



**EVALUATING MENTAL HEALTH COMMUNICATION PRACTICES IN GHANAIAN
WORKPLACES THROUGH THE LENS OF PARTICIPATORY COMMUNICATION**

BY

ESENAM AGYEKUMHENE

MADC24053

**A DISSERTATION/THESIS SUBMITTED TO THE UNIVERSITY OF MEDIA, ARTS AND
COMMUNICATION (UniMAC) IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR
THE AWARD OF MA IN DEVELOPMENT COMMUNICATION**

NOVEMBER 2025

CANDIDATES DECLARATION

I hereby declare that this research is a result of my own original research and that, no part of it has been presented for another degree in this university or any other higher education institute. I further declare that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

ESENAM AGYEKUMHENE MADC24053



8/12/2025

Student

Index Number


Signature

Date

CERTIFICATION BY SUPERVISOR

This Dissertation has been prepared and presented under my supervision according to the guidelines for supervision and formatting of Dissertation laid down by the University of Media, Arts and Communication, UniMAC.

DR. ROSEMARY OBENG-HINNEH



8/12/2025

Supervisor

Signature

Date

DEDICATION

I dedicate this work to anyone dealing with a mental health concern.

I speak peace over your mind, strength into your heart, and clarity into your journey.

May you find the courage to seek support, the confidence to speak your truth, and the comfort

of knowing that you are never alone.

This work is for your healing, your growth, and your voice.

ACKNOWLEDGEMENT

I am grateful to the Lord for the strength and wisdom that guided me throughout this work. My sincere appreciation goes to my supervisor, Dr. Rosemary Obeng-Hinneh for the consistent direction, constructive feedback, and support that shaped this thesis.

I thank the management and staff of the participating organisation for their cooperation and willingness to share their experiences. I am also thankful to my husband, family, friends, and colleagues at the University of Media, Arts and Communication for their encouragement and support during this journey.

To everyone who contributed in any way, I express my heartfelt gratitude.

ABSTRACT

This study examined workplace mental health communication in a Ghanaian Financial Technology (FinTech) organisation and explored how employees disclose, negotiate, and seek support for psychological concerns. Although mental health is increasingly recognised as a public health and development issue in Ghana, communication about it in workplaces remains limited, informal, and shaped by stigma, confidentiality concerns, and organisational culture. Guided by Communication Privacy Management Theory and grounded in a participatory communication orientation, the study analysed how employees manage privacy boundaries, assess risks, and decide whether to disclose distress within professional settings. The study addressed four objectives: to examine employees' perceptions of existing mental health communication practices, assess gender differences in communication experiences, identify preferred communication approaches, and explore how development communication strategies can inform inclusive workplace mental health policies.

The research adopted an explanatory sequential mixed methods design. A quantitative survey of fifty employees provided an overview of existing communication practices, perceptions of stigma, disclosure comfort, and preferred support channels. This was followed by five in-depth qualitative interviews that explored the experiences, reasoning, and cultural dynamics underlying the patterns identified in the survey. The data were analysed using descriptive statistics and thematic analysis, allowing for integration of both numerical trends and lived experiences.

The findings revealed that while employees acknowledge the importance of mental health, formal communication channels are underdeveloped. Many employees were unsure about policies, focal persons, and available support. Fear of judgement, breach of confidentiality, and potential career consequences led most respondents to prefer peer-based communication over engagement with managers or HR personnel. The study also found that gender does not significantly shape communication patterns; instead, organisational culture, trust, and leadership behaviour strongly influence disclosure decisions. Employees expressed a desire for participatory communication spaces, reasonable work adjustments, and clear, confidential pathways for support.

The study concludes that improving workplace mental health communication in Ghana requires intentional, structured, and participatory systems that build trust, enhance confidentiality, and normalise dialogue. Recommendations include policy development, managerial training, peer-support structures, and national guidelines to strengthen psychological safety in organisations.

