator of the intervention or the researcher. More specifically, if you have questions after your participation has finished, you may contact the researcher Nefeli Pavlaki at her personal e-mail (N.Pavlaki@acg.edu) and/or the supervisor of the study Dr. Olivia Kyriakidou (okyriakidou@acg.edu).

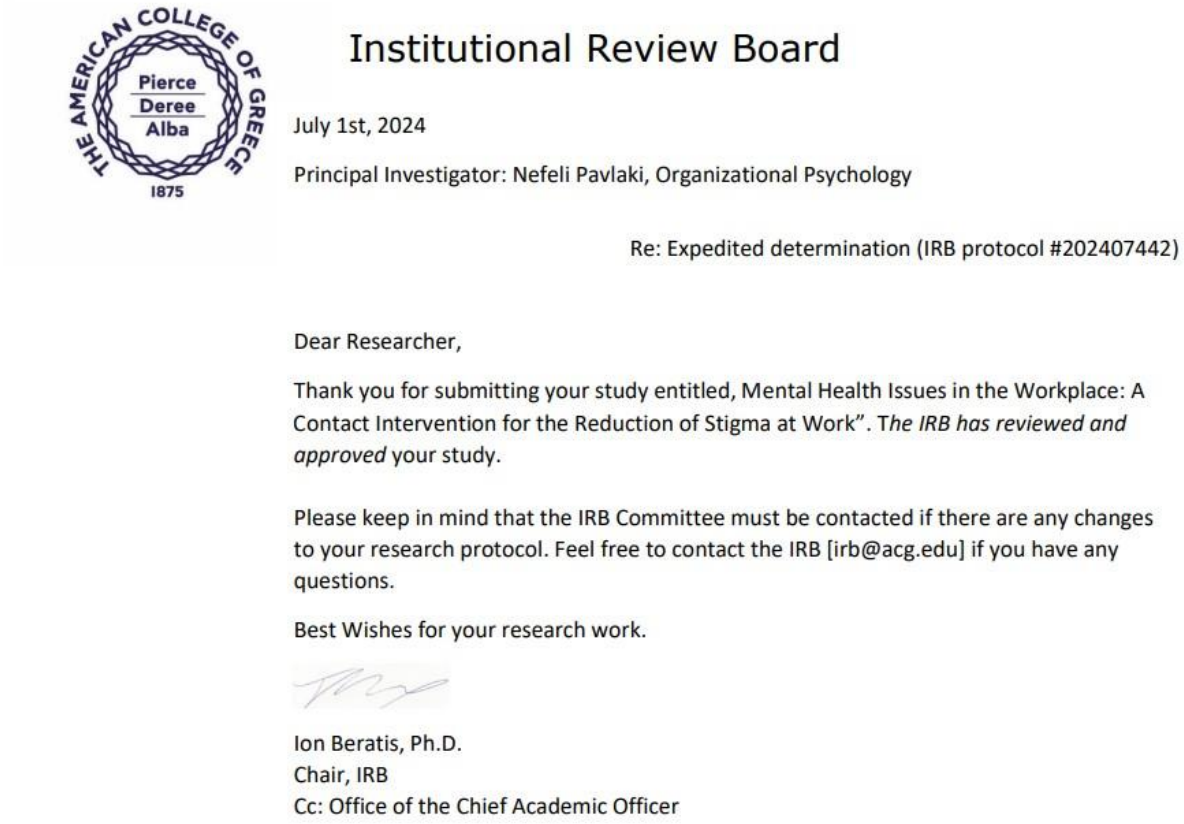
Hereby freely agree to take part in the study described right above, by ticking the corresponding box. By doing that, you are indicating that you have read and understood the information provided above, that you are over 18 and that you willingly agree to participate and that you are not waiving any legal claims.

☐ I confirm that I have read the above text, and I have understood the purposes and procedures of the study, as well as my willingness to participate.

Date:

Appendix C

Institutional Review Board - IRB Approval



THE AMERICAN COLLEGE OF GREECE
Pierce
Deree
Alba
1875

Institutional Review Board

July 1st, 2024

Principal Investigator: Nefeli Pavlaki, Organizational Psychology

Re: Expedited determination (IRB protocol #202407442)

Dear Researcher,

Thank you for submitting your study entitled, Mental Health Issues in the Workplace: A Contact Intervention for the Reduction of Stigma at Work". T*he IRB has reviewed and approved* your study.

