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COLLEGE OF EDUCATION AND LANGUAGE STUDIES

SCHOOL OF PSYCHOLOGY

**Relationship Between Spiritual Beliefs and Perceptions of Mental Health Stigma: A Case
Study of Employees at Pinnacle Business Group, Ethiopia**

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**Relationship Between Spiritual Beliefs and Perceptions of Mental Health Stigma: A Case
Study of Employees at Pinnacle Business Group, Ethiopia**

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Relationship Between Spiritual Beliefs and Perceptions of Mental Health Stigma: A Case Study
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Abstract

This study aims to explore the relationship between spiritual beliefs and perceptions of mental health stigma among employees at Pinnacle Business Group, a holding company in Ethiopia, and examined how spiritual interpretations of mental illness influence workplace attitudes toward mental health. A mixed-methods cross-sectional convergent design was employed, combining quantitative and qualitative approaches to provide a comprehensive understanding of the phenomenon. Quantitative data were collected from all 30 employees through a structured questionnaire using a census sampling approach, while qualitative data were gathered through in-depth interviews with 10 purposively selected participants using a semi-structured interview guide. Quantitative data were analyzed using descriptive and inferential statistical techniques, whereas qualitative data were analyzed thematically to identify recurring patterns and perspectives. The findings revealed that employees held moderately high levels of spiritual beliefs regarding mental illness and moderate levels of mental health stigma. Correlation analysis indicated a statistically significant positive relationship between spiritual beliefs and mental health stigma ($r = 0.52, p < 0.05$), suggesting that employees who more strongly endorsed spiritual explanations of mental illness were more likely to express stigmatizing perceptions. The qualitative findings further revealed the existence of a dual belief system in which mental distress was understood through both spiritual and biomedical frameworks, while organizational silence surrounding mental health contributed to the persistence of stigma in the workplace. The study concludes that perceptions of mental health stigma among employees are shaped by the interaction of spiritual beliefs and workplace culture and recommends the development of workplace mental health interventions that recognize employees' spiritual perspectives while promoting evidence-based mental health awareness, open dialogue, and support mechanisms.

Keywords: Spiritual beliefs, Mental health stigma, Mental health perceptions, Workplace mental health, Employees, Ethiopia

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Table of Contents

Abstract	i
Acknowledgements.....	ii
List of Tables	vi
List of Figures	vii
Chapter One: Introduction.....	1
1.1 Background of the Study	1
1.1.1 Historical Background	1
1.1.3 Conceptual Background	2
1.1.4. Empirical and Workplace Context.....	2
1.1.5. Personal and Contextual Motivation	3
1.2 Statement of the Problem	3
1.3 Objectives and Research Questions.....	4
1.3.1 General Objective	4
1.3.2 Specific Objectives	4
1.3.3 Research Questions	4
1.4 Significance of the Study	5
1.4.1 Theoretical Significance	5
1.4.2 Practical Significance.....	5
1.4.3 Policy Significance	5
1.4.4 Research Significance.....	6
1.5 Operational Definition of Key Terms	6
1.6 Limitations of the Study	7
1.7 Delimitations of the Study	7
1.8 Organization of the Study	7
Chapter Two: Review of Related Literature.....	9
2.1 Introduction	9
2.2 Conceptual Review.....	11
2.2.2 Concept of Mental Health Stigma.....	13
2.3 Spiritual Beliefs and Mental Health	16
2.3.1. Positive Contributions of Spirituality	17
2.3.2. Negative Contributions of Spirituality	17
2.4 Relationship Between Spiritual Beliefs and Mental Health Stigma	19

2.5 Workplace Mental Health Stigma	21
2.6 Mental Health and Spiritual Beliefs in Ethiopia	25
2.7 Empirical Review of Related Studies.....	29
2.7.1 Global Empirical Studies	29
2.7.2 Empirical Studies in Africa.....	30
2.7.3 Empirical Studies in Ethiopia.....	31
2.7.4 Workplace Empirical Studies	37
2.8 Methodological Review	38
2.9 Theoretical Framework.....	40
2.10.1 Stigma Theory	40
1.10 Conceptual Framework of the Study.....	41
Chapter Three: Methods.....	44
3.1 Research Design	44
3.2 Study Area	44
3.3 Study Population.....	45
3.4 Sampling Technique and Sample Size	45
3.4.1 Quantitative Component	45
3.4.2 Qualitative Component.....	46
3.5 Data Collection Instruments	47
3.5.1 Structured Questionnaire	47
3.5.2 Semi Structured Interview Guide.....	48
3.6 Data Collection Procedure	49
3.6.1. Quantitative Data Collection Procedure	49
3.6.2. Qualitative Data Collection Procedure	50
3.7 Pretest and Reliability Test of Instruments.....	50
3.8 Data Analysis	51
3.8.1 Quantitative Data Analysis.....	51
3.8.2 Qualitative Data Analysis	52
3.9 Ethical Considerations.....	53
Chapter Four: Result and Discussion	54
4.1 Quantitative Results.....	54
4.1.1 Response Rate.....	54
4.1.2 Socio-demographic Characteristics.....	54

4.1.3 Descriptive Analysis for Spiritual Beliefs about Mental Health Problems (RQ1)	55
4.1.4 Descriptive Analysis for Level of Mental Health Stigma (RQ2)	56
4.1.5 Relationship Between Spiritual Beliefs and Mental Health Stigma (RQ3)	56
4.2 Qualitative Findings	57
4.3 Discussion of Key Findings	58
4.3.1 Spiritual Beliefs About Mental Health Problems	58
4.3.2 Level of Mental Health Stigma	59
4.3.3 Relationship Between Spiritual Beliefs and Mental Health Stigma	59
4.3.4 Organizational and Cultural Factors Shaping Attitudes	61
4.4 Integration of Quantitative and Qualitative Findings	62
Chapter Five: Summary, Conclusion and Recommendation	63
5.1 Summary of the Study	63
5.2 Conclusion	63
5.3 Limitations of the Study	64
5.4 Recommendations	64
5.4.1 Organizational Level Recommendations	64
5.4.2 Culturally Sensitive Interventions	64
5.4.3 Policy Level Recommendations	65
5.4.4 Recommendations for Future Research	65
5.5 Final Remark	65
References	66
Appendices	69
ANNEX I: Questionnaire	69
ANNEX II: Semi Structured Interview Guide	71
ANNEX III: Consent Form	71
ANNEX IV: SPSS Variable Coding Sheet	72
ANNEX V: Reliability Test Output	72
ANNEX VI: Ethical Clearance Summary	72

List of Tables

Table 1: Forms of Mental Health Stigma	9
Table 2: Common Spiritual Interpretations of Mental Illness in Ethiopia.....	28
Table 3: Summary of Related Studies on Mental Health Stigma and Help-Seeking in Ethiopia.	35
Table 4: Key policy and WHO reports relevant to Ethiopia’s mental health.	36
Table 7: Descriptive Statistics of Spiritual Beliefs	55
Table 8: Descriptive Statistics of Mental Health Stigma.....	56
Table 9: Correlation Between Spiritual Beliefs and Mental Health Stigma.....	56
Table 10: Integrated Summary of Findings	62

List of Figures

Figure 1: Ethiopian Mental Health Policy Timeline.....	32
Figure 2: Estimated fraction of Ethiopian mental health patients receiving modern treatment (from Asnakew et al., 2024).	33
Figure 3: Conceptual Framework of the Study	42
Figure 4 : Relationship Between Spiritual Beliefs and Workplace Mental Health	43

Chapter One: Introduction

1.1 Background of the Study

1.1.1 Historical Background

In many Ethiopian communities, psychological distress has historically been interpreted through supernatural and religious frameworks. Mental illness has often been associated with beliefs such as spirit possession, divine punishment, or moral wrongdoing, which continue to influence perceptions of mental health in contemporary society. These traditional interpretations coexist with modern biomedical understandings, shaping how individuals and communities respond to psychological distress.

At the global level, mental health has increasingly been recognized as a critical component of overall wellbeing and human development. Contemporary health discourse has shifted from viewing mental health as simply the absence of mental illness to understanding it as a dynamic state of psychological, emotional, and social wellbeing that enables individuals to function effectively in daily life, manage stress, and contribute productively to society (World Health Organization, 2022).

1.1.2. Theoretical Background

This study is grounded in the understanding that mental health perceptions and stigma are shaped by cognitive and social processes. Attribution Theory provides a key theoretical lens for explaining how individuals interpret the causes of mental illness. When mental health conditions are attributed to supernatural, moral, or spiritual causes, they are more likely to generate fear, blame, and social distance, contributing to stigmatizing attitudes.

In addition, stigma theory explains how labeling and stereotyping of individuals with mental health conditions can lead to discrimination and exclusion, particularly in social and workplace settings. These theoretical perspectives highlight how beliefs about the causes of mental illness influence attitudes and behaviors toward affected individuals.

1.1.3 Conceptual Background

Conceptually, this study focuses on the relationship between spiritual beliefs and mental health stigma within workplace settings. Spiritual beliefs refer to religious, cultural, and supernatural explanations used to understand mental health conditions. Mental health stigma refers to negative attitudes, stereotypes, and discriminatory behaviors directed toward individuals experiencing mental health problems.

These two constructs are examined within the organizational context, where workplace culture, awareness levels, and institutional support systems may shape how mental health is understood and addressed. The study also considers how stigma may influence workplace interactions, disclosure of mental health conditions, and support-seeking behaviors among employees.

1.1.4. Empirical and Workplace Context

Globally, mental and substance use disorders account for a significant proportion of years lived with disability and represent a major public health and socioeconomic concern (GBD Mental Disorders Collaborators, 2022). These conditions are particularly prevalent among the working-age population and contribute to reduced productivity, absenteeism, and presenteeism, thereby affecting organizational performance and economic output (Harvey et al., 2017; OECD, 2021).

In Ethiopia, workplace mental health support remains limited due to resource constraints, shortages of mental health professionals, and weak integration of mental health services into existing systems (Fekadu et al., 2019; World Health Organization, 2022). Within this context, mental health stigma remains a major barrier to help-seeking behavior. Stigma is characterized by negative attitudes, stereotypes, and discriminatory behaviors toward individuals with mental illness (Corrigan, 2016), and it significantly influences whether individuals disclose or seek support for mental health challenges.

Spiritual and religious beliefs also play a central role in shaping understandings of mental illness in Ethiopia. Mental health conditions are frequently explained through supernatural interpretations such as spirit possession or divine punishment (Abera et al., 2015; Teferra & Shibre, 2020). While such beliefs may offer emotional comfort and coping mechanisms, they may also reinforce stigma and discourage individuals from seeking biomedical treatment or formal psychological support.

1.1.5. Personal and Contextual Motivation

The motivation for this study also arises from my personal observation of how spiritual interpretations of mental health can shape workplace attitudes and responses toward individuals experiencing psychological distress. These experiences highlighted the need to better understand how cultural and spiritual belief systems interact with organizational environments to influence stigma, disclosure, and support-seeking behavior among employees.

1.2 Statement of the Problem

Public awareness of mental health in Ethiopia has improved in recent years, while mental health stigma continues to limit help-seeking, disclosure of psychological distress, and use of available mental health services. Many individuals continue to avoid professional support, which affects wellbeing and contributes to worsening psychological outcomes.

Workplace environments, particularly within private sector organizations, involve performance expectations, interpersonal interactions, and concerns about judgment from colleagues and supervisors. These conditions influence how employees perceive and respond to mental health challenges within the workplace setting. Limited understanding remains regarding how mental health stigma is experienced and expressed in Ethiopian organizational contexts, especially within private companies.

Spiritual and religious beliefs play an important role in shaping interpretations of mental health in Ethiopia. These belief systems influence how individuals understand the causes and treatment of mental illness. The relationship between these beliefs and mental health stigma within workplace environments has not been sufficiently examined.

Workplace mental health in Ethiopian private sector organizations remains underexplored, with limited evidence drawn from specific organizational settings. Little is known about how employees interpret mental health issues within their day-to-day workplace experiences and how these interpretations influence attitudes and behavior.

From a personal academic perspective, this study was motivated by the need to understand how cultural and spiritual belief systems shape perceptions of mental health within organizational environments and how these perceptions relate to workplace stigma.

This study addresses these gaps by examining the relationship between spiritual beliefs and mental health stigma among employees at Pinnacle Business Group using a mixed methods case study approach. The study combines quantitative and qualitative evidence to generate statistical findings and contextual understanding that can inform culturally sensitive workplace mental health strategies.

1.3 Objectives and Research Questions

1.3.1 General Objective

“To examine the relationship between spiritual beliefs and mental health stigma among employees in Ethiopia’s private sector, using Pinnacle Business Group as a case study”.

1.3.2 Specific Objectives

1. *To assess employees’ spiritual beliefs regarding mental health problems*
2. *To examine the level of mental health stigma among employees*
3. *To analyze the relationship between spiritual beliefs and mental health stigma*
4. *To explore employees’ perceptions of mental health awareness and support within the workplace*
5. *To identify organizational and cultural factors influencing attitudes toward mental health*

1.3.3 Research Questions

1. What spiritual beliefs about mental health problems are held by employees at Pinnacle Business group?

2. What is the level of mental health stigma among employees at Pinnacle Business group?
3. What relationship exists between spiritual beliefs and mental health stigma?
4. How do employees at Pinnacle Business group perceive workplace mental health awareness and support?
5. What organizational and cultural factors shape Pinnacle Business group employees' attitudes toward mental health?

1.4 Significance of the Study

1.4.1 Theoretical Significance

It contributes to the understanding of how spiritual beliefs influence perceptions of mental illness in low and middle-income countries especially in the workplace area and also contributes to stigma theory by highlighting the interaction between cultural belief systems and workplace mental health

1.4.2 Practical Significance

It practically helps in better understanding of employees' perceptions of mental health and the factors contributing to stigma in the workplace area and will support the development of workplace mental health programs support systems that are culturally appropriate.

1.4.3 Policy Significance

It provides useful insights for policymakers, mental health professionals, and organizational leaders seeking to promote workplace mental health in Ethiopia by contributing to the development of organizational policies and national strategies aimed at reducing mental health stigma and improving access to mental health support services in workplace settings.