Keywords:

mental health communication, workplace wellbeing, Communication Privacy Management Theory, participatory communication, Ghana, FinTech, disclosure behaviour, organisational communication.

Table of Contents

CANDIDATES DECLARATION	i
CERTIFICATION BY SUPERVISOR	i
DEDICATION.....	ii
ACKNOWLEDGEMENT	iii
ABSTRACT	iv
CHAPTER ONE	1
INTRODUCTION	1
1.0 Background of Study	1
1.1 Problem Statement	3
1.2 Research Aim	4
1.3 Research Questions	4
1.4 Research Objectives.....	5
1.6 Significance of the Study	5
1.7 Scope of the Study.....	6
1.8 Organisation of the Study.....	7
1.9 Chapter Summary.....	8
CHAPTER TWO	9
LITERATURE REVIEW AND THEORETICAL FRAMEWORK	9
2.0 Introduction	9
2.1 Conceptualizing Workplace Mental Health	9

2.2 Global Perspectives on Workplace Mental Health Communication	10
2.3 African Perspectives on Workplace Mental Health Communication	12
2.4 The Ghanaian Context.....	14
2.5 Gender, Stigma, and Workplace Communication	17
2.6 Development Communication and Mental Health.....	18
2.7 Theoretical Framework	20
2.8 Summary of Gaps in the Literature	21
2.9 Chapter Summary.....	23
CHAPTER THREE	24
RESEARCH METHODOLOGY.....	24
3.1 Introduction	24
3.2 Research Philosophy	24
3.3 Research Approach.....	25
3.4 Research Design.....	26
3.5 Study Area.....	26
3.6 Population.....	27
3.7 Sampling.....	27
3.8 Data Collection Methods.....	29
3.9 Data Collection Instrument	30
3.9.1 Structured Questionnaire (Quantitative Phase).....	30
3.9.2 Semi-Structured Interview Guide (Qualitative Phase).....	31
3.10 Data Analysis.....	31

3.11 Ethical Consideration	32
3.12 Chapter Summary.....	33
CHAPTER FOUR.....	34
DATA ANALYSIS, PRESENTATION OF FINDINGS AND DISCUSSIONS	34
4.0 Introduction	34
4.1 Demographic Characteristics of Respondents.....	35
4.2 Perceptions of Workplace Mental Health Communication	36
4.3 Gender Differences in Mental Health Communication.....	43
4.4 Preferred Communication Approaches	45
4.5 Development Communication Strategies for Inclusive Mental Health Policies.....	53
4.5 Chapter Summary.....	55
CHAPTER FIVE	56
SUMMARY, CONCLUSION AND RECOMMENDATIONS	56
5.0 Introduction	56
5.1 Summary of Key Findings	56
5.1.1 Perceptions of Workplace Mental Health Communication.....	57
5.1.2 Gender Differences in Mental Health Communication.....	57
5.1.3 Preferred Communication Approaches for Addressing Mental Health.....	58
5.1.4 Development Communication Strategies for Inclusive Mental Health Policies.....	59
5.2 Recommendations	60
5.2.1 Development of Clear and Comprehensive Workplace Mental Health Policies.....	60
5.2.2 Creation of Confidential and Accessible Communication Channels	60
5.2.3 Institutionalisation of Peer Support and Employee Wellbeing Structures	61

5.2.4 Integration of Mental Health Communication into Organisational Culture.....	61
5.2.5 Strengthening Managerial Empathy and Communication Competence	61
5.2.6 Introduction of Reasonable Work Adjustments for Staff Experiencing Distress	61
5.2.7 Promotion of Awareness of the Mental Health Act within Workplaces	62
5.3 Limitations of the Study	62
5.4 Suggestions for Future Research.....	63
5.4.1 Broadening Contexts and Theoretical Exploration	63
5.4.2 Methodological and Intervention-Focused Studies.....	63
5.5 Conclusion.....	64
REFERENCES.....	66
APPENDICES.....	72
Appendix A: Survey Form	72
Appendix B: Volunteer Form for Follow-Up Interview Participation	78
Appendix C: Semi-Structured Interview Guide	80
Appendix D: Coding Matrix of Emerging Themes.....	84