Please keep in mind that the IRB Committee must be contacted if there are any changes to your research protocol. Feel free to contact the IRB [irb@acg.edu] if you have any questions.

Best Wishes for your research work.

Ion Beratis, Ph.D.
Chair, IRB
Cc: Office of the Chief Academic Officer

Appendix D

Example of a Scenario for the Role Player (Condition 1)

You are an HR Consultant, part of a team with other consultants and you are in the same level with the participant, who come into contact with clients and various candidates, have tight deadlines, a lot of meetings etc. You may during the day conduct interviews, analyze reports from psychometric tests, create detailed reports for each candidate, meet clients in their premises and discuss about the ongoing projects, design developmental activities for individuals etc. Currently, you have started showing symptoms of tiredness, demotivation, and overt stress. You have requested to meet with someone you trust from the team in order to talk about the situation. You do not ask for their help, but only to hear you, hence if they try to assist you can say "*that there is no need, I just need someone to be heard as I have my psychologists to help me get through this phase*". Also, you it is important to stress out from the beginning that you are contacting them in order to get this out of you and calm your stress, as there is no issue of performance and productivity, bur rather of fear that your co-workers will comment on you negatively. You can also remind this during the conversation, if you feel like the participant forgets it.

Apart from that, you should always try and provide feedback when the participants hear you and ask good questions that makes you comfortable sharing more details about your story (eg Thank you for asking this, it is the first time someone pays attention to this, thank you very much for hearing me, it means a lot, what you do know it is very helpful in order to make me feel more included in the company, I wish everyone was like you during a conversation etc. This feedback should be short and you should

provide it only in periods you have felt better or there is an acceptable question based on the literature that you have read about it)

Your symptoms are the following:

Unlike before, you are down and sad without being able to identify a concrete reason for feeling low. You appear serious and worried, with little laughter. You feel that you underperform and have the impression of doing everything wrong. You complaint of often waking up in the middle of the night and not being able to get back to sleep. Already in the morning, you are exhausted and without energy.

Additionally, you frequently seem restless and fidgety during meetings, often tapping your foot or drumming your fingers on the table. You've noticed that you have become more irritable and snap at colleagues over minor issues, which is unusual for you. During team discussions, you often seem preoccupied and distracted, sometimes zoning out completely or appearing to be lost in thoughts. You find it difficult to concentrate on the job; for instance, you write a candidate report in twice the time it took before, hence more time for review is needed. You always check it though and there is not any circumstance where you have sent something wrong to the client. It is just that it affects only your psychological well-being and more time. You have observed that the last few meetings, before welcoming the client, you say to yourself "*I am not good enough*," or "*I am going to mess everything up*". What it had raised more your concern, is that the last three months you have started complaining of headaches, muscle tension, and stomach issues, often attributing them to stress. You need to say again at this point that this has not affected your work, hence there is no need to worry about any results. It is just a conversation because you wish to speak with someone as you are a little overwhelmed.

As this is something that has happened to you before, a couple years back, you immediately understand that these are the signs of poor mental health and you start remembering the incidents that you have experienced in the past due to your similar issues, in other companies that you have worked before. An example is when you were a candidate with mental health issues and you had applied for a job role in a position that you met all the criteria and it was quite advanced, with very specific experience that was required. You had done three interviews and you were in the stage of the official final offer for the position, as they have confirmed that you were the best fit. Also, this position for you was your dream job and you were ready to follow your dream! During this meeting, you decided to disclose that you have mental health issues during a questionnaire for medical record that was distributed and they decided to withdraw the offer to you suddenly, after receiving your responses. You were devasted and you could not even believe it, as you had the best possible skills for this job and you had brought similar results with the ones that they were asking in your previous company, as you do also it the current position that you are in. You were able to bring into your previous company a raise in the revenue up to 12% annually, while you were experiencing mental health issues, as the environment was supportive and all the resources were provided to you in order to perform at your own standards. However, the company that you went for an interview did not give you the chance to prove what you can do and this diminished also your self-esteem as an employee. You can elaborate also to some other negative emotions if needed, but not aggression, rudeness etc.

Another story that could share is when you were in a managerial position in another consulting company, and you had intense symptoms of poor mental health with strong

emotional responses to anxiety, closing to panic attacks. It was very difficult for you, as you had nightmares, you were feeling that you were not able to breath and you were afraid that you will get embarrassed if others would see that. Even if this is a common situation at work, you believed that you were alone. Once you had to go the office and leave a meeting in order to calm your heartbeat and your physical arousal. Suddenly, your manager, once you opened up, advised you to step out of the workforce, as she was afraid that your results will be diminished. You were shocked with that, as you felt no support! You decided to leave the company, even though it was a hard choice for you, as she insisted that staying in the company would threaten the image of the company to the clients.