1.4.4 Research Significance

This thesis addresses an important gap in the Ethiopian mental health literature by focusing on workplace mental health stigma within the private sector by serving as a foundation for future research examining mental health.

1.5 Operational Definition of Key Terms

- I. **Mental Health Stigma:** In this study, mental health stigma refers to employees' negative perceptions, stereotypes, and discriminatory attitudes toward individuals experiencing mental health problems, as measured using responses from the structured questionnaire and supported by qualitative interview data.
- II. **Spiritual Beliefs:** In this study, spiritual beliefs refer to employees' religious, cultural, and supernatural explanations regarding the causes, meaning, and treatment of mental health problems, as assessed through the spiritual beliefs scale and participants' interview responses.
- III. **Perceptions of Mental Health Stigma:** In this study, perceptions of mental health stigma refer to employees' subjective views and understandings of how mental illness is viewed, discussed, and treated within the workplace environment.
- IV. **Workplace:** In this study, workplace refers specifically to Pinnacle Business Group, a holding company in Ethiopia, where the data were collected.
- V. **Employee:** In this study, an employee refers to any individual formally employed at Pinnacle Business Group at the time of data collection and included in either the quantitative census or qualitative interview sample.

- VI. **Mental Health:** In this study, mental health refers to the psychological, emotional, and cognitive well-being of individuals, particularly in relation to stress, distress, and mental illness as perceived within the workplace context.
- VII. **Mixed Belief System:** In this study, mixed belief system refers to the coexistence of spiritual and biomedical explanations of mental illness among employees, as identified in qualitative interview findings.

1.6 Limitations of the Study

The limitations of this thesis are that it focused only on a single private organization, this limits the generalizability of the findings to other organizations or sectors in Ethiopia and it relied on self-reported data, which can be influenced by social desirability bias, especially considering the sensitive nature of mental health issues. Also, the cross-sectional design of the thesis limited the ability to establish causal relationships between spiritual beliefs and mental health stigma.

1.7 Delimitations of the Study

It is limited to employees working at Pinnacle Business Group and focused specifically on the relationship between spiritual beliefs and mental health stigma within a private sector workplace setting, it only considered perceptions related to mental health rather than clinical diagnosis or treatment outcomes. This research only focused on employed adults within the private sector and did not include public sector institutions or unemployed populations.

1.8 Organization of the Study

- Chapter 1 presents the introduction section, including the background of the study, statement of the problem, objectives, research questions, significance of the study, definitions of key terms, limitations, delimitations, and organization of the study.

- Chapter 2 reviews relevant theoretical, empirical, and methodological literature related to spiritual beliefs and mental health stigma.
- Chapter 3 describes the research methodology, including the research design, sampling procedures, data collection instruments, data collection procedures, and methods of data analysis.
- Chapter 4 presents the findings of the study and discusses the quantitative and qualitative results.
- Chapter 5 summarizes the major findings, presents conclusions, discusses limitations, and provides recommendations for practice and future research.

Chapter Two: Review of Related Literature

2.1 Introduction

This chapter presents a review of literature related to mental health stigma, spiritual beliefs, and workplace mental health, with particular emphasis on how these concepts interact within organizational environments. The review includes theoretical literature, empirical studies, methodological perspectives, and contextual discussions relevant to Ethiopia and other comparable settings. The purpose of this chapter is not only to summarize existing knowledge but also to critically analyze previous findings, identify inconsistencies and limitations in the literature, and establish the foundation for the present study.

Globally, mental health has increasingly become an important public health, social, and organizational issue. International organizations such as the World Health Organization recognize mental health as a fundamental component of overall wellbeing, productivity, and social functioning. In recent years, growing attention has been given to the impact of mental health problems on workplaces, economies, and organizational performance. Conditions such as depression, anxiety, burnout, and work-related stress have been associated with absenteeism, reduced concentration, lower productivity, and decreased employee engagement. Despite these developments, attitudes toward mental illness continue to vary significantly across societies due to differences in cultural beliefs, religious values, and social norms.

In many African societies, including Ethiopia, mental health is not always understood through biomedical or psychological frameworks alone. Instead, interpretations of mental illness are often shaped by spiritual, religious, and traditional belief systems. Mental illness be viewed as the result of supernatural forces, curses, spirit possession, divine punishment, or moral failure. Such beliefs are deeply embedded within social and cultural structures and influence how individuals respond to psychological distress, where they seek help, and how communities treat people experiencing mental health problems.

Within the Ethiopian context, spirituality and religion play a central role in daily life and social identity. Religious institutions, traditional healers, holy water sites, and spiritual leaders often serve as important sources of emotional and psychological support. While these systems provide

comfort, meaning, and community support, they also contribute to misunderstandings about mental illness when psychological conditions are interpreted primarily as spiritual problems rather than health conditions requiring professional intervention. This creates a complex relationship between spiritual beliefs, stigma, and help seeking behavior.

From my observation of workplace environments in Ethiopia, mental health remains a sensitive and relatively neglected issue within many organizations. Discussions related to emotional distress, anxiety, depression, or psychological exhaustion are often avoided in professional settings. Employees fear being labeled as weak, unstable, or incapable if they openly discuss mental health challenges. In many workplaces, psychological difficulties are viewed as personal weaknesses rather than legitimate health concerns. As a result, employees choose to remain silent, suppress emotional distress, or seek informal support rather than professional help.

In private sector organizations, these challenges become even more significant due to performance expectations, competition, and concerns about career advancement. Employees worry that disclosing mental health problems could negatively affect how supervisors, managers, or colleagues perceive them. Mental health stigma contributes not only to individual suffering but also to reduced organizational productivity, lower employee morale, poor teamwork, and increased workplace stress.

Despite the increasing growth of Ethiopia's private sector and the global expansion of workplace mental health research, there remains limited empirical evidence examining how spiritual beliefs influence mental health stigma within Ethiopian organizational settings. Most previous Ethiopian studies have focused on community attitudes, healthcare settings, or general public perceptions, with relatively little attention given to workplace environments and employed populations. In addition, many previous studies rely primarily on quantitative methods, limiting deeper understanding of employees lived experiences and organizational realities.

This chapter therefore reviews literature related to mental health stigma, spiritual beliefs, workplace mental health, and help seeking behavior from global, African, and Ethiopian perspectives. The review also examines relevant theoretical frameworks and methodological approaches used in previous studies. By integrating these discussions, the chapter establishes the conceptual and empirical foundation for examining the relationship between spiritual beliefs and mental health stigma among employees at Pinnacle Business Group.

2.2 Conceptual Review

Mental health is widely recognized as one of the fundamental components of overall human health and wellbeing. It affects how individuals think, feel, behave, relate to others, and cope with everyday life situations. Unlike traditional views that define health merely as the absence of disease, modern perspectives emphasize that mental health involves emotional, psychological, and social wellbeing. According to the World Health Organization, mental health refers to a state of wellbeing in which individuals realize their abilities, cope effectively with the normal stresses of life, work productively, and contribute meaningfully to their communities (WHO, 2022).

This definition highlights that mental health is not limited to severe psychiatric conditions alone. Rather, it exists on a field ranging from psychological wellbeing to psychological distress and mental illness. An individual may not have a diagnosed mental disorder but may still experience emotional difficulties, stress, burnout, anxiety, or reduced psychological functioning. Similarly, individuals living with mental illness can still maintain meaningful relationships, employment, and social participation when appropriate support systems are available.

Globally, mental health has become an increasingly important public health concern. Mental disorders such as Depression, Anxiety Disorder, bipolar disorder, schizophrenia, and substance use disorders affect millions of people across all regions of the world. According to global estimates, more than one billion people experience some form of mental health condition, making mental illness one of the leading contributors to disability worldwide. In addition to personal suffering, mental health problems are associated with reduced quality of life, social isolation, family conflict, unemployment, and economic hardship.

The economic impact of mental illness has also attracted significant global attention in recent years. The World Health Organization reports that depression and anxiety alone contribute to approximately 12 billion lost workdays every year due to reduced productivity, absenteeism, and presenteeism. This demonstrates that mental health is not only a medical issue but also an economic and organizational concern affecting workplaces, communities, and national development.

Within workplace environments, mental health plays a critical role in employee performance, motivation, creativity, communication, and decision making. Employees who experience positive

psychological wellbeing are generally more productive, engaged, and capable of maintaining healthy interpersonal relationships with colleagues and supervisors. In contrast, employees experiencing untreated psychological distress struggle with concentration, emotional regulation, time management, and teamwork.

Mental health challenges in the workplace can manifest in different ways. Some employees experience chronic stress and burnout due to heavy workloads, unrealistic expectations, or poor organizational support. Others experience anxiety related to job insecurity, financial pressure, or interpersonal conflict within the workplace. If these challenges remain unaddressed, they negatively affect both individual wellbeing and organizational effectiveness. It is further indicated that poor workplace mental health contributes to several organizational problems, including: increased absenteeism, reduced productivity, workplace conflict, employee turnover, low job satisfaction, reduced organizational commitment and presenteeism

From my perspective, mental health in many workplaces, particularly within developing countries such as Ethiopia, is still insufficiently recognized as an organizational issue. Discussions related to stress, anxiety, emotional exhaustion, or depression are often treated as personal matters rather than legitimate workplace concerns. In many organizations, employees are expected to continue performing regardless of emotional difficulties, which discourage open communication and help seeking behavior.

In the Ethiopian context, understanding mental health becomes even more complex because psychological wellbeing is strongly shaped by cultural, religious, and social beliefs. Many individuals interpret emotional distress through spiritual or moral frameworks rather than biomedical explanations. As a result, mental health problems are not always openly discussed or professionally addressed. Instead, individuals seek support through religious practices, spiritual healing, family networks, or traditional coping mechanisms.

Despite these challenges, awareness of mental health is gradually increasing in Ethiopia due to urbanization, globalization, educational expansion, and growing public health attention. Organizations are slowly beginning to recognize that employee mental health affects productivity, organizational climate, and long-term sustainability. However, stigma and limited mental health literacy continue to remain major barriers to progress.

2.2.2 Concept of Mental Health Stigma

Mental health stigma refers to negative beliefs, stereotypes, prejudices, and discriminatory behaviors directed toward individuals experiencing mental illness or psychological distress. It is a social process through which individuals are judged, labeled, excluded, or treated differently because of their mental health condition. Mental health stigma is recognized as one of the major barriers to mental health awareness, help seeking behavior, treatment utilization, and social inclusion across many societies.

The concept of stigma was originally developed by Erving Goffman (1963), who described stigma as a deeply discrediting attribute that reduces an individual from a “whole and usual person” to someone viewed negatively or socially undesirable. According to Goffman, stigma occurs when society labels certain characteristics or conditions as unacceptable, leading affected individuals to experience rejection, discrimination, and social exclusion.

In the context of mental health, stigma often develops because mental illness is misunderstood, feared, or associated with negative stereotypes. Individuals with mental health problems are perceived as dangerous, weak, unstable, incompetent, or unpredictable. These stereotypes contribute to fear, avoidance, and discriminatory behavior within families, communities, schools, healthcare systems, and workplaces.

Modern scholars such as Patrick W. Corrigan et al. (2017) classify mental health stigma into three major forms: public stigma, self-stigma, and structural stigma. These dimensions interact with one another and collectively shape how individuals experiencing mental illness are treated within society.

Public Stigma

Public stigma refers to negative societal attitudes, stereotypes, and discriminatory behaviors directed toward individuals experiencing mental illness. It reflects how society as a whole perceives and reacts to people with mental health conditions.

Public stigma can include beliefs that individuals with mental illness are: dangerous or violent, incapable of making decisions, weak or morally flawed, socially undesirable or unable to work effectively

These attitudes often result in social distancing, exclusion, rejection, and discrimination. For example, individuals experiencing depression or anxiety can be judged as emotionally weak, while individuals with severe mental illness be feared or avoided. In workplace settings, public stigma discourages employees from discussing psychological difficulties because they fear being negatively evaluated by colleagues or supervisors.

In many societies, including Ethiopia, public stigma is strongly influenced by cultural and spiritual interpretations of mental illness. When mental health problems are viewed as curses, divine punishment, or spirit possession, affected individuals face shame, blame, and social rejection.

Self-Stigma

Self-stigma occurs when individuals experiencing mental illness internalize negative societal stereotypes and begin to apply these beliefs to themselves. In other words, individuals accept society's negative views and develop feelings of shame, inferiority, hopelessness, or self-blame.

Self-stigma can have serious psychological consequences because it affects self-esteem, confidence, identity, and motivation. Individuals experiencing self-stigma believe that they are incapable, weak, or unworthy because of their mental health condition. As a result, they avoid seeking help, withdraw socially, or conceal their symptoms from others. Self-stigma is closely associated with: reduced self-confidence, low self-worth, social isolation, poor treatment adherence and delayed recovery

Within workplace environments, self-stigma leads employees to suppress emotional distress or avoid discussing mental health concerns due to fear of appearing unprofessional or incapable.

Structural Stigma

Structural stigma refers to institutional policies, organizational practices, and systemic inequalities that disadvantage individuals experiencing mental illness. Unlike public stigma, which exists at the individual or social level, structural stigma is embedded within systems and institutions.

Structural stigma include: lack of workplace mental health policies, discrimination in hiring or promotion, inadequate mental health services, limited insurance coverage for mental health treatment, absence of organizational support systems or exclusionary workplace cultures

In organizational settings, structural stigma occurs when workplaces fail to provide psychological support, ignore employee wellbeing, or create environments where discussing mental health is discouraged. Employees fear that disclosing mental health problems could affect promotion opportunities, job security, or professional reputation.

In developing countries such as Ethiopia, structural stigma is often intensified by limited mental health infrastructure, shortage of trained professionals, and low investment in workplace mental health programs. Many organizations lack formal systems to support employees experiencing psychological distress.

Mental health stigma has significant social, psychological, and economic consequences. Research by Sarah Clement et al. (2015) demonstrates that stigma negatively affects help seeking behavior, treatment adherence, social participation, and recovery outcomes. Individuals who fear stigma are more likely to conceal symptoms, avoid professional treatment, and rely solely on informal coping mechanisms.