CHAPTER ONE

INTRODUCTION

1.0 Background of Study

Mental health is now widely recognized as a critical global health and development concern. According to the World Health Organization (WHO, 2022), one in every eight people worldwide lives with a mental health disorder, and conditions such as depression and anxiety are among the leading contributors to disability and reduced productivity. The economic impact is equally significant: depression and anxiety alone cost the global economy more than US\$1 trillion annually in lost productivity. These challenges highlight the importance of workplaces not only as sites where mental health challenges emerge but also as spaces that can provide critical avenues for intervention and support.

In response, many high-income countries have integrated workplace mental health into occupational health frameworks. Strategies such as Employee Assistance Programs (EAPs), workplace wellness initiatives, and formal policies have been implemented to encourage disclosure, reduce stigma, and improve productivity (LaMontagne et al., 2014). Importantly, these initiatives recognize communication as a key determinant of whether employees feel safe to seek help or disclose their struggles.

In Africa, however, workplace mental health has not received comparable attention, despite evidence of its profound effects on organizational performance and individual well-being. The persistence of cultural stigma, underfunded health systems, and limited organizational policies leaves employees vulnerable to silence and discrimination (Dako-Gyeke & Asumang, 2013). Studies suggest that many workers are hesitant to disclose mental health issues for fear of being

judged, sidelined, or perceived as unprofessional (Adom, Mensah & Agyemang, 2021). Gender dynamics add complexity: women are often viewed as “too emotional” when they raise such issues, while men are socialized to suppress vulnerability, leading to a culture of silence (Lawrence, Boateng & Amankwah, 2024).

In Ghana, the passage of the Mental Health Act (Act 846) in 2012 signaled national recognition of mental health as a priority. Yet implementation remains limited, particularly in workplace settings. Only about 2% of Ghanaians with mental disorders have access to formal psychiatric care (Amenah, Owusu-Ansah & Appiah, 2025). Within organizations, workplace-specific mental health policies are virtually absent, and there is limited data on how mental health is currently communicated or addressed (Nimoh, 2024). Consequently, employees face a dual burden: dealing with personal challenges while navigating organizational silence and the risk of stigma.

Scholarly engagement with mental health in Ghana has largely focused on access to psychiatric care, stigma in communities, or the perspectives of health workers (Dako-Gyeke & Asumang, 2013; Zobi, Aninagyei & Appiah, 2024). What remains underexplored is how communication within the workplace shapes stigma, disclosure, and support. Even less is known about how gender differences influence employees’ experiences or preferences for mental health communication. Moreover, participatory communication approaches—where employees and employers jointly identify strategies they trust—have yet to be incorporated into workplace policy design (Zuurmond, Kikumbih & van der Geest, 2025).

This context demonstrates that while global recognition of workplace mental health is advancing, Ghana still lags in developing communication-centered, inclusive strategies that address stigma and enable safe disclosure. This gap in knowledge and practice provides the foundation for the present study.

1.1 Problem Statement

In 2019, mental disorders were among the leading causes of ill health globally, with depression and anxiety topping the list. The World Health Organization (WHO) estimated that approximately 1 in every 8 people, nearly 970 million globally were living with a mental disorder (WHO, 2022). The COVID-19 pandemic had an immediate and profound effect on mental health. Systematic analyses showed a 26% increase in anxiety disorders and a 28% increase in major depressive disorders globally during the first year of the pandemic (The Lancet, Santomauro et al., 2021).