You need to finish by saying that here you have more support than in other companies, explain the need to educate and train colleagues on how approach people with mental health issues and assist them at work, in order to flourish and feel included. This is your wish for the future and more supportive working environment as poor mental health is the new reality in the workplace, but there is inclusion yet. Either people avoid it or do not know how to help and create an unsupportive environment of distance. You smile and you say that you wish to have an ally like the participant, to make a more inclusive world!

Appendix E

Example of a Scenario for the Participants (Condition 1)

You are an HR Consultant in the Consulting Department, in the current company that you are in, with the same job description as now. The person you will meet is a colleague working in the same team, sharing the same position, who experiences mental health issues at work the past few months. You have observed that one team member has started showing symptoms of tiredness, demotivation, and overt stress. You have realized that the symptomatology is intense and it affects her every-day life, without diminishing her performance up until that time. You are kindly requested to explore the situation and hear what your colleague experiences during working life. There is no need to try and assist her in resolving the issues, you just need to pay attention and engage in the conversation, in order to understand what she is experiencing. The meeting has been requested by her, as she trusts you and feels comfortable to talk with you.

Appendix F

An Example of a Scenario/Script for the Role Player (Condition 2)

Project for Executive Search & Selection Services – Senior Manager

The project refers to a search & selection assignment of a Senior Business Development Manager for a Greek medium size Company with food ingredients. Your goal is to ask for the participant to hear what you have done up until now (or what you have though on doing) and give you an honest opinion, based on their experience. You need to seem competent and show confidence. No information about the mental health issues should be made. Lastly, you can put as many details as you wish to each stage in order to show your competence.

The project includes:

- Meeting the client to understand the need, the job profile, the accountabilities as well as the skills of the right incumbent (Studies, experience, competences etc). Additionally, the philosophy and culture of the company in order to select the appropriate candidate. You have already researched in the Linked in about the person you will meet, previous experience etc. Also, you have researched about the company, its culture, history, job roles etc in order to be prepared and let the client understand that you care about them.
- Agree on the methodology of the search, the sources, the deliverables, the timeframe. You should be prepared with having ready-to-be-delivered documents regarding the standard SLAs of the company and possible timelines from your end as a draft.

- A proposal will be sent with the fees, terms and conditions, in order to be signed and confirm the collaboration. It should be read carefully and make sure that all the specific terms are there.
- Further step, the briefing internally to the advisors that will support the project in order to be well informed about the targeted candidate profile. Project Management planning.
- Selection of sourcing strategy that usually includes utilization of ATS (Applicant Tracking System – data base with previous candidates), LinkedIn Search, existing network of contacts in Greece & abroad, prior experience in relevant projects.
- Evaluation process: Mapping of the targeted market, identification & screening of potential candidates, telephone short interview, on-line test, competency-based interview. Proper evaluation of the candidate.
- Next stage includes the submission of short list of recommended candidates (usually 4-6), according to agreed recruitment strategy. The deliverables include a detailed comprehensive evaluation report for every shortlisted candidate, documenting their know-how, professional skills, personal attributes, and achievements against the agreed job requirements. Additionally, detailed references will be discretely collected, upon the client's request and the candidate's consent, from former employees and business associates.
- Arrangement of a meeting with the client in order to present the results of the short-list of recommended candidates for the role assigned and the market findings and assist in making decisions for the next steps.
- Information of the candidates for the following steps.

- Following the decision of the client to extend an offer to the most suitable candidate (will remain involved until the appointment decision is made).
- Lastly, we will contact both the company and the incumbent, six months after the hiring to collect feedback and review the success of the assignment.
- Of course, daily tasks include also other duties such as business development activities, internal meetings, billings, internal trainings, reporting & KPIs, employer branding activities, evaluation of subordinates, participation to events etc.