In workplace settings, stigma can negatively affect organizational productivity and employee wellbeing. Employees experiencing psychological distress continue working while emotionally exhausted, leading to presenteeism, reduced performance, burnout, and workplace disengagement. Fear of judgment also prevent employees from accessing available support systems.

From my observation, mental health stigma within many Ethiopian workplaces often operates silently rather than openly. Employees avoid discussing stress, anxiety, or depression because psychological difficulties are frequently associated with weakness or personal failure. In some cases, colleagues sympathize privately while still avoiding open conversations about mental health. This creates an environment where emotional struggles remain hidden and unsupported.

At the same time, it is important to recognize that stigma is not simply the result of ignorance alone. It is also shaped by broader cultural, religious, organizational, and historical factors. Therefore, reducing mental health stigma requires more than awareness campaigns; it also requires

changes in organizational culture, mental health literacy, leadership attitudes, and social beliefs about mental illness.

2.3 Spiritual Beliefs and Mental Health

Spiritual beliefs refer to culturally and socially embedded systems of meaning through which individuals interpret life experiences, suffering, health, illness, and human existence. These beliefs are often shaped by religion, tradition, cultural values, and community practices, and they influence how people understand the causes of illness, emotional distress, and recovery. In many societies, spirituality forms an important part of personal identity and daily life, affecting how individuals respond to difficult experiences such as grief, stress, trauma, and mental illness.

Unlike purely biomedical perspectives, spiritual belief systems often explain illness through supernatural, moral, or religious frameworks. In many non-Western societies, including Ethiopia, mental illness is not always viewed as a medical or psychological condition alone. Instead, emotional and psychological disturbances are interpreted as signs of spiritual imbalance, divine punishment, spirit possession, curses, evil eye, witchcraft, or moral transgression.

Within the Ethiopian cultural context, spirituality and religion play a particularly significant role in shaping people's understanding of health and illness. Ethiopia is a deeply religious society where religious institutions and spiritual practices are strongly integrated into social life. As a result, many individuals rely on spiritual explanations when interpreting mental health problems. Conditions such as depression, anxiety, psychosis, or severe emotional distress can sometimes be viewed as manifestations of spiritual attack or punishment rather than medical conditions requiring professional treatment. Common spiritual interpretations of mental illness in Ethiopia include: spirit possession, divine punishment for wrongdoing, curses or evil eye, witchcraft or supernatural attack, ancestral displeasure, moral or spiritual weakness, and lack of religious commitment

These beliefs significantly influence help seeking behavior and treatment choices. Many individuals experiencing psychological distress first seek support from: religious leaders, holy water sites, traditional healers, prayer groups, family elders or community spiritual practices

In many cases, these forms of support provide emotional comfort, social belonging, and hope. However, reliance on spiritual explanations alone can also delay access to professional mental health care. Research by Harold Koenig (2018) suggests that spirituality has both positive and negative influences on mental health. Rather than viewing spirituality as entirely beneficial or harmful, contemporary research recognizes that spirituality plays a complex and multidimensional role in psychological wellbeing.

2.3.1. Positive Contributions of Spirituality

Spirituality can positively contribute to mental health in several important ways. For many individuals, religious faith and spiritual practices provide emotional strength, meaning, and psychological resilience during periods of stress and suffering. Spiritual communities also provide social support, belonging, and encouragement. Positive contributions of spirituality include: emotional support during difficult life experiences, increased hope and optimism, resilience during stress and adversity, social belonging and community connection, improved coping mechanisms, moral guidance and personal meaning and reduced feelings of loneliness and isolation.

Religious and spiritual practices such as prayer, meditation, fasting, worship, and community gatherings help individuals manage stress and maintain emotional stability. In workplace contexts, spirituality can also support resilience by helping employees cope with work related pressure, uncertainty, and emotional exhaustion.

From my observation, many Ethiopians view spirituality as an important source of psychological comfort. During periods of emotional distress, people often turn to prayer, religious counseling, or spiritual rituals for support before considering professional mental health services. In many cases, these practices help individuals feel emotionally supported and socially connected.

2.3.2. Negative Contributions of Spirituality

Despite its positive aspects, spirituality also contributes negatively to mental health when psychological problems are interpreted exclusively through supernatural or moral frameworks.

Certain spiritual beliefs reinforce misconceptions about mental illness and contribute to stigma, blame, and fear. Negative influences include: reinforcing supernatural explanations of mental illness, delaying biomedical or psychological treatment, increasing stigma and social discrimination, encouraging secrecy and concealment, blaming individuals for their condition, discouraging professional help seeking and promoting fear of social judgment.

For example, when mental illness is viewed as punishment from God or evidence of spiritual weakness, individuals experiencing psychological distress be blamed for their condition. Families also hide affected individuals to avoid shame or community judgment. In some situations, individuals rely solely on spiritual healing methods while delaying or avoiding medical treatment altogether.

Research conducted in Ethiopia demonstrates that many individuals with mental health symptoms seek help primarily through holy water treatment, prayer, or traditional healing systems before accessing formal psychiatric care. Although these systems are culturally meaningful, excessive reliance on spiritual explanations widen the treatment gap and reduce mental health literacy within communities.

The relationship between spirituality and mental health is therefore highly complex. Spiritual beliefs simultaneously provide emotional support while also reinforcing stigma and misunderstanding. This dual role makes spirituality an especially important factor in understanding mental health attitudes within culturally traditional societies such as Ethiopia.

In workplace settings, employees do not leave their cultural and spiritual beliefs outside the organization. Instead, these beliefs continue to shape interpersonal relationships, attitudes toward mental illness, and help seeking behavior within professional environments. Employees who interpret mental illness spiritually are less likely to recognize psychological conditions as medical issues and respond differently to colleagues experiencing emotional distress.

Understanding spiritual beliefs is therefore essential for examining mental health stigma in Ethiopian workplaces. Without considering cultural and spiritual perspectives, workplace mental health interventions fail to address the deeper belief systems that influence employee attitudes and behavior.

2.4 Relationship Between Spiritual Beliefs and Mental Health Stigma

The relationship between spiritual beliefs and mental health stigma is complex, multidimensional, and highly influenced by cultural context. Across different societies, the way individuals interpret the causes of mental illness often shapes how they respond to people experiencing psychological distress. In many traditional and religious communities, mental illness is not always viewed as a medical or psychological condition. Instead, it is understood through spiritual, supernatural, or moral explanations. These interpretations can strongly influence attitudes toward individuals experiencing mental health problems and can either increase or reduce stigma depending on the nature of the belief system.

Research shows that people who strongly endorse supernatural explanations of mental illness are generally more likely to hold stigmatizing attitudes toward affected individuals (Pescosolido & Martin, 2015). In many cases, mental illness is associated with ideas such as spirit possession, curses, divine punishment, witchcraft, or lack of faith. When mental illness is interpreted in these ways, individuals experiencing psychological distress are viewed as dangerous, spiritually weak, morally flawed, or socially undesirable. Such perceptions often contribute to fear, discrimination, and social distancing.

Studies conducted across sub-Saharan Africa consistently demonstrate a strong connection between spiritual attribution and mental health stigma. In several African societies, beliefs about supernatural causes of mental illness remain deeply rooted within cultural and religious traditions. People experiencing mental disorders are sometimes excluded from social activities, denied employment opportunities, or hidden by their families because of shame and fear of public judgment. Research by Oye Gureje et al. (2015) found that supernatural explanations of mental illness significantly predicted stigmatizing attitudes, including fear of interaction, blame attribution, and rejection of biomedical treatment approaches.

One important issue identified in the literature is that spiritual interpretations can influence help seeking behavior. Individuals who believe that mental illness originates from evil spirits or divine punishment are more likely to seek assistance from religious leaders, traditional healers, or spiritual rituals before considering professional mental health services. While these spiritual support systems can provide emotional comfort and social support, they can also delay access to

psychological or psychiatric treatment. In some cases, families spend long periods pursuing spiritual interventions while symptoms worsen due to lack of medical care.

From my observation of Ethiopian society, this issue is highly visible in everyday life. Many people still believe that severe emotional distress or unusual behavior is connected to spiritual forces rather than psychological conditions. It is common for families to first take individuals experiencing mental illness to holy water sites, prayer centers, or traditional healers before seeking professional medical assistance. Although these practices are culturally respected and spiritually meaningful, they also unintentionally reinforce stigma by framing mental illness as something shameful or spiritually abnormal rather than a health condition requiring care and support.

Another important aspect of the relationship between spirituality and stigma is the role of fear and misunderstanding. In communities where mental illness is associated with supernatural danger or curses, individuals experiencing mental health problems can be socially isolated because others fear contamination, unpredictability, or spiritual harm. Such beliefs can create barriers to social inclusion, employment, education, and interpersonal relationships. In workplace settings, employees avoid discussing stress, anxiety, or depression because they fear being misunderstood or labeled negatively by coworkers and supervisors.

The relationship between spirituality and stigma is not entirely negative. It is sometimes believed that spiritual beliefs can also reduce stigma under certain conditions. Some religious traditions emphasize compassion, empathy, forgiveness, communal care, and emotional support. In these contexts, spirituality encourages acceptance and supportive attitudes toward individuals experiencing psychological distress. Faith communities can also sometimes provide emotional resilience, social belonging, and coping mechanisms that help individuals manage stress and mental health challenges.

Harold Koenig (2018) argues that spirituality can serve as an important protective factor for mental wellbeing when it promotes hope, purpose, and social connectedness. Religious communities provide strong support networks that reduce loneliness and encourage emotional healing. Similarly, some spiritual leaders increasingly promote balanced approaches that combine prayer and faith with professional psychological treatment. Such approaches help reduce stigma while encouraging individuals to seek appropriate care.

The literature therefore suggests that spiritual beliefs should not automatically be viewed as harmful or beneficial. Their impact depends largely on how mental illness is interpreted within specific cultural and organizational contexts. Spiritual beliefs become problematic when they encourage blame, fear, discrimination, or rejection of professional treatment. On the other hand, spirituality can become supportive when it promotes understanding, empathy, and emotional support alongside modern mental health care.

Within workplace environments, this relationship becomes especially important because organizational culture interacts with broader cultural beliefs. Employees do not leave their cultural and spiritual beliefs outside the workplace. Instead, these beliefs influence how workers perceive stress, emotional struggles, mental illness, and help seeking behavior. In organizational settings where mental health awareness is limited, spiritual misconceptions can reinforce workplace stigma and discourage open discussion of psychological wellbeing.

In Ethiopia's private sector, where workplace mental health discussions are still relatively uncommon, the interaction between spiritual beliefs and stigma significantly influence employee experiences. Workers experiencing anxiety, burnout, depression, or emotional distress choose silence rather than disclosure due to fear of judgment or misunderstanding. This silence contributes to reduced productivity, presenteeism, emotional exhaustion, and lack of organizational support.

Despite the importance of this issue, relatively few studies have examined how spiritual beliefs influence mental health stigma specifically within Ethiopian workplace environments. Most existing studies focus on community attitudes, clinical populations, or help seeking behavior rather than organizational experiences. This creates a significant research gap that the present study seeks to address by examining the relationship between spiritual beliefs and mental health stigma among employees at Pinnacle Business Group.

2.5 Workplace Mental Health Stigma

Mental health in workplace settings has gained increasing global attention due to its significant impact on employee wellbeing, organizational performance, and national economic productivity. In recent years, organizations, policymakers, and public health experts have increasingly

recognized that mental health is not only a personal issue but also an important workplace and development concern. Healthy employees are generally more productive, motivated, engaged, and capable of maintaining positive working relationships. In contrast, poor mental health can negatively affect both individual performance and organizational effectiveness.

According to the World Health Organization (WHO, 2024), mental health conditions such as depression, anxiety, stress related disorders, and burnout contribute substantially to lost productivity worldwide. Employees experiencing psychological distress often struggle with concentration, decision making, communication, and emotional regulation. These challenges reduce work quality, increase absenteeism, and weaken teamwork within organizations. Globally, depression and anxiety alone are estimated to result in approximately 12 billion lost working days annually, creating major economic consequences for employers and governments.

Within workplace environments, mental health difficulties are often accompanied by stigma and discrimination. Employees experiencing mental health problems frequently encounter negative assumptions about their competence, reliability, emotional stability, and professional capability. Such attitudes influence workplace relationships, performance evaluations, career advancement opportunities, and overall organizational inclusion. Employees experiencing mental health difficulties commonly face: discrimination in workplace interactions, fear of disclosing psychological distress, negative performance evaluations, reduced promotion opportunities, workplace isolation and exclusion, gossip and social labeling and lack of managerial understanding.

These experiences can create emotionally unsafe working environments where employees feel pressured to conceal their struggles rather than seek support. Studies by Evans Lacko et al. (2016) indicate that workplace stigma contributes significantly to presenteeism, which refers to employees remaining physically present at work while functioning below their normal productivity level due to psychological distress. Presenteeism is often less visible than absenteeism but have equally serious organizational consequences. Employees appear present and functional externally while internally experiencing anxiety, exhaustion, emotional burnout, or depression that affects their efficiency and wellbeing.

In many organizational settings, employees avoid discussing mental health concerns because they fear being perceived as weak, incompetent, unstable, or incapable of handling professional

responsibilities. This fear is particularly strong in highly competitive workplaces where performance expectations are high and job security feel uncertain. Employees worry that disclosing emotional difficulties could damage their professional image, reduce trust from supervisors, or negatively affect promotion opportunities.

From my observation, this fear of disclosure is highly relevant in Ethiopian workplace environments. Mental health is still considered a sensitive topic in many organizations, and open discussion about emotional distress remains limited. Employees often prefer to remain silent about stress, anxiety, depression, or burnout because they fear judgment from colleagues or managers. In some cases, individuals even avoid seeking professional support altogether because they worry that others may question their competence or emotional stability. This workplace silence can create several negative consequences. Employees who do not receive appropriate support experience worsening psychological distress, reduced motivation, emotional exhaustion, and declining job performance. Over time, this can affect organizational productivity, employee retention, teamwork, and workplace morale. In addition, untreated mental health problems contribute to interpersonal conflict, increased sick leave, and higher turnover rates within organizations.