Beyond the health burden, mental health disorders come with immense economic consequences. Depression and anxiety alone are responsible for an estimated US \$1 trillion in lost productivity each year globally, primarily due to absenteeism and reduced work performance (WHO, 2022 Mental Health at Work). In the United Kingdom, employers bore direct and indirect costs totaling £56 billion in 2020–2021 due to mental health-related absenteeism, presenteeism, and turnover (Deloitte UK, 2022).

In Ghana, while the Mental Health Act of 2012 (Act 846) marked progress in national regulation, mental health services remain chronically under-resourced. Only about 2% of people with mental disorders in Ghana are able to access formal psychiatric care, according to national surveys and estimates (Amenah et al., 2025; Zobi et al., 2024). Additionally, workplace-specific mental health policies are nonexistent, and data on workplace mental health prevalence is virtually unavailable.

This context of under-diagnosis, under-treatment, and institutional silence exacerbates the mental health burden in professional settings, where fear of discrimination, organizational silence, and cultural stigma remain pervasive. These realities call for an urgent, evidence-informed, participatory approach to workplace mental health policy and communication,

particularly in developing countries like Ghana. Yet, little is known about how mental health is currently communicated within Ghanaian workplaces, or how such communication practices shape stigma, silence, and disclosure — creating a critical gap this study seeks to explore.

Moreover, research in Ghana has yet to incorporate stated preference methods to assess what types of communication — whether formal or informal, anonymous or interpersonal — employees actually trust and prefer. These approaches are essential for designing policies that are not only evidence-based but also aligned with stakeholder realities. While some studies suggest gender affects communication behavior, few have explored how men and women differ in mental health disclosure within the workplace, or how such differences could influence policy design (Winifred et al., 2022; Barbara et al., 2025; Thornicroft et al., 2022). This study responds to these gaps by exploring how gender, stigma, and participatory communication approaches can inform inclusive workplace mental health policy in Ghana.

1.2 Research Aim

The aim of this study is to examine how mental health is communicated within Ghanaian workplaces and to explore participatory approaches that can inform the design of inclusive workplace mental health policies and practices.

1.3 Research Questions

1. What are employees' perceptions of mental health communication within Ghanaian workplaces?
2. How do gender differences influence employees' experiences with mental health communication at work?
3. What communication approaches do employees and employers in Ghana prefer for addressing mental health in the workplace?

4. How can development communication strategies guide the creation of inclusive workplace mental health policies in Ghana?

1.4 Research Objectives

1. To examine employees' perception of mental health communication in Ghanaian workplaces.
2. To analyze the influence of gender differences on employees' experiences with mental health communication at work.
3. To identify preferred communication approaches for addressing workplace mental health among employees and employers.
4. To explore how development communication strategies can inform inclusive workplace mental health policies in Ghana.

1.6 Significance of the Study

This study is significant for several reasons. First, it contributes to the academic discourse on workplace communication by addressing the intersection of mental health, gender, stigma, and participatory approaches—areas that remain underexplored in the Ghanaian context. By situating workplace mental health within the broader field of development communication, the study expands theoretical applications beyond traditional health campaigns to organizational and policy communication.

Second, the research has policy relevance. In Ghana, the absence of workplace-specific mental health policies has created a gap between the Mental Health Act (2012) and its practical

implementation in employment spaces. Findings from this study will offer evidence-based insights to guide government bodies, employers, and labor unions in designing inclusive policies that promote safe and supportive work environments.

Third, the study holds practical importance for organizations and employees. Employers will gain understanding of communication approaches that employees trust and prefer, while employees may benefit from improved communication structures that reduce stigma, foster disclosure, and enhance productivity. In the long term, this can reduce organizational costs related to absenteeism, presenteeism, and turnover.

Finally, the study is socially relevant. By addressing stigma and silence, it contributes to national and global goals of ensuring health equity and workplace well-being, aligning with the Sustainable Development Goals (SDGs), particularly Goal 3 (Good Health and Well-being) and Goal 8 (Decent Work and Economic Growth).