Appendix G

An Example of a Scenario/Script for the Participant (Condition 2)

You are a Senior Manager in Executive Search & Selection in the Consulting Department, in the current company that you are in, with the same job description as now. The person you will meet is a colleague working in the same team, sharing the same position, who experiences mental health issues at work the past few months. She has requested to speak with you and asked for a meeting, in order to receive honest feedback from you regarding her progress currently, as she trusts your opinion and you have similar experience. In greater detail, she has taken on a project similar with a one that you had the last year, hence she wishes to know is she has approached it correctly and make sure that the quality of the work will be high and it will be delivered also on time. The project seems to be on time and very effective up until today. This meeting will last approximately 15 minutes and you need to talk solely about the project. You are kindly requested to have a discussion with her and let her express her thoughts to you, as well as the steps she has done or she will do. You should provide your honest feedback to her, whether you would do something differently or not.

Appendix H

Example of Personal Story – Narrative for Empathy

My name is Anna and I am currently working with a team of consultants in a company that provides related services, in which I am coming into contact with clients, but also with a lot of individuals/candidates of various job levels and industries. I have multiple projects during the day and I spend my day mostly with clients, analyzing reports/results from psychometric tests, exploring the various options that are for my client based on the results, creating presentations, planning in order to meet deadlines, etc. Also, I am a colleague who suffers from mental health issues and I would like to share my experiences.

The last few months I have started showing symptoms of tiredness, demotivation, and overt stress. Unlike before, I am down and sad without being able to identify a concrete reason for feeling low. I appear serious and worried, with little laughter. I complaint of often waking up in the middle of the night and not being able to get back to sleep. Already in the morning, I am exhausted and without energy.

Additionally, I frequently seem restless and fidgety during meetings, often tapping my foot or drumming my fingers on the table. During team discussions, I often seem preoccupied and distracted, sometimes zoning out completely or appearing to be lost in thoughts.

I find it difficult to concentrate on the job; for instance, I write a candidate report in twice the time it took before and make mistakes in the presentations due to carelessness, hence more time for review is needed for me. In contrast with previous times, during presentations with clients, I am not as active and generally avoid communication apart

from the necessary interactions during working hours. I have observed that the last few meetings, before welcoming the client, I say to myself "*I am not good enough*," or "*I am going to mess everything up*". What it had raised more my concern, is that the last three months I have headaches, muscle tension, and stomach issues, often attributing them to stress.

As this is something that has happened to me before, a couple years back, I immediately understood that these are the signs of poor mental health and I would like to share some experiences that I had in other companies while I was employed. I remember when I was a candidate with mental health issues and I had applied for a job role in a position that I met all the criteria and it was quite advanced, with very specific experience that was required. I had done three interviews and I was in the stage of the official final offer for the position, as they have confirmed that I was the best fit. Also, this position for me was my dream job and I was ready to follow my dream! During this meeting, I decided to disclose that I have mental health issues during a questionnaire for medical record that was distributed and they decided to withdraw the offer to me suddenly. I was devasted and I could not even believe it, as I had the best possible skills for this job and I had brought similar results with the ones that they were asking in other companies that I have worked with. I was able to bring into my previous company a raise in the revenue up to 12% annually, as the environment was supportive and all the resources were provided to me in order to perform at the best standards. However, the company that I went for an interview did not give me chance to prove what I can do and this diminished also my self-esteem as an employee. I felt that I was discriminated for a characteristic of

me that it does not interfere with my job and this made me feel very upset and extremely sad at this point.

Another story that could share is when I had my first managerial position in another consulting company, and I had intense symptoms of poor mental health with strong emotional responses to anxiety, closing to panic attacks. It was very difficult for me, as I had nightmares, I was feeling that I was not able to breath and I was afraid that I will get embarrassed if others would see that. Even if this is a common situation at work, I believed that I was alone. When I decided to open up to my manager, she advised me to step out of the workforce, as she was afraid that my results will be diminished. I was shocked with that, as I felt no support and had approached her for her assistance, and I could not believe that I was excluded from the workforce just because of my symptoms. When I tried to explain that the results will not get affected, but I just need some accommodations and flexibility during the working hours, she proposed to work providing my assistance to the team and give up the leading role in the team, up until this problem is reduce. I decided to leave the company, as they did not really understand my needs and they tries to find solutions that would were only useful for them, but not for me. I felt that I was not heard, once again.

Companies need to educate and train colleagues on how to approach people with mental health issues and assist them at work, in order to flourish and feel included. This is my wish for the future and more supportive working environment as poor mental health is the new reality in the workplace, but there is inclusion yet. I do not want for other people with same characteristics as me to experience any similar situations. I wish to have you, now that you are reading this, as an ally, to make a more inclusive world!