Another important issue discussed in workplace mental health literature is organizational culture. Organizational culture refers to the shared values, attitudes, norms, and practices that shape employee behavior within a workplace. Research suggests that supportive organizational cultures significantly reduce mental health stigma and improve employee wellbeing. Organizations that openly discuss mental health, provide psychological support, and encourage help seeking behavior are more likely to create healthy and productive work environments. Supportive workplace environments often include: mental health awareness programs, employee assistance services, confidential counseling support, flexible work arrangements, stress management training, supportive leadership practices and anti-discrimination policies.

These interventions help normalize mental health discussions and reduce stigma within organizations. Workplace mental health initiatives remain underdeveloped in many low and middle-income countries, including Ethiopia. Although awareness of mental health issues is gradually increasing, organizational investment in workplace mental health remains limited. Many companies focus primarily on physical productivity and operational performance while paying relatively little attention to employees' psychological wellbeing. In Ethiopia, many organizations

still lack: formal mental health policies, employee assistance programs (EAPs), workplace mental health awareness initiatives, counseling and psychological support systems, manager training on mental health and structured anti stigma interventions.

As a result, mental health stigma often remains unaddressed within organizational settings. The situation may be even more complicated in private sector organizations where employees often face demanding workloads, competitive environments, and concerns about job security. Under such conditions, workers feel pressure to appear emotionally strong and professionally capable at all times. This can discourage vulnerability, emotional expression, and help seeking behavior.

In Ethiopia's evolving private sector, organizational modernization is occurring alongside strong cultural and spiritual traditions. While companies increasingly adopt modern business practices, employee attitudes toward mental health can still reflect broader societal beliefs and stigma. This creates tension between organizational development and cultural perceptions of mental illness. Employees can work in modern corporate environments while still holding traditional beliefs about psychological distress, spirituality, and emotional suffering.

Existing evidence suggests that many Ethiopian workplaces have not yet fully integrated mental health into occupational health and employee wellness strategies. Compared to physical health and workplace safety, psychological wellbeing receives relatively limited institutional attention. Furthermore, there is little published research specifically examining mental health stigma within Ethiopian workplace settings, particularly in private organizations.

Because of this limited evidence, it remains unclear how employees in Ethiopian organizations experience mental health stigma, how spiritual beliefs influence workplace attitudes, and how organizational culture shapes help seeking behavior. This lack of workplace focused research creates an important gap in both organizational and mental health literature.

The present study therefore seeks to contribute to this area by examining the relationship between spiritual beliefs and mental health stigma among employees at Pinnacle Business Group. Understanding these dynamics is important for developing culturally appropriate workplace mental health interventions that acknowledge both organizational realities and broader sociocultural belief systems.

2.6 Mental Health and Spiritual Beliefs in Ethiopia

Mental health in Ethiopia is deeply influenced by cultural, religious, and spiritual belief systems that shape how individuals understand illness, emotional suffering, and psychological distress. Unlike purely biomedical models that explain mental illness through psychological, neurological, or social factors, many Ethiopian communities interpret mental health conditions through spiritual and supernatural frameworks. These cultural interpretations influence attitudes toward mental illness, patterns of help seeking behavior, and responses toward individuals experiencing psychological difficulties.

Studies conducted in Ethiopia demonstrate that many individuals interpret mental illness through spiritual explanations rather than biomedical perspectives (Fekadu et al., 2019). In many communities, emotional or behavioral disturbances are often viewed as signs of spiritual attack, divine punishment, curses, or supernatural imbalance rather than medical conditions requiring psychiatric care. Such interpretations are strongly connected to Ethiopia's religious traditions, cultural values, and long-standing healing practices.

Common spiritual interpretations of mental illness in Ethiopia include: possession by evil spirits, punishment from God, witchcraft or sorcery, curses and evil eye, ancestral displeasure, spiritual imbalance and moral transgression.

These explanations remain influential across both rural and urban areas and affect people regardless of educational background. Even among individuals who recognize psychological explanations of mental illness, spiritual interpretations often continue to coexist with biomedical understanding. This creates a dual belief system where people simultaneously accept both spiritual and medical explanations of mental health conditions.

From my observation of Ethiopian society, spiritual beliefs remain highly influential in shaping attitudes toward mental illness. In many situations, unusual behavior, emotional breakdown, depression, or psychotic symptoms are first interpreted through religious or supernatural perspectives before being considered medical issues. Families often seek culturally familiar explanations that align with their spiritual beliefs and community values. As a result, individuals experiencing mental illness are frequently directed toward spiritual healing systems before professional mental health services are considered.

Therefore, many individuals first seek support from: religious leaders, holy water sites, traditional healers, family elders, spiritual counselors and community support networks before accessing psychiatric or psychological treatment.

One of the most visible examples of spiritual help seeking in Ethiopia is the widespread use of holy water treatment, especially within Orthodox Christian communities. Individuals experiencing severe psychological distress are commonly taken to holy water sites where religious rituals, prayer, fasting, and spiritual cleansing practices are performed. Similar practices are also found within other religious and traditional belief systems throughout the country.

These spiritual support systems often provide emotional comfort, hope, community support, and a sense of meaning during difficult experiences. Religious institutions and spiritual communities also offer social acceptance and guidance for families dealing with emotional or behavioral problems. In some cases, spirituality helps individuals cope with stress, grief, uncertainty, and emotional suffering.

Research indicates that reliance on spiritual healing practices often delays access to formal psychiatric treatment (Hailemariam et al., 2020). Many individuals spend extended periods pursuing traditional or religious interventions while symptoms continue to worsen. Delayed treatment can increase the severity of mental health conditions and reduce opportunities for early intervention and recovery.

Another important issue is that spiritual interpretations of mental illness unintentionally reinforce stigma. When mental illness is associated with curses, divine punishment, or spiritual weakness, affected individuals are blamed, feared, or socially excluded. Families experience shame and attempt to hide relatives with mental illness to protect family reputation and avoid community judgment.

Despite growing awareness about mental health, stigma remains widespread in Ethiopian society and continues to affect help seeking behavior and social inclusion. Individuals experiencing mental illness commonly face: social exclusion, discrimination, shame and embarrassment, fear of disclosure, gossip and labeling, reduced employment opportunities and reluctance to seek professional help

These forms of stigma create major barriers to mental health care utilization. Many individuals avoid openly discussing emotional distress because they fear being judged, misunderstood, or socially rejected. In workplace settings, employees hesitate to disclose psychological difficulties due to concerns about professional reputation, discrimination, or job security.

From my perspective, mental health stigma in Ethiopia is often reinforced by silence and limited public conversation. Compared to physical illness, mental illness remains less openly discussed and less socially understood. People sympathize more easily with visible physical health problems while reacting negatively or fearfully toward psychological conditions. This contributes to misunderstanding, misinformation, and low mental health literacy within many communities.

The Ethiopian mental health system also faces significant structural and institutional challenges that further limit access to care. Although the government has made efforts to improve mental health services through programs such as the WHO Mental Health Gap Action Programme (mhGAP), mental health infrastructure remains insufficient relative to the country's population needs.

Major challenges facing Ethiopia's mental health system include:

- shortage of trained mental health professionals
- underfunding of mental health services
- limited psychiatric facilities
- concentration of services in urban areas
- low mental health literacy
- inadequate workplace mental health programs
- and limited organizational support systems

These challenges contribute to a large treatment gap, meaning that many individuals' experiencing mental illness do not receive appropriate professional support. At the same time, Ethiopia is undergoing rapid social and economic transformation. Urbanization, modernization, and private sector growth are reshaping workplace environments and social interactions. Traditional cultural and spiritual belief systems continue to remain highly influential. Modern organizational structures often coexist with deeply rooted cultural interpretations of mental illness.

Within workplace environments, employees carry societal beliefs and stigma into organizational settings. Workers experiencing emotional distress remain silent because they fear being viewed as weak, unstable, spiritually troubled, or professionally incapable. This workplace silence can contribute to stress, presenteeism, emotional exhaustion, and reduced productivity.

Mental health stigma cannot be fully understood without considering spirituality, religion, and social context. Similarly, workplace mental health cannot be effectively addressed without understanding the broader cultural environment influencing employee attitudes and behaviors. The following tables summarize important concepts related to mental health stigma and spiritual interpretations in Ethiopia.

Table 1: Forms of Mental Health Stigma

Type of Stigma	Description
Public Stigma	Negative societal attitudes toward individuals with mental illness
Self-Stigma	Internalization of negative stereotypes by affected individuals
Structural Stigma	Institutional discrimination and policy related barriers

Table 2: Common Spiritual Interpretations of Mental Illness in Ethiopia

Spiritual Interpretation	Description
Spirit Possession	Belief that mental illness is caused by evil spirits
Divine Punishment	Belief that illness results from sin or moral failure
Curse/Evil Eye	Belief that supernatural forces cause psychological distress
Witchcraft	Attribution of illness to harmful spiritual practices

The Ethiopian context demonstrates that mental health is closely connected to spirituality, religion, culture, and social structure. Spiritual beliefs continue to shape how mental illness is understood and managed, while stigma remains a major barrier to treatment, disclosure, and social inclusion. At the same time, limited mental health infrastructure and lack of workplace support systems further complicate the situation. Understanding these interconnected factors is therefore essential for developing culturally appropriate mental health interventions, stigma reduction programs, and workplace support systems within Ethiopia's evolving organizational environment.

2.7 Empirical Review of Related Studies

2.7.1 Global Empirical Studies

Empirical research conducted globally has consistently demonstrated that mental health stigma remains one of the most significant barriers to help seeking behavior, treatment adherence, and overall psychological wellbeing. Across different cultural and economic contexts, individuals experiencing mental health problems often face negative labeling, discrimination, and social exclusion, which in turn discourage them from seeking formal psychological support.

A study by Patrick W. Corrigan et al. (2017) found that public stigma significantly reduces the likelihood of individuals seeking professional mental health care, particularly when mental illness is associated with perceptions of weakness, unpredictability, or dangerousness. The study further emphasized that stigma operates through both social attitudes and internalized beliefs, where individuals begin to adopt society's negative views about mental illness, leading to self-stigma and reduced self-esteem.

Similarly, research by Sarah Clement et al. (2015) identified stigma as one of the strongest and most consistent predictors of delayed mental health service utilization across diverse populations. Their findings suggest that even in countries with well-developed mental health systems, stigma continues to be a critical barrier that prevents early intervention and timely treatment.

In workplace contexts, studies by Evans Lacko et al. (2016) highlight that employees frequently avoid disclosing mental health conditions due to fear of discrimination, job loss, or negative career consequences. This concealment often results in reduced productivity, increased absenteeism, and presenteeism, where employees continue working despite poor mental health but perform below their capacity.

Global occupational health literature further indicates that organizational culture, leadership behavior, and workplace mental health awareness programs play a major role in shaping employee attitudes toward mental illness. Supportive workplaces that promote psychological safety and open communication tend to reduce stigma and increase help seeking behavior, while unsupportive environments reinforce silence and avoidance.

Most global studies are conducted in high income countries where mental health services are more accessible and workplace policies are relatively developed. This creates a contextual gap when applying findings to low and middle-income countries, where cultural beliefs and limited mental health infrastructure shape stigma differently.

2.7.2 Empirical Studies in Africa

Empirical studies conducted across Africa reveal that mental health stigma is deeply influenced by cultural, spiritual, and traditional belief systems. In many African societies, mental illness is not only understood as a medical condition but also as a phenomenon influenced by supernatural forces such as witchcraft, ancestral spirits, curses, or divine punishment.

Research by Oye Gureje and colleagues (2015) found that supernatural explanations of mental illness are strongly associated with higher levels of stigma and increased social distance from affected individuals. Individuals who attribute mental illness to spiritual causes are more likely to perceive affected persons as unpredictable, dangerous, or socially undesirable.

Across several African contexts, help seeking behavior is strongly shaped by these belief systems. Many individuals and families initially consult traditional healers or religious leaders before seeking biomedical care. This pattern reflects the strong influence of cultural interpretations of illness and the perceived compatibility of spiritual healing with local worldviews.

Studies from different African countries also show that mental health stigma is reinforced by limited mental health literacy, shortage of mental health professionals, and weak integration of mental health services into primary healthcare systems. These structural limitations contribute to delayed diagnosis, treatment gaps, and continued reliance on non medical explanations of mental illness.

Although there is growing awareness of mental health issues across the continent, workplace focused mental health research remains limited. Most African studies concentrate on community or clinical populations, with relatively little attention given to employees in formal employment sectors. This creates a significant gap in understanding how workplace environments interact with cultural beliefs to shape mental health stigma in African settings.

2.7.3 Empirical Studies in Ethiopia

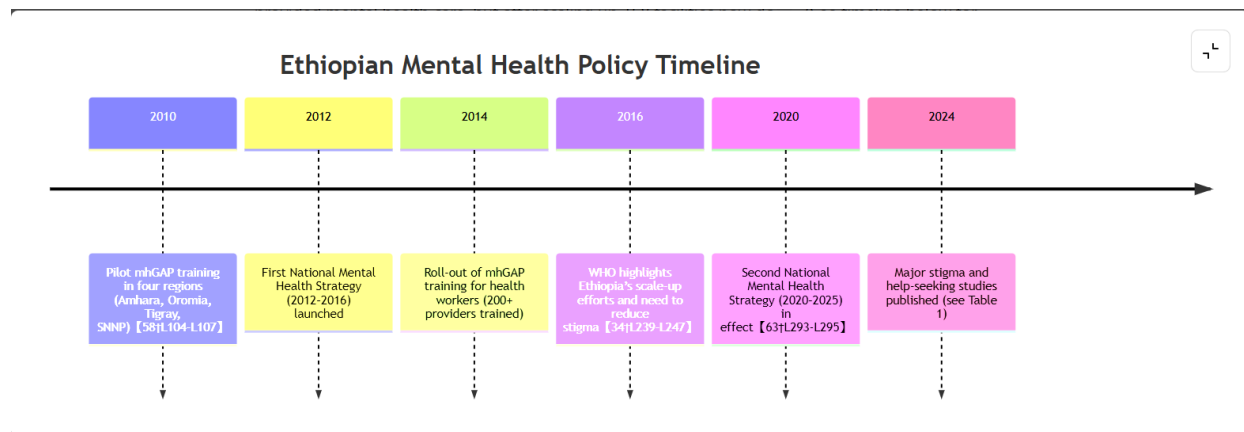
In Ethiopia, empirical research shows that mental health stigma is widespread and strongly influenced by cultural and spiritual beliefs. Studies by Fekadu et al. (2019) and Hailemariam et al. (2020) found that many Ethiopians attribute mental illness to spiritual causes and prefer traditional or religious healing practices. Similarly, research by Reta et al. (2016) reported high levels of public stigma, including social exclusion and discrimination toward individuals with mental illness.