1.7 Scope of the Study

This study focuses on mental health communication within a formal workplace in Ghana, specifically a FinTech organisation located in Accra. The research examines how employees express, manage, and seek support for mental health concerns, as well as how organisational structures and communication practices influence these processes. The scope is therefore centred on employee experiences, communication patterns, and organisational responses within this particular work environment.

The study is limited to exploring communication dynamics rather than clinical assessment or treatment. It does not investigate diagnostic processes, therapeutic interventions, or medical outcomes. Instead, it concentrates on the policies, practices, confidentiality concerns, and relational factors that shape mental health communication in the workplace.

Although demographic characteristics such as gender, age, and position appear in the data, they are analysed only in relation to communication behaviour when relevant. The findings are not intended to represent all workplaces in Ghana but offer insights that may be useful for similar organisational contexts.

1.8 Organisation of the Study

This thesis is organized into five chapters.

Chapter One introduces the study, presenting the background, problem statement, research aims, objectives, questions, significance, scope, limitations, and overall structure.

Chapter Two reviews relevant literature and theoretical frameworks, including development communication theories, stigma reduction, and participatory approaches, as well as empirical studies on workplace mental health communication.

Chapter Three outlines the research methodology, detailing the research design, population, sampling techniques, data collection methods, instruments, and ethical considerations.

Chapter Four presents and discusses the findings of the study, integrating empirical results with theoretical perspectives.

Chapter Five summarises the key findings, offers recommendations based on the study's insights, proposes directions for future research, and presents the overall conclusion of the thesis.

1.9 Chapter Summary

This chapter introduced the study on improving mental health communication in Ghanaian workplaces. It highlighted the global and local burden of mental health, identified gaps in workplace policies, and presented the problem statement, research aims, objectives, and questions. The significance, scope, and limitations of the study were discussed to clarify its academic, policy, and practical relevance. The chapter concluded with an outline of the study's organization, setting the stage for the literature review in Chapter Two.

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.0 Introduction

Mental health is now recognized as a key component of workplace well-being and productivity. The World Health Organization (WHO, 2022) and the International Labour Organization (ILO, 2021) identify poor communication, stigma, and psychosocial risks as major barriers to decent work. Within organizations, mental health depends not only on policy or clinical support but also on communication practices that foster trust, empathy, and openness.

In Ghana, despite the passage of the Mental Health Act (Act 846, 2012), workplace communication on mental health remains limited. Stigma, managerial silence, and weak institutional support discourage employees from seeking help (Adom et al., 2021; Asare-Doku et al., 2022).

This chapter reviews existing literature on workplace mental health communication globally, in Africa, and in Ghana. It highlights how communication, culture, and gender shape disclosure and support-seeking, and concludes by identifying gaps that inform the focus of this study.

2.1 Conceptualizing Workplace Mental Health

Mental health is an essential aspect of overall well-being and organizational performance. The World Health Organization (WHO, 2022) defines it as a state of well-being that enables individuals to cope with life's stresses, work productively, and contribute to their communities. Within the workplace, it extends beyond the absence of illness to include psychological safety, inclusion, and a supportive organizational climate (LaMontagne et al., 2014). Employees' mental well-being is shaped by communication, leadership, workload, and access to social or institutional support.

The International Labour Organization (ILO, 2020) recognizes mental health as a prerequisite for decent and sustainable work. From a development perspective, workplace mental health contributes to national productivity and aligns with Sustainable Development Goals (SDGs) 3 and 8, which promote good health and decent work. Servaes (2008) and Melkote and Steeves (2015) emphasize that communication for development fosters participation, dialogue, and empowerment—principles necessary for creating supportive work environments.