Appendix I

Behavioral Intention in the Workplace for MHI (BIW-MHI)

Section A

This scale measure people's familiarity of interacting with individuals with mental health issues. Think of yourself as if you are currently in the situation that is presented in each item and write the number that represents you the best, depending on the degree to which you would be willing to engage in each behavior. You need to answer the statements without thinking too much the answer and as honestly as possible. In case you have any unknown words in the English language, do not hesitate to ask the administrator for a translation in your native language.

Below the correspondence of each number is presented:

I am not at all willing	I am somewhat unwilling	I am neither willing nor unwilling	I am somewhat willing	I am very willing
1	2	3	4	5

____ 1 Lend a colleague with mental health issues, a pencil or pen

____ 2 Stand next to a colleague exhibiting mental health issues when you are simultaneously in common rooms (eg to the kitchen, water bottle etc)

____ 3 Go up to a colleague experiencing mental health issues and say hello

____ 4 Discuss with a colleague with mental health issues during work-break or lunch

____5 Choose a colleague with mental health issues to be on your team in a work project

____6 Work with a colleague with mental health issues on a project at work

____7 Sit next to a colleague with mental health issues on a corporate event

____8 Spend time with a colleague with mental health issues outside of work

____9 Make a colleague who suffers from mental health issues, your friend at work

____10 Invite a colleague with mental health issues to your home, for a corporate informal meeting with other colleagues

____11 Go to after work social activities-with a colleague with mental health issues

____12 Talk about your work-related issues with a colleague with mental health issues

Appendix J

Attitudes Towards Employees with MHI in the Workplace (ATE-MHI)

Section B

This scale presents statements regarding people with mental health issues in the workplace. Read the statements carefully and rate each statement from 1-5, depending on the degree to each you agree or disagree to each statement. You need to answer the statements without thinking too much the answer, as honestly as possible. In case you have any unknown words in the English language, do not hesitate to ask the administrator for a translation in your native language.

Below the correspondence of each number is presented:

I strongly disagree	I somewhat disagree	Neither I agree nor disagree	I somewhat agree	I strongly agree
1	2	3	4	5

____ 1 There is something about people with mental health issues that makes it easy to tell them from people that do not suffer from any symptoms

____ 2 As soon as a colleague shows signs of mental health issues, they should be withdrawn from the workplace

____ 3 Mental health issues equal with any other discomforting physical symptoms

____ 4 Less emphasis should be placed on protecting the employees from colleagues with mental health issues

____ 5 Mental hospitals are an outdated means of treating people with mental health issues

____ 6 Virtually anyone can suffer from mental health issues

____ 7 People with mental health issues have for too long been the subject of ridicule

____ 8 We need to adopt a far more tolerant attitude toward people with mental health issues in our workplace

____ 9 We have a responsibility to provide the best possible care for people with mental health issues

____ 10 People with mental health issues don't deserve our sympathy

____ 11 People with mental health issues are a burden on the organization

____ 12 Increased spending on mental health services is a waste of money for the organization

____ 13 There are sufficient existing services in the workplace/organizations for people with mental health issues

____ 14 People with mental health issues should not be given any significant responsibility at work

____ 15 It would be unwise for a manager to promote someone who has suffered from mental health issues, even though they seem fully recovered

____ 16 I would not want to work in the same office with a colleague who has mental health issues

____ 17 Anyone with a history of mental health issues should be excluded from taking leadership positions

____ 18 No-one has the right to exclude people with mental health issues from their team

____ 19 Employees with mental health issues are far less of a danger than most people suppose

____ 20 Employees who were once patients in a mental hospital can be trusted in the workplace for significant responsibilities

____ 21 The best therapy for many people with mental health issues is to be part of the working life of an organization

____ 22 As far as possible, mental health services should be provided as benefit at work to all.

____ 23 Employees have nothing to fear from co-workers with mental health issues using the premises of their organization to obtain mental health services.

____ 24 It is frightening to think of people with mental health issues working closely with you in projects

____ 25 Locating mental health facilities inside the company downgrades the organization

____ 26 People with mental health issues should have the same rights at a job as anyone else

____ 27 One of the main causes of mental health issues is a lack of self-discipline and willpower

Appendix K

Scale for Empathy with Definitions

Section C

Please read the statements carefully, and rate from 1 – 7, the extent to which you are experiencing each of the following feelings for the person who has mental health issues at work:

I do not experience this feeling at all	I feel this feeling very slightly	I feel this feeling slightly	I feel this feeling moderately	I feel this feeling quite a bit	I feel this feeling very much	I feel this feeling extremely
1	2	3	4	5	6	7