A recent study by Demeke et al. (2025) revealed that a large proportion of individuals with mental health symptoms had never accessed biomedical care, largely due to stigma and reliance on spiritual healing systems. However, most Ethiopian studies: focus on community or clinical populations, use cross sectional quantitative designs, lack workplace focused investigations and rarely examine private sector employees

In Ethiopia mental disorders are common and long neglected. WHO and local reports estimate roughly 15% of Ethiopians have a major mental illness or substance use disorder. For example, depression, anxiety disorders, schizophrenia and bipolar disorders affect many families across the country. Yet Ethiopia has very few specialized providers: as of the late 2010s only a few dozen psychiatrists served over 100 million people (Maclean, 2012). Most care is at the primary level if at all, and mental health has only recently been integrated into primary care.

The Ethiopian Ministry of Health and partners have begun scaling up services. Ethiopia launched WHO's mhGAP program in 2014 and has trained hundreds of non specialist health workers to treat mental illness at clinics. A National Mental Health Strategy (2020–2025) was adopted to further expand community and hospital services (Ministry of Health, 2020). The recent strategy emphasizes integration of mental health into primary care and community services, greater funding, and stigma reduction. For example, a WHO feature story notes that Ethiopia's government has "been increasing the budget for mental health" and working with WHO and partners to implement mhGAP across the country. Ethiopia's mental health program now aligns with WHO guidance to train health staff and expand services nationwide. These policy efforts aim to improve access: for instance, a WHO report states that in 2010–2013 only 19 health facilities provided mental health care, but after scaling up 158 facilities now do. Please see below timeline for key developments:

Figure 1: Ethiopian Mental Health Policy Timeline



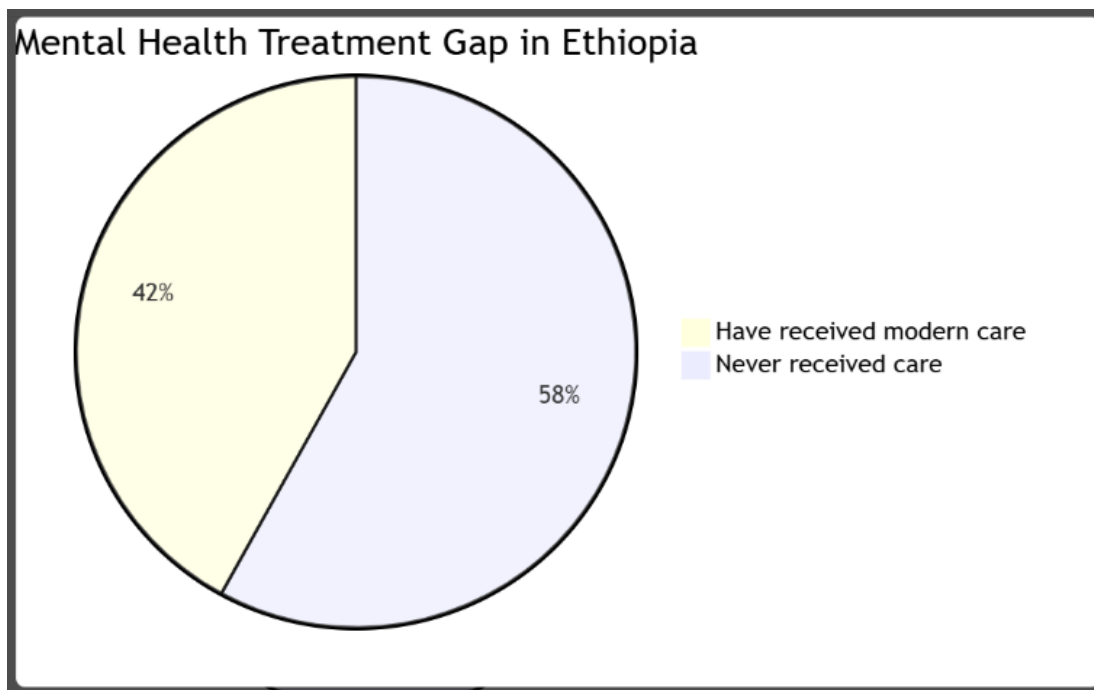
A major feature of the Ethiopian context is the strong role of religion and spirituality in how people interpret illness. Many communities view mental health problems as having supernatural causes. For example, Girma *et al.* (2024) report that Ethiopians “*still viewed mental health problems as curses from God,*” linked to spiritual punishment or evil spirits. This worldview leads many families to seek religious or traditional solutions first. In Orthodox Christian areas, “*holy water*” sites (near churches) are a common treatment: sufferers are brought to priests for prayers and water rites. In fact, a recent study found only 16.8% of Ethiopians who went to holy water sites had ever contacted a medical professional, whereas 61.6% had seen traditional healers. Common beliefs also include that mental illness is caused by witchcraft, evil spirits, or moral failing. Such beliefs can provide emotional comfort or community support, but they also delay formal care. For instance, Girma *et al.* note that victims are often blamed or seen as needing spiritual help, which “*creates stigma*” and fear. Similarly, surveys report that many Ethiopians do not even recognize mental illness as a medical issue: it be seen as bad luck or divine test.

A large proportion of mentally ill individuals in Ethiopia seek help outside the formal health system. Many go first to faith healers, traditional healers or family supports. One study noted that “*the most popular method of treating mental illnesses in Ethiopia is holy water*”. Given this pattern, the formal treatment gap is very large (see next section). Importantly, these cultural factors also reinforce stigma: if mental illness is seen as a curse or moral failing, patients and families hide it to avoid shame.

Social stigma around mental illness is pervasive in Ethiopia. People with conditions like schizophrenia or depression often face discrimination in the community, and even within families. Patients and caregivers report being blamed, insulted, or excluded because of mental illness. For example, Girma *et al.* found that stigma “*may have a variety of adverse impacts on... employment opportunities*” and community participation. Stigma also creates fear: in one survey, virtually all respondents (95.9%) cited “*fear of being perceived as bad parents*” as a barrier to seeking help. In short, many Ethiopians avoid mental health services because they do not want the social label.

These attitudes contribute to a very large *treatment gap*. Demeke *et al.* (2025) reported that 82.2% of patients with mental symptoms at holy water sites had never obtained modern psychiatric care. Likewise, a meta-analysis by Asnakew *et al.* (2024) found only 42.2% of Ethiopians with mental illness ever sought any modern treatment. In other words, about 58% of patients never get medical help. The reasons are cultural beliefs, stigma, and lack of awareness. Worldwide, treatment gaps are also high (WHO estimates ~70% globally do not receive care), but Ethiopia’s gap is exacerbated by its traditional care patterns.

Figure 2: Estimated fraction of Ethiopian mental health patients receiving modern treatment (from Asnakew et al., 2024).



Public health experts emphasize the need for community education. The Frontiers review concludes that “*mobilization of the community*” through awareness campaigns is crucial to improve help seeking. Anti stigma strategies suggested for Ethiopia include training health workers to use respectful language, sharing recovery stories, and engaging religious leaders to provide correct information. Indeed, Girma *et al.* note that “*social contact, lived experience sharing and training of service providers*” are relevant strategies to reduce stigma. However, formal anti stigma campaigns in Ethiopia are still few and often centered in clinics or NGOs.

Within Ethiopian workplaces, stigma likely adds another layer of difficulty. No published study has directly measured stigma at Ethiopian companies, insights from related contexts suggest that employees with mental health issues often hide them. Globally, workers report fear of being seen as weak or unreliable if they disclose mental problems. For example, a recent global survey found 60% of laid off workers did not discuss their mental health for “*fear of being perceived as weak*”. In Ethiopia’s private sector, where jobs can be scarce and performance expectations high, such fears are likely similar or greater. An Ethiopian worker who mentions depression might worry about gossip or even job loss. This dynamic can lead to *presenteeism* (working while ill) and reduced productivity.

Quantitative data on Ethiopian workplace impacts are lacking. The general principles apply: mental health problems can reduce concentration, increase absenteeism, and undermine teamwork. WHO notes that “*lack of effective structures and support at work*” can “*affect a person’s ability to enjoy their work and do their job well*”. In a country where formal employment is growing (private sector employment has been rising with urban economic growth), ignoring mental health in the workplace risks lost productivity and talent. To date, Ethiopian companies have rarely published reports on employee mental wellbeing. Anecdotally, few have formal EAPs or mental health policies. Experts suggest that, as awareness increases, companies could adopt global best practices manager training, employee counselling, and anti stigma education to improve worker health and performance.

Table 3: Summary of Related Studies on Mental Health Stigma and Help-Seeking in Ethiopia

Year	Study (Author)	Design & Sample	Key Findings
2024	Girma et al.	Qualitative study using in-depth interviews (n = 16) in rural Ethiopia	Found that mental illness is often attributed to spiritual or supernatural causes such as curses from God. Stigma was strongly linked to these beliefs, and the study recommended culturally sensitive, context-specific anti-stigma interventions.
2025	Demeke et al.	Cross-sectional survey conducted at holy water sites (n = 393)	Reported that 61.6% of participants relied on traditional healers, while only 17.8% sought care from modern health services. About 82.2% had never accessed formal mental health care, mainly due to stigma and fear of being judged.
2024	Asnakew et al.	Systematic review of 16 studies (pooled sample approximately reported across studies)	Found that only 42.2% of individuals with mental illness in Ethiopia sought modern treatment while 57.8% did not. Key predictors of help-seeking included education level, beliefs about treatment, and social support.

Table 4: Key policy and WHO reports relevant to Ethiopia’s mental health.

Report / Organization	Key Stats / Notes	Recommendations / Actions
WHO (2024), <i>Mental health at work</i>	~15% of working age adults have a mental disorder; 12 billion workdays lost annually to depression/anxiety.	Calls for supportive work environments, manager training, and stigma reduction in workplace.
WHO (2025), News “1 billion+ with mental health conditions”	Over 1 billion people worldwide affected; anxiety/depression are 2nd leading cause of long-term disability.	Urges urgent scale up of mental health services globally; highlights cost of untreated illness (\$1T/year).
WHO (2016), <i>Mainstreaming mental health in Ethiopia</i>	Ethiopia: ~15% population with a mental illness; very few specialists outside Addis Ababa; mental health users are “most marginalized” and stigmatized.	Describes government’s adoption of mhGAP and new funding. Emphasizes political commitment to integrate mental health into primary care.
Ethiopia MoH (2020), <i>National Mental Health Strategy 2020–2025 (NMHSP)</i>	(Not publicly citable); aligns with WHO mhGAP, expands services.	Aims to integrate mental health in PHC, train staff, reduce stigma, and include mental health in NCD programs.
AFSC (2026), <i>Psychosocial Support & Peacebuilding in Ethiopia</i>	Notes Ethiopia’s 2020–2025 mental health strategy; emphasizes stigma reduction.	Recommends integrating mental health/PSS into community, education, and governance; stresses stigma reduction and gender equity.

The timeline above illustrates Ethiopia's mental health policy milestones. Notably, Ethiopia implemented WHO's mhGAP in 2014 and adopted strategic plans in 2012–2016 and 2020–2025. These policies call for scaling up services, integrating care into primary health, and addressing stigma.

Mental health is increasingly recognized as vital to economic development. In Ethiopia, a combination of high need (15% prevalence) and low service capacity has left most patients untreated. Spiritual beliefs and stigma compound the problem: people often turn first to holy water or herbal remedies rather than clinics. Empirical studies confirm very low help seeking rates (e.g. only ~42% seek modern care) and pervasive social fear. In workplaces, these factors likely manifest as silent suffering: employees hide symptoms, leading to presenteeism and disengagement. Data on private companies like Pinnacle Business Group are lacking but the country's cultural patterns suggest that without targeted programs, stigma and belief barriers will similarly undermine workplace wellbeing.

2.7.4 Workplace Empirical Studies

Empirical studies on workplace mental health consistently demonstrate that mental health conditions significantly affect employee performance, organizational productivity, and overall workplace efficiency. Globally, workplace mental health research shows that depression, anxiety, and stress related conditions contribute to absenteeism, reduced concentration, poor decision making, and presenteeism, where employees continue working despite being psychologically unwell but function at reduced capacity.

Studies by Graham Thornicroft emphasize that stigma within workplace environments is a major barrier preventing employees from disclosing mental health challenges. Fear of discrimination, negative performance evaluations, and job insecurity often lead employees to conceal their psychological difficulties, even when organizational support systems exist. Research by Harvey et al. (2017) highlights that workplace mental health problems not only affect individual employees but also have broader organizational consequences, including reduced productivity, increased staff turnover, and financial losses. The study further notes that supportive workplace environments can significantly improve recovery outcomes and reduce the severity of mental health impacts.

Organizational culture is identified as a critical determinant of workplace mental health outcomes. Workplaces that promote open communication, psychological safety, and mental health awareness are more likely to reduce stigma and encourage help seeking behavior. In contrast, workplaces characterized by high pressure, poor management practices, and lack of awareness tend to reinforce silence and concealment of mental health issues.

Despite extensive global evidence, workplace mental health research in low and middle-income countries remains limited. In many African and developing country contexts, formal workplace mental health policies are still emerging, and employee assistance programs are either absent or poorly implemented. This limits employees' access to structured psychological support within organizations.

In Ethiopia specifically, empirical evidence on workplace mental health stigma is extremely scarce. Most available studies focus on general population attitudes or clinical settings rather than employees in organizational environments. As a result, little is known about how Ethiopian employees perceive mental health issues in the workplace, how stigma manifests in organizational interactions, or how spiritual and cultural beliefs influence workplace behavior.