Communication, therefore, is a key determinant of mental well-being. Open, empathetic, and participatory communication builds trust and psychological safety, while closed or hierarchical systems reinforce stress and silence (Wu et al., 2021; Asare-Doku et al., 2022). In Ghana, limited dialogue and managerial openness perpetuate stigma and discourage help-seeking (Adom et al., 2021). Understanding workplace mental health thus requires examining how communication practices, leadership styles, and cultural expectations interact to enable or constrain employee well-being.

2.2 Global Perspectives on Workplace Mental Health Communication

Globally, mental health has become a central organisational and policy concern, particularly following the COVID-19 pandemic, which intensified stress, anxiety, and burnout among workers (World Health Organization [WHO], 2022; Santomauro et al., 2021). The WHO (2022) estimates that one in every eight people worldwide live with a mental health disorder, with depression and anxiety alone contributing to productivity losses exceeding US \$1 trillion annually. As workplaces increasingly serve as settings for health promotion, effective communication has emerged as a key strategy for enhancing awareness, reducing stigma, and encouraging disclosure and help-seeking behaviours (LaMontagne et al., 2014; Thornicroft et al., 2022).

In high-income countries, organisations have integrated mental health communication into corporate wellness programmes that rely on storytelling, peer advocacy, and open dialogue to normalise conversations about mental well-being. Initiatives such as Time to Talk in the United Kingdom, Bell Let's Talk in Canada, and Beyond Blue in Australia demonstrate that participatory, two-way communication reduces stigma and strengthens employee empathy and engagement (Henderson et al., 2020). Research indicates that when communication is embedded in organisational culture, retention and productivity improve substantially (Deloitte, 2022).

Leadership communication is crucial to this process. When leaders discuss their own well-being openly, they legitimise employee disclosure and foster psychological safety (Kohls et al., 2021). Evidence from the United States and the United Kingdom shows that managerial empathy and transparency correlate strongly with employee trust and mental well-being (Milner et al., 2019; Wu et al., 2021). The Organisation for Economic Co-operation and Development (OECD, 2021) also stresses that workplace communication should move beyond information delivery to empowerment, enabling employees to participate actively in shaping wellness strategies.

Global policy frameworks have strengthened this emphasis. The WHO's Comprehensive Mental Health Action Plan 2021–2030 identifies communication as essential for improving literacy, reducing stigma, and cultivating supportive work cultures, while the ILO–WHO Joint Policy Brief on Mental Health at Work (2022) promotes participatory dialogue and multi-stakeholder engagement to integrate psychosocial support into occupational systems. These frameworks call for communication strategies that are inclusive, culturally sensitive, and contextually adapted to diverse workforce realities.

The digitalisation of work has further transformed mental health communication by introducing online wellness platforms, anonymous chat systems, and AI-based employee assistance programmes that increase accessibility and disclosure comfort, especially among younger workers (Mind Share Partners, 2022). However, technology must complement rather than replace interpersonal trust and dialogue, which remain central to sustainable communication cultures (Thornicroft et al., 2022). The most effective global initiatives integrate digital tools with participatory dialogue, leadership visibility, and supportive policy frameworks (LaMontagne et al., 2014; Henderson et al., 2020). The WHO (2022) cautions that no universal model fits all contexts; therefore, applying these lessons to sub-Saharan Africa requires adaptation to local languages, cultural norms, and stigma dynamics. These global experiences set the foundation for exploring African perspectives in the next section.

2.3 African Perspectives on Workplace Mental Health Communication

Cultural beliefs and structural weaknesses profoundly shape perceptions and communication of mental health across Africa. In Ghana, Nigeria, and South Africa, mental illness is often attributed to supernatural or moral causes, leading to labeling, exclusion, and silence (Eaton et al., 2018). Such beliefs foster communication avoidance as employees fear reputational harm or job insecurity if psychological distress becomes known (Atilola, 2021). Weak occupational-health policies and the absence of employee-assistance programmes further restrict open dialogue (Amoateng & Kalichman, 2020). In Ghana, employees frequently equate mental illness with “madness,” discouraging even mild disclosures (Dako-Gyeke & Asumang, 2013). Similarly, Nigerian civil servants fear stigma and negative evaluations from supervisors, deterring help-seeking (Fadeyi & Afolabi, 2023). These findings point to a pervasive culture of silence sustained by hierarchy and low mental-health literacy.