____ **sympathetic** (Feeling concern about someone who experiences a negative/difficult situation)

____ **compassionate** (The feeling that arises when you are confronted with another's suffering and feel motivated to relieve that suffering)

____ **warmth** (Liveliness of feelings, emotions, that are characterized as warm)

____ **softhearted** (Has a very sympathetic and kind nature, without criticism and judge)

____**tender** (Very loving and gentle: showing affection and love/care for someone)

____ **moved** (Being affected with emotion or passion; touched)

Appendix L

Item for Self-Confidence

Section D

Please read the question below and rate the statement with a number between 1-5, for the scale that is provided below:

Not at all confident	Somewhat not confident	Neutral	Somewhat Confident	Extremely Confident
1	2	3	4	5

____ How confident do you feel in coming into contact at work with someone that has mental health issues?

Appendix M

Demographics Form

1. What best describes your gender?
    a. Male
    b. Female
    c. Other
    d. Prefer not to say
    e. Prefer to self-describe _____

2. What is your age? _____

3. How close have you come into contact with issues of mental health (mild or intense)?
    a. I have experienced personally mental health issues
    b. A close friend or a family member has faced mental health issues
    c. I know that an acquaintance of me has issues with mental health
    d. I have not come into contact with somebody that I know that they are having mental health issues

4. What is your ability in **reading** in English?

1 2 3 4 5 6 7

Almost none Native speaker ability

5. What is your ability in **understanding** English?

1 2 3 4 5 6 7

Almost none Native speaker ability

6. What is your ability in **writing** in English?

1 2 3 4 5 6 7

Almost none Native speaker ability

7. It would be very helpful if you could tell us at this point whether you have taken part seriously, so that we can use your answers for the scientific analysis.
    A I have taken part seriously
    B I have just answered randomly, please throw my data away.

Appendix N

Debriefing Form

The purpose of this study is to reduce the stigma that exists in the workplace regarding people with mental health issues, creating a more inclusive workplace. It should be noted that mental health issues, include symptoms of poor psychological state and not clinical cases that does not allow individuals to be capable to work. The current project, there were three conditions with different interventions. In the first one, participants engaged with a role player acting as a colleague experiencing mental health issues in the workplace. Throughout the interaction, the role player was referring to the challenges somebody with mental health issues can face at work as colleague, in order to elicit emotions of empathy, emphasizing at the same to their competence for the role. Also, during the interaction, feedback was giving to the participant for their actions for their effort in order to increase the self-confidence of the individual to approach someone with mental health issues again. The second condition, involved a conversation with a role player experiencing mental health issues, but there was no reference to any challenges, in order not to elicit any feelings and thoughts of empathy and just have a neutral contact together, as well as there was no effort to increase self-confidence. In the third condition, the person had to read just a story with experiences of an individual in the workplace who suffers from mental health (without a role-play), in order to induce feelings of empathy. Based on the literature, contact is essential in order to reduce stigma, and the way through which this is happening, is through the empathetic feelings. The reduction of stigma in the current study is addressed via measuring the intention of the individual to approach somebody with mental health issues at work as well as the attitudes towards people with

mental health issues, which were the two main outcome variables that I was measuring through the scales. In addition, the roles of self-confidence and empathy were investigated, in order to understand their impact on the relationship between contact and stigma. Hence, the hypotheses of the study are the following:

H1: Participants in the contact conditions (role play) (condition 1 & 2) will demonstrate significantly better scores on attitude towards employees with mental health issues, and behavioral intention towards people with mental health issues in the workplace, compared to those who do not undergo the intervention with the contact, with condition sowing significantly better results than all of them.

H2: It is hypothesized that empathy will be positively correlated with Behavioral Intention and with better Attitudes towards employees with mental health issues. It is also expected for higher scores to be related with the presence of contact.

H3: It is hypothesized that empathy will mediate the relationship between contact and the two dependent variables (Behavioral Intention and the Attitudes)

H4: It is hypothesized that self-confidence will moderate the relationship between contact and the two dependent variables (Behavioral Intention and the Attitudes)

Also, be informed that in case you have experienced any distress you can communicate with the Ψ-Δίκτυο (https://psy-diktyo.gr/).

Finally, we would like to kindly ask not to disclose any information about the projects to other possible participants, as it might affect the results, due to the nature of the study.

If you have any questions, please contact me at N.Pavlaki@acg.edu.

THANK YOU VERY MUCH FOR YOUR PARTICIPATION AND YOUR TIME!