Given Ethiopia's rapidly growing private sector and ongoing economic transformation, workplace mental health is becoming increasingly relevant. However, the lack of empirical workplace-based studies creates a significant knowledge gap that limits the development of effective organizational mental health policies and interventions. This highlights the importance of context specific research that explores how cultural beliefs and workplace dynamics interact to shape employee mental health experiences in Ethiopia.

2.8 Methodological Review

Existing literature on mental health stigma and spiritual beliefs has predominantly relied on quantitative cross sectional survey designs. These designs are widely used because they allow me s to measure the prevalence of attitudes, behaviors, and relationships between variables within a relatively short period of time. Studies in both global and Ethiopian contexts often use standardized

questionnaires and statistical techniques such as correlation and regression analysis to examine the association between stigma, help seeking behavior, and cultural beliefs.

However, while quantitative approaches are useful for identifying patterns and testing relationships between variables, they are limited in their ability to explain the deeper meanings behind those patterns. In the context of mental health stigma, purely quantitative studies often fail to capture how individuals interpret mental illness, how cultural and spiritual belief systems shape those interpretations, and how these beliefs influence everyday workplace interactions. As a result, important contextual and lived experiences remain unexplored.

On the other hand, qualitative studies provide rich, detailed insights into individuals' perceptions, experiences, and meaning making processes. Through methods such as interviews and focus group discussions, qualitative research allows participants to express their views in their own words. This is particularly important in studies of mental health stigma, where cultural beliefs, spirituality, and personal experiences strongly influence attitudes and behaviors. However, qualitative studies are often limited by small sample sizes and lack of generalizability.

Because of these limitations in both approaches, recent methodological literature strongly recommends the use of mixed methods research designs in mental health studies. According to John W. Creswell and Vicki L. Plano Clark (2018), mixed methods research integrates both quantitative and qualitative data within a single study to provide a more complete understanding of complex social phenomena. This approach allows for triangulation, where findings from different methods are compared and validated against each other, thereby improving the credibility and depth of the research.

In the context of this thesis, the mixed methods convergent design is particularly appropriate because it enables the simultaneous examination of statistical relationships between spiritual beliefs and mental health stigma, as well as the exploration of employees lived experiences within the workplace. This integration provides a more holistic understanding of how cultural and organizational factors interact in shaping mental health perceptions among employees. Therefore, the use of a mixed methods approach in this thesis is justified not only by methodological gaps in previous research but also by the need to generate contextually grounded findings that reflect both measurable trends and personal experiences within Ethiopian workplace settings.

2.9 Theoretical Framework

This thesis is guided by two major theoretical perspectives: Stigma Theory and Cultural Attribution Theory. These theories collectively provide a comprehensive explanation of how mental health stigma develops and how spiritual beliefs influence perceptions of mental illness.

2.10.1 Stigma Theory

Stigma theory was originally developed by Erving Goffman (1963), who defined stigma as a deeply discrediting attribute that reduces an individual from a complete and socially accepted person to a “tainted” or “less valued” individual. According to Goffman, stigma is a social process that leads to labeling, stereotyping, separation, and discrimination, ultimately resulting in the loss of social identity and status.

Building on Goffman’s foundation, modern stigma scholars such as Patrick W. Corrigan (2017) expanded stigma theory into three interrelated components:

- Public stigma – societal attitudes and discriminatory behaviors toward individuals with mental illness
- Self-stigma – internalization of negative stereotypes by individuals experiencing mental health problems
- Structural stigma – institutional policies and organizational practices that limit opportunities for individuals with mental illness

In workplace settings, stigma theory explains how employees experiencing mental health challenges face exclusion, negative labeling, or reduced opportunities for advancement. It also explains why employees choose to hide their mental health status due to fear of discrimination or negative career consequences. Within organizational environments, stigma is not only an individual attitude but also a systemic issue embedded in workplace culture and institutional practices.

2.10.2 Cultural Attribution Theory

Cultural Attribution Theory explains how individuals interpret events, health conditions, and behaviors based on culturally learned belief systems. According to this perspective, people do not interpret mental illness purely through biomedical explanations; instead, they assign meaning based on cultural, religious, and spiritual frameworks.

In the Ethiopian context, mental illness is often attributed to a combination of spiritual and supernatural causes, including: evil spirits or spirit possession, divine punishment or moral wrongdoing, curses or witchcraft, social or spiritual imbalance.

These cultural interpretations significantly influence emotional responses, social behavior, and help seeking decisions. When mental illness is viewed as a spiritual or moral issue rather than a medical condition, individuals are more likely to seek help from religious leaders, traditional healers, or family networks instead of professional mental health services.

Cultural Attribution Theory therefore helps explain how deeply rooted belief systems shape stigma formation. In workplace contexts, employees bring these cultural interpretations into their professional environments, influencing how they perceive colleagues with mental health problems and how they respond to psychological distress.

1.10 Conceptual Framework of the Study

Variables of the Study

Independent Variable:

- Spiritual Beliefs

Dependent Variable:

- Mental Health Stigma

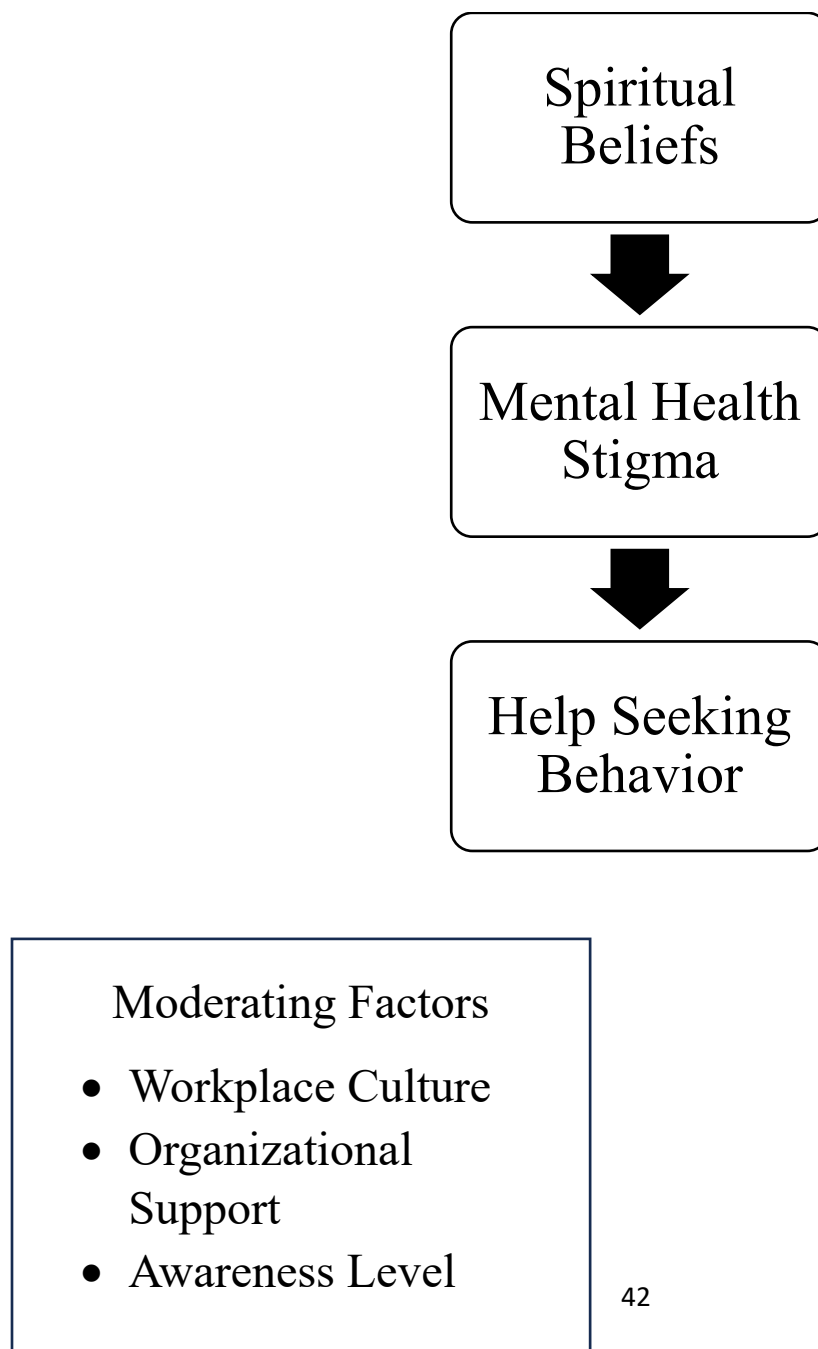
Outcome Variable

- Help Seeking Behavior

Moderating / Contextual Variables:

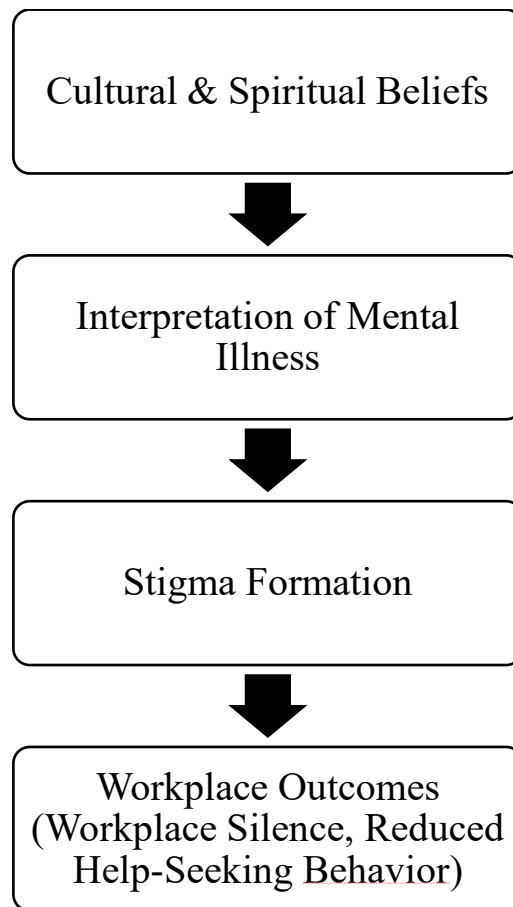
- Workplace culture
- Organizational support
- Mental health awareness level

Figure 3: Conceptual Framework of the Study



The below figure demonstrates how cultural and spiritual beliefs influence interpretation of mental illness, contribute to stigma formation, and affect workplace behavior and employee wellbeing.

Figure 4 : Relationship Between Spiritual Beliefs and Workplace Mental Health



This shows that spiritual beliefs influence how employees interpret mental illness.

Chapter Three: Methods

3.1 Research Design

The choice of this exploratory design was influenced by the nature of the research problem and the need to understand mental health stigma within a real organizational context. This study adopted a mixed methods case study design, focusing on Pinnacle Business Group as a single bounded system. A mixed methods approach was used to integrate both quantitative and qualitative data in order to provide a more comprehensive understanding of the phenomenon. The quantitative component generated numerical data on the level and relationship between spiritual beliefs and mental health stigma, while the qualitative component provided in-depth explanations of participants' perceptions of mental illness, workplace attitudes, and organizational culture related to mental health.

This design was considered good because it allowed me to compare, contrast, and combine findings from both methods study findings. using only a quantitative survey would not have been sufficient for this thesis because attitudes toward mental health in Ethiopia are highly shaped by culture, spirituality, religion, and personal experience and the quantitative data alone could indicate whether stigma exists, So, combining both approaches made it possible to understand both the existence of stigma and cultural and organizational reasons behind it. the quantitative data were analyzed using SPSS version 26, the qualitative data were analyzed using thematic analysis, which involved organizing interview responses into meaningful patterns and themes.

3.2 Study Area

The company I studied works on real estate, trading, manufacturing, hospitality, and related investment sectors, the organization is located in Addis Ababa which is the capital city of the country and hosts a large concentration of private companies and emerging business institutions, this made it a good case study to work on. urbanization and economic modernization continue to expand so workplace expectations in private organizations have also become demanding, competitive, and performance oriented. These changes have impact on employee wellbeing and

mental health so this company was considered relevant because of its diverse workforce, it's gradual transformation as a company and also there was no documented workplace mental health policies and there was a mix of both modern and traditional perspectives in the company. Conducting the thesis at the company, Pinnacle Business Group helped me to explore individual attitudes toward mental health and wider organizational and cultural dynamics that influence these attitudes.

3.3 Study Population

Full-time employees who were in different departments and functional areas were my target population this included administrative operational technical positions and managerial positions, the focus was on employees who has been working there for a minimum period of six months. This was to make sure that participants had enough time to see the organizational environment, and workplace culture influencing both my variables of spiritual beliefs and mental health stigma within the workplace the six months period made sure that responses were based on actual workplace experience and not initial impressions in their early stages of joining the company. the population/employees are characterized as diverse in age, educational background, professional experience, and their cultural and religious beliefs this was important for my thesis because it gave me an opportunity to explore how different personal and cultural backgrounds influence perceptions of mental health and stigma within the same organizational setting.

3.4 Sampling Technique and Sample Size

3.4.1 Quantitative Component

For the quantitative part, a census sampling technique was used with the total number of eligible employees which was 30 individuals that were permanent employees, the census approach was chosen to ensure all target population participated, using a census method had several advantages,

it minimized sampling error because every eligible employee had an equal chance of participating, it increased the representativeness of the data, the validity of statistical analysis was strengthened.

3.4.2 Qualitative Component

For the qualitative part, purposive sampling was used to select participants who were considered most suitable and a total of 10 employees were selected for in-depth interviews. These participants were not chosen randomly; they were intentionally selected from different departments within the company, including administration, finance, human resources, operations, and customer service., and the group included 6 operational staff members, 2 supervisors, 1 team leader, and 1 manager. They all had enough experience in the company to be familiar with its workplace culture and organizational practices, also fortunately for me were willing to share their views on the issue with me. They were selected by,

- i. length of employment
- ii. representation from different departments
- iii. willingness to participate
- iv. exposure to workplace interactions relevant to mental health and organizational culture

Selecting participants based on length of employment was important because it ensured that participants had sufficient exposure to the organizational environment to provide informed perspectives on workplace culture, interpersonal dynamics, and attitudes toward mental health. Employees with longer tenure are more likely to have observed how mental health issues are perceived, discussed, and responded to within the organization over time, including patterns of support, stigma, or silence surrounding affected individuals. This was particularly relevant to the study because the research aimed not only to capture general perceptions of spiritual beliefs and mental health stigma, but also to understand how these perceptions are reflected and reinforced within actual workplace interactions and organizational practices.

The purposive sampling approach was therefore appropriate for the qualitative component because it enabled the deliberate selection of information rich participants who could provide deeper insights into how spiritual beliefs and mental health stigma are experienced and expressed within the workplace context of Pinnacle Business Group.

3.5 Data Collection Instruments

3.5.1 Structured Questionnaire

- i. the questionnaire was designed in a clear and simple format to ensure that All respondents could easily understand and complete it without external influence, thereby reducing interviewer bias
- ii. the questionnaire mainly used a Likert scale format (strongly agree to strongly disagree), which allowed respondents to express the intensity of their opinions in a clear and standard manner. Which made it suitable for statistical analysis and enabled me to quantify levels of spiritual belief and stigma
- iii. where it was possible, items in the questionnaire were adapted from previously validated instruments used in mental health stigma research. These items were then modified to ensure cultural relevance and contextual appropriateness for the Ethiopian workplace setting. Adjustments were made to reflect cultural understanding of mental health and workplace realities within the Ethiopian private sector context

The questionnaire was divided into three main sections:

I. Socio demographic characteristics

The socio demographic section was included to describe the characteristics of respondents and to help identify whether variations in spiritual beliefs and stigma were associated with demographic factors

II. Spiritual beliefs related to mental health

This section included items that assessed participants' agreement with statements related to spiritual and religious explanations of mental illness, including beliefs in supernatural causes, divine punishment, curses, or spiritual influence on psychological wellbeing

III. Mental health stigma attitude within the workplace

This section measured mental health stigma attitudes among employees. These included statements assessing perceptions of individuals with mental illness, willingness to interact and beliefs about workplace competence and reliability of affected individuals.

3.5.2 Semi Structured Interview Guide

A semi structured interview guide was used to collect qualitative data from selected participants; The reason this method was chosen was because it provides flexibility while still keeping that key research themes throughout all the interviews. It also allowed me to ask guiding questions while also giving participants the freedom to talk in their own words; it really helped explore sensitive topics such as mental health stigma and spiritual beliefs

The interview guide's main focus was the following:

- Their general beliefs about mental health and mental illness
- Interpretations of psychological distress Spiritually and culturally
- Perceptions or observations of stigma, discrimination, or support within the workplace
- Openness of the organization regarding mental health issues
- Improving mental health awareness and support in the workplace

3.6 Data Collection Procedure

The data collection process was as follows:

I got permission from the management of the organization. After permission was received, I coordinated with department heads to identify eligible participants who met the inclusion criteria.

All selected participants were informed about the purpose of the study before the data collection started about the procedures involved, and how voluntary their participation is. I clearly explained that participation was not mandatory and that individuals had the right to decline or withdraw from the study at any time without any consequences.

Written informed consent was then obtained from all participants. The consent process clearly mentioned participants responses would be used only for research purposes and would not be shared with management in a way that could identify individual responses.

3.6.1. Quantitative Data Collection Procedure

For the quantitative part,

1. Structured questionnaires were distributed and I explained how to complete the questionnaire and provided clarification where necessary. Participants were given sufficient time to complete the questionnaires privately in order to minimize external influence and reduce response bias.
2. After completion, I collected the questionnaires while making sure confidentiality was kept during collection and handling of completed forms. Each questionnaire was checked for completeness at the point of collection to minimize missing data and ensure data quality.

3.6.2. Qualitative Data Collection Procedure

For the qualitative part,

1. In depth interviews were conducted with selected participants using a semi structured interview guide and at a comfortable location.
2. The interviews took 30 to 45 minutes, I used questions to check key themes in greater depth and with their consent recorded the audio and wrote field notes after so I don't forget clues the audio didn't pick. All identifying information was removed during transcription to maintain anonymity and confidentiality of participants

3.7 Pretest and Reliability Test of Instruments

- i. The pilot study involved five individuals who had similar those of the target population but were not included in the final study sample. 3 people were used to pretest the questionnaire and 2 people were used to assess the semi-structured interview guide and their responses and observations made during the filling of the instruments helped identify areas requiring improvement.
- ii. Based on the feedback received from them i made a few modifications to enhance the quality of the instruments. These included rephrasing unclear items and adapting certain items to better reflect the Ethiopian workplace context. The interview guide was also updated and adjusted.
- iii. The finalized questionnaire was distributed to the 30 respondents included in the quantitative phase of the study. The reliability of the questionnaire scales was then assessed using Cronbach's Alpha coefficient in SPSS.

The reliability test results are presented in **Table 5** below.

Table 5: Reliability Test Results

Scale	Number of Items	Cronbach's Alpha
Spiritual Beliefs Scale	8	0.81
Mental Health Stigma Scale	10	0.84

The results shows that the Spiritual Beliefs Scale recorded a Cronbach's Alpha value of 0.81, while the Mental Health Stigma Scale achieved a value of 0.84. Since both coefficients exceed the recommended threshold of 0.70, the instruments is then considered reliable

3.8 Data Analysis

The data collected were analyzed using both quantitative and qualitative analytical techniques in line with the mixed methods convergent research design this was done because using dual analysis methods helped ensure that statistical relationships and lived experiences were both adequately examined and interpreted.

With the convergent mixed methods design, quantitative and qualitative data were analyzed separately using appropriate analytical procedures and were later integrated during interpretation. Integrating the two data analysis enhanced the credibility, validity, and depth of the study by allowing findings from one method to complement and support those of the other.

3.8.1 Quantitative Data Analysis

Quantitative data obtained from the structured questionnaires were analyzed using SPSS.

1.The data were first coded, cleaned, and entered into the software to ensure accuracy and consistency before analysis which focused on examining both descriptive and inferential statistics in order to address the research objectives of the study.

2.Descriptive statistics, including frequencies, percentages, means, and standard deviations, were used to summarize the socio demographic characteristics of respondents as well as levels of spiritual beliefs and mental health stigma among employees of Pinnacle Business Group.

3. Pearson correlation analysis was conducted to examine the relationship between spiritual beliefs and mental health stigma; this was appropriate because it measures the strength and direction of the linear relationship between two continuous variables

3.8.2 Qualitative Data Analysis

Qualitative data collected through in-depth interviews were analyzed using thematic analysis. The thematic analysis process followed a structured sequence of steps which were,

1.Transcription of recorded interviews

All audio recorded interviews were transcribed verbatim to ensure that participants' responses were accurately captured.

2. Familiarization with the data

I repeatedly read through the transcripts to gain a deep understanding of the content and context of participants' responses

3. Coding of meaningful statements

Statements and ideas related to spiritual beliefs, mental health stigma, and workplace experiences were identified and assigned initial codes

4. Identification of patterns and themes

Related codes were grouped together to form broader categories and emerging themes that reflected recurring ideas across participants

5. Interpretation of emerging themes

The themes were analyzed and interpreted in relation to the research objectives and existing literature

3.9 Ethical Considerations

The following ethical considerations were checked and made sure were followed properly:

Before data collection began, all participants were fully informed about the purpose of the study, the nature of their involvement, and how the data would be used, no employee was forced or pressured to take part in the thesis. All participant gave informed consent before completing the questionnaire or taking part in interviews in which they confirmed that they understood the study and agreed to participate freely. confidentiality was strictly paid attention to and all information was only accessible to me. Personal details were not shared with the organization anyone and the data were reported in aggregated form so that individual responses could not be identified. Anonymity was also checked and done by removing any identifying information from the data set and from the final report. Participants were assigned codes rather than names. The rights of the participants to withdraw anytime was clearly stated and that will not have any negative effect on them. The questions were made sure when designed to be in a respectful and non-intrusive manner, and participants were free to skip any question they did not feel comfortable answering.

Chapter Four: Result and Discussion

4.1 Quantitative Results

4.1.1 Response Rate

30 questionnaires were distributed and were fully completed and returned which resulted in a 100% response rate. This high response rate was achieved because the study used a census approach in which all eligible employees were included in the data collection process.

4.1.2 Socio-demographic Characteristics

Table 6: Socio Demographic Characteristics of Respondents (N = 30)

Variable	Category	Frequency	Percentage (%)
Gender	Male	18	60.0
	Female	12	40.0
Age	20–29	14	46.7
	30–39	10	33.3
	40 and above	6	20.0
Education Level	Diploma	6	20.0
	Bachelor's Degree	18	60.0
	Master's Degree	6	20.0
Work Experience	6 months–2 years	12	40.0
	3–5 years	11	36.7
	6 years and above	7	23.3

Please note that, Age and work experience are in this categorized way to allow comparison of respondents in early, middle, and late career stages this help describe workforce composition and variability in experience levels.

As it is shown in **Table 6** above this below is the detailed description of the table:

Gender of Respondents

60.0% (n = 18) of the respondents were male, while 40.0% (n = 12) were female.

Age Distribution of Respondents

46.7% (n = 14) of respondents were aged 20–29 years, 33.3% (n = 10) were aged 30–39 years, and 20.0% (n = 6) were aged 40 years and above.

Educational Level of Respondents

60.0% (n = 18) held a bachelor's degree, 20.0% (n = 6) held a diploma, and 20.0% (n = 6) held a master's degree.

Work Experience of Respondents

40.0% (n = 12) had 6 months to 2 years of experience, 36.7% (n = 11) had 3–5 years of experience, and 23.3% (n = 7) had 6 years and above.

4.1.3 Descriptive Analysis for Spiritual Beliefs about Mental Health Problems (RQ1)

Table 5: Descriptive Statistics of Spiritual Beliefs

Variable	Mean	Std. Deviation
Spiritual Beliefs Score	3.78	0.62

The results indicate a mean spiritual beliefs score of 3.78 (SD = 0.62).

The below shows the Item-level analysis

Showed varying levels of agreement across statements related to spiritual beliefs and mental health. The highest mean scores were recorded for the belief that prayer plays an important role in mental healing (M = 4.25), the belief that mental illness can be influenced by spiritual forces (M = 4.10), and the belief that abnormal or disturbed behaviour may be explained by evil spirit possession (M = 3.90).

- Lower mean scores were observed for statements that rejected biomedical explanations of mental illness in favour of exclusively spiritual explanations.

4.1.4 Descriptive Analysis for Level of Mental Health Stigma (RQ2)

Table 6: Descriptive Statistics of Mental Health Stigma

Variable	Mean	Std. Deviation
Stigma Score	3.41	0.69

The results show a mean mental health stigma score of 3.41 (SD = 0.69).

The below shows Item-level analysis

Higher mean scores were recorded for concerns related to disclosure of mental health conditions affecting job security (M = 3.75), hesitation to work closely with individuals experiencing mental health problems (M = 3.60), and perceptions that employees with mental health conditions may be less productive (M = 3.45).

Lower mean scores were observed for willingness to support colleagues experiencing mental health challenges (M = 3.10) and agreement that mental illness is treatable (M = 3.20).

4.1.5 Relationship Between Spiritual Beliefs and Mental Health Stigma (RQ3)

Pearson Correlation Analysis was conducted to examine the relationship between Pinnacle Business Group employees' spiritual beliefs and their levels of mental health stigma and this inferential analysis was used to determine whether a statistically significant relationship exists between the two variables and the direction of that relationship.

Table 7: Correlation Between Spiritual Beliefs and Mental Health Stigma

Variables	r value	p value
Spiritual Beliefs & Stigma	0.52	0.004

the results revealed a positive correlation between spiritual beliefs and mental health stigma ($r = 0.52$, $p = 0.004$). The p -value was below the 0.05 level of significance, indicating that the relationship was statistically significant.

4.2 Qualitative Findings

Qualitative Findings: Thematic Analysis

Theme 1: Spiritual Framing of Mental Illness

A dominant theme across interviews was the tendency of participants to explain mental illness using spiritual and religious frameworks. Most participants described mental health problems in terms of supernatural or moral causes rather than purely medical or psychological explanations.

Typical responses included:

“Some people think it is caused by evil spirits or God’s punishment.”

“Before going to hospital, people usually try prayer or holy water.”

Theme 2: Coexistence of Spiritual and Medical Beliefs

An important finding was that most participants did not rely exclusively on spiritual explanations. Instead, a dual belief system emerged in which both spiritual and biomedical perspectives were acknowledged in understanding mental health.

Participants stated:

“We believe in doctors, but prayer also helps healing.”

“Both hospital and church are important.”

Theme 3: Workplace Stigma and Fear of Disclosure

Participants expressed concern regarding the presence of stigma within the workplace, particularly fear of disclosure and perceived negative consequences associated with mental health problems.

Responses included:

“If you say you have mental problems, people think you are not strong.”

“Managers may doubt your performance.”

Theme 4: Lack of Organizational Mental Health Structures

Participants indicated that there are no structured mechanisms or formal systems in place to support mental wellbeing within the organization.

Responses included:

“There is no counseling or awareness in the company.”

“We don’t talk about mental health at work.”

4.3 Discussion of Key Findings

4.3.1 Spiritual Beliefs About Mental Health Problems

Employees of Pinnacle Business Group reported moderately high levels of spiritual beliefs regarding mental health problems. The quantitative findings indicate that respondents generally agree that mental illness can be influenced by spiritual forces and that prayer plays an important role in healing. These findings are consistent with previous studies conducted in similar contexts, which have shown that spiritual and supernatural explanations remain widely used in understanding mental illness (Abera et al., 2015; Fekadu et al., 2019).

The qualitative findings further support this result, as participants frequently described mental health problems in spiritual terms, including beliefs related to evil spirits and divine punishment. In addition, the qualitative data revealed a coexistence of spiritual and biomedical explanations, indicating a dual belief system in understanding mental illness within the workplace context.

4.3.2 Level of Mental Health Stigma

Employees of Pinnacle Business Group reported a moderate level of mental health stigma. The quantitative findings indicate that stigma is particularly reflected in concerns related to workplace interaction, perceived productivity, and fear of negative consequences following disclosure of a mental health condition. These findings are consistent with previous literature which shows that stigma in workplace settings often manifests through concerns about competence, reliability, and professional capability (Corrigan, 2017; Corrigan et al., 2016).

Similarly, Clement et al. (2015) found that fear of negative evaluation is one of the most significant barriers to mental health disclosure and help-seeking behavior, particularly in occupational contexts where individuals anticipate discrimination or reduced opportunities.

The qualitative findings further support these results, as participants reported reluctance to disclose mental health challenges due to fear of being perceived as weak, unstable, or unreliable by colleagues and supervisors. This alignment between quantitative and qualitative data strengthens the conclusion that workplace mental health stigma is strongly linked to anticipated negative judgment and professional consequences.

4.3.3 Relationship Between Spiritual Beliefs and Mental Health Stigma

The correlation coefficient ($r = 0.52$) indicates a moderate positive relationship between spiritual beliefs and mental health stigma, meaning that higher endorsement of spiritual explanations for mental illness is associated with higher levels of stigmatizing attitudes. This relationship was

statistically significant ($p = 0.004$, $p < 0.01$), suggesting that the observed association is unlikely to have occurred by chance. It is important to note that correlation does not imply causation; rather, the findings indicate an association between the two variables within the study population.

These findings are consistent with attribution theory, which argues that individuals tend to form attitudes toward mental illness based on perceived causes. When mental illness is attributed to supernatural, moral, or spiritual causes, it is more likely to be associated with blame, fear, and social distance. This is supported by Pescosolido and Martin (2015), who found that supernatural or moral explanations of mental illness are strongly associated with stigmatizing attitudes and reduced social acceptance of individuals with mental health conditions. Similarly, Gureje et al. (2015) highlight that in African contexts, spiritual interpretations of mental illness are commonly linked with negative attitudes, fear, and social exclusion.

The qualitative findings further support these results. Participants who explained mental illness in spiritual terms also expressed concerns about workplace interaction, trust, and perceived reliability of individuals experiencing mental health problems. These perspectives suggest that spiritual interpretations are not only abstract beliefs but are also reflected in everyday workplace attitudes and behavioral expectations toward colleagues with mental health conditions.

4.3.4 Workplace Mental Health Awareness and Support

Employees of Pinnacle Business Group reported a lack of structured workplace mental health services, including counseling services, formal awareness programs, and organized interventions addressing psychological wellbeing. This suggests that employees are more likely to rely on personal coping strategies or informal support networks when dealing with mental health challenges. Organizational psychology literature supports this finding, indicating that the absence of workplace mental health infrastructure is associated with lower help-seeking behavior and increased likelihood of untreated psychological distress among employees (World Health Organization, 2022; LaMontagne et al., 2018; OECD, 2021). These studies emphasize that organizational systems, policies, and supportive environments play a critical role in facilitating early identification and help-seeking for mental health concerns in workplace settings.

The qualitative findings further reinforce this result, as participants reported that mental health is not openly discussed within the organization and that there are no dedicated systems or programs addressing psychological wellbeing at their workplace. This lack of formal support structures was described as contributing to silence around mental health issues and limiting opportunities for employees to seek professional or organizational assistance, thereby reinforcing reliance on informal coping mechanisms.

4.3.4 Organizational and Cultural Factors Shaping Attitudes

Employees' attitudes toward mental health within Pinnacle Business Group can be understood through the interaction of organizational conditions and cultural belief systems. Although the organization operates within a formal workplace structure, mental health perceptions remain strongly influenced by cultural and spiritual interpretations. The qualitative findings indicate that supernatural forces and divine explanations are commonly used to understand mental health problems among employees, while biomedical explanations are also present, suggesting a coexistence of belief systems. This dual framework aligns with previous literature which shows that in many African and low-resource contexts, individuals often integrate both spiritual and biomedical models in explaining mental illness rather than relying on a single explanatory system (Abera et al., 2015; Hailemariam et al., 2020; Koenig, 2018).

From an organizational perspective, the absence of formal mental health policies, awareness programs, and counseling services appears to limit structured engagement with mental health issues in the workplace. This finding is consistent with organizational and workplace mental health literature, which emphasizes that the lack of institutional mental health support systems contributes to reduced help-seeking behavior, increased stigma, and reliance on informal coping mechanisms among employees (LaMontagne et al., 2018; World Health Organization, 2022; OECD, 2021). These studies highlight that organizational environments play a critical role in shaping whether mental health is openly addressed or remains socially silenced within workplaces.

4.4 Integration of Quantitative and Qualitative Findings

The integration of quantitative and qualitative findings was conducted in line with the convergent mixed methods design.

Table 8: Integrated Summary of Findings

Quantitative Finding	Qualitative Explanation
Positive correlation between spirituality and stigma	Spiritual beliefs shape how mental illness is interpreted, often through supernatural or moral frameworks
Moderate level of mental health stigma	Fear of workplace judgment, labeling, and job insecurity discourages open discussion and increases stigma
Significant relationship between variables	Workplace attitudes influenced by cultural beliefs and organizational environment
Dual explanatory model observed	Employees combine biomedical and spiritual interpretations

Both tools demonstrate a strong level of convergence. The quantitative results showed a statistically significant positive relationship between spiritual beliefs and mental health stigma ($r = 0.52$, $p = 0.004$) and the qualitative findings showed contextual explanations by showing how spiritual interpretations of mental illness are associated with perceptions and expressions of stigma in the workplace.

Both data sets consistently indicate that employees who strongly endorse spiritual explanations of mental illness are more likely to express stigmatizing attitudes, particularly in relation to workplace interaction, trust, and disclosure concerns and the qualitative findings further clarify this relationship by showing that spiritual beliefs are commonly used to explain mental illness in supernatural or moral terms.

The integration of quantitative and qualitative data strengthens the overall interpretation of the study results. The triangulation enhances the validity and reliability of the study findings and supports the use of a mixed methods convergent design.

Chapter Five: Summary, Conclusion and Recommendation

5.1 Summary of the Study

Spiritual beliefs and mental health stigma relationship study was guided by 4 main objectives which are assessing employees' spiritual beliefs regarding mental health, examining level of mental health stigma, analyzing their relationship and exploring workplace perceptions of mental health awareness & support. The interpretation of the findings were that employees showed moderately high levels of spiritual beliefs regarding mental health and that the level of mental health stigma among employees was moderate a statistically significant positive relationship between spiritual beliefs and mental health stigma ($r = 0.52$, $p < 0.01$) was found qualitative findings revealed that “employees often avoid discussing mental health issues due to fear of judgment, job insecurity, and lack of organizational support systems such as counseling or awareness programs” and it also identified that workplace mental health structures within the organization are limited, contributing to silence and reinforcing stigma in the workplace environment.

5.2 Conclusion

Spiritual beliefs play a significant role in shaping how employees understand mental health problems and that in this case study mental illness is still largely interpreted through both spiritual and biomedical frameworks, Mental health exists in workplace specially in relation to perceptions of competence, productivity, and reliability. level of stigma is moderate rather than extreme, it is still sufficient to influence employee behavior particularly in relation to disclosure and help seeking, it is confirmed that after this research there is a meaningful and statistically significant relationship between spiritual beliefs and mental health stigma, workplace environment plays a critical role in shaping mental health attitudes the absence of formal mental health policies, awareness programs, and employee support systems contributes to silence and discourages open discussion of mental health challenges. Finally from this thesis it can be concluded that Addressing Mental Health Stigma in Ethiopian Private Sector Organizations requires a culturally sensitive approach that pays attention to both the role of spiritual beliefs and biomedical understanding.

5.3 Limitations of the Study

This study was conducted within a single organization, Pinnacle Business Group, which limits the generalizability of the findings to other workplace settings in Ethiopia due to differences in organizational culture and employee experiences. This was addressed by adopting a case study design, which allowed for an in depth, context specific exploration of the phenomenon rather than broad generalization. The cross-sectional design of the study limits the ability to establish causal relationships between spiritual beliefs and mental health stigma. The findings therefore reflect associations at a single point in time rather than cause-and-effect relationships, and were interpreted strictly within this scope. The limited number of qualitative interviews reduced the range of perspectives captured within the organization. This was managed through purposive sampling of participants with varied roles and lengths of employment, which helped ensure depth and variation in the data collected.

1.4 Recommendations

5.4.1 Organizational Level Recommendations

There should be a confidential support system such as counseling service or working with mental health professionals and have an open communication when it comes to mental health so that fear of disclosure and workplace discrimination can be reduced.

5.4.2 Culturally Sensitive Interventions

Mental health related programs should also give attention to the existing spiritual beliefs, not ignore or dismiss them and maybe work with religious leaders and community figures to fill the gap between spiritual explanations and medical reasoning.

5.4.3 Policy Level Recommendations

Private sector organizations should be encouraged to adopt structured workplace mental health frameworks aligned with international best practices, as current national mental health strategies in Ethiopia provide only limited guidance on workplace-specific mental health promotion and stigma reduction.

5.4.4 Recommendations for Future Research

In the future researchers should expand the research topic to include multiple organizations and sectors while also using larger sample sizes and possibly explore additional variables like working styles, company culture and stuff like that.

5.5 Final Remark

Through this study, I learned that mental health stigma is not only an individual level issue but is deeply embedded within cultural beliefs, workplace environments, and organizational systems. The findings demonstrated that spiritual interpretations of mental illness, combined with limited workplace mental health structures, significantly shape employees' perceptions and attitudes toward mental health. I also learned that stigma influences not only how individuals view mental illness but also how organizations respond to employees experiencing psychological distress.

In communicating these findings, I would emphasize that mental health stigma should be understood as a critical national and organizational concern rather than only a personal health issue. It directly affects employee wellbeing, productivity, and overall organizational effectiveness. Therefore, addressing mental health stigma requires integrated approaches that combine cultural sensitivity, workplace policy development, and mental health awareness initiatives at both organizational and national levels.

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Appendices

ANNEX I: Questionnaire

Title: Questionnaire on Spiritual Beliefs and Mental Health Stigma Among Employees

Introduction:

Dear Participant,

This questionnaire is about collecting information for an academic study on relationship between spiritual beliefs and mental health stigma. Your participation is voluntary, and all responses will be kept strictly confidential and used only for academic purposes. **There are no right or wrong answers.**

Section A: Socio Demographic Information

Gender

☐ Male ☐ Female

Age

☐ 20–29 ☐ 30–39 ☐ 40 and above

Education Level

☐ Diploma ☐ Bachelor's Degree ☐ Master's Degree

Work Experience

☐ 6 months to 2 years ☐ 3 to 5 years ☐ 6 years and above

Section B: Spiritual Beliefs Related to Mental Health

Rating scale: 1 = Strongly Disagree, 2 = Disagree, 3 = Slightly Disagree, 4 = Slightly Agree, 5 = Agree, 6 = Strongly Agree

	Item	1	2	3	4	5
1	Mental illness can be caused by spiritual forces.					
2	Prayer is important in the treatment of mental illness.					
3	Evil spirits can influence a person's behavior.					
4	Mental illness be a punishment from God.					
5	Traditional and spiritual healing are effective for mental illness.					
6	Both medical treatment and spiritual practices are necessary for healing.					
7	Mental illness is related to moral or spiritual failure.					
8	Religious practices help improve mental health.					

Section C: Mental Health Stigma

Rating scale: 1 = Strongly Disagree, 2 = Disagree, 3 = Slightly Disagree, 4 = Slightly Agree, 5 = Agree, 6 = Strongly Agree

	Item	1	2	3	4	5
1	I would feel uncomfortable working closely with someone who has a mental illness.					
2	Employees with mental illness are less productive.					
3	I would be worried about job security if I had a mental health problem.					
4	People with mental illness should keep it private.					
5	I believe mental illness can be treated effectively.					
6	I would support a colleague experiencing mental health problems.					
7	Mental illness is a sign of weakness.					
8	I would avoid social interaction with someone who has a mental illness.					
9	Employees with mental health problems can perform well at work.					
10	I would feel safe working with someone who has a mental illness.					

ANNEX II: Semi Structured Interview Guide

Introduction:

This aim of this interview to explore your views on mental health, spiritual beliefs, and workplace experiences. Your participation is voluntary and confidential.

Interview Questions

1. *“What do you understand by mental health or mental illness?”*
2. *“What do you think are the main causes of mental health problems?”*
3. *“Do you think spiritual or religious beliefs have any relation to mental illness?”*
4. *“What role do you think prayer, holy water, or religious practices play in mental health”*
5. *“How is mental health seen in your workplace?”*
6. *“Do you as an employee feel comfortable discussing mental health issues at work?”*
7. *“Have you observed any attitude related to stigma about mental health at work?”*
8. *“What kind of support systems is there in your organization for employees with mental health issues that you know of?”*
9. *“What improvements do you want to see in the workplace regarding mental health?”*

ANNEX III: Consent Form

Study Title: Spiritual Beliefs and Mental Health Stigma Among Employees

I understand that:

- My participation is voluntary
- I withdraw at any time without penalty
- My responses will remain confidential
- My identity will not be revealed in any report

I give my consent to take part in this thesis.

Signature: _____

Date: _____

ANNEX IV: SPSS Variable Coding Sheet

Variable	Description	Coding
Gender	Respondent gender	1 = Male, 2 = Female
Age	Age group	1 = 20–29, 2 = 30–39, 3 = 40+
Education	Education level	1 = Diploma, 2 = Bachelor, 3 = Master
Experience	Work experience	1 = 6 months–2 years, 2 = 3–5 years, 3 = 6+ years

Scale Variables

Variable	Items	Type
Spiritual Beliefs Score	8 items	Continuous
Stigma Score	10 items	Continuous

ANNEX V: Reliability Test Output

Scale	Items	Cronbach's Alpha
Spiritual Beliefs	8	0.81
Mental Health Stigma	10	0.84

Interpretation: Both scales demonstrate good internal consistency ($\alpha > 0.70$).

ANNEX VI: Ethical Clearance Summary

- Permission granted by Pinnacle Business Group management
- Participants provided informed consent
- Confidentiality and anonymity ensured throughout the study