Organisational communication in African workplaces mirrors broader societal hierarchies, where respect for authority and collective harmony discourage open expression. Employees often mask distress through absenteeism or coded communication rather than direct disclosure (Asare-Doku et al., 2022). This aligns with Petronio's (2002) Communication Privacy Management Theory, which explains how individuals manage disclosure based on perceived risk and trust. In collectivist cultures, privacy boundaries are shaped by the need to protect family and institutional reputation (Greene, 2020).

Nonetheless, emerging initiatives indicate gradual progress. Participatory peer-support groups, psychosocial clubs, and wellness committees in Kenya, South Africa, and Ghana encourage open discussion through storytelling and shared reflection (Zuurmond et al., 2025). These efforts, consistent with Servaes's (2008) Participatory Communication Model, reframe mental health as a social and dialogic issue rather than a purely medical one.

Policy frameworks at continental and national levels remain inconsistent. Although the African Union and WHO Africa Regional Office urge integration of mental-health communication into occupational-health policies (WHO AFRO, 2021), implementation is uneven. Only a few countries, including South Africa and Kenya, have developed comprehensive workplace programmes (Odejide, 2020). Elsewhere, informal networks remain dominant.

Faith and spirituality also influence communication. Many employees interpret distress through religious frameworks and turn to spiritual leaders rather than formal counselling (Atilola, 2021). In Ghana, King (2024) found that public figures use hybrid coping strategies—combining prayer, selective disclosure, and avoidance—to navigate stigma. Incorporating faith-based dialogue and culturally resonant messaging may therefore enhance acceptance and relevance.

Overall, African literature highlights pervasive stigma, limited institutional capacity, and emerging participatory solutions. Achieving sustainable change requires shifting from awareness-based interventions to inclusive organisational dialogue that embeds participation, trust, and cultural understanding into workplace communication.

Empirical studies across Africa confirm limited structured workplace mental-health programmes compared to Western contexts. Atilola (2021) found that African organisations often adopt reactive approaches, responding only when crises emerge rather than establishing preventive communication systems. Dako-Gyeke and Asumang (2013) and Atilola (2021) empirically demonstrate that cultural interpretations of mental illness as spiritual or moral failure restrict disclosure and reinforce stigma. Participatory approaches are emerging as promising models. Zuurmond et al. (2025) reported success with participatory peer-support groups in Kenyan and Ghanaian organisations, showing improvements in employee willingness to discuss psychological distress. Tufte & Mefalopulos (2009) also demonstrated in African contexts that dialogue-based interventions foster ownership and reduce stigma more sustainably than top-down awareness campaigns.

2.4 The Ghanaian Context

In Ghana, awareness of mental health as both a public health and development issue has grown over the past decade, yet workplace communication about mental well-being remains limited. The passage of the Mental Health Act (Act 846) in 2012 marked a major policy milestone by establishing the Mental Health Authority (MHA) and providing a national framework for promoting dignity, non-discrimination, and confidentiality. Despite this framework, implementation challenges—particularly inadequate funding, limited cross-sector collaboration, and shortages of trained mental health professionals—continue to constrain

workplace-level interventions (Aidoo & Harpham, 2021; Roberts et al., 2020). WHO (2022) reports that only 2% of Ghana's health budget is devoted to mental health, with fewer than 50 psychiatrists serving a population of over 32 million, creating major barriers to sustained workplace counselling or referral systems. Appiah et al. (2022) further found that only a small proportion of organisations have formal mental health policies or employee assistance programmes, leading many workers to rely on informal support.

Cultural beliefs remain a dominant influence on how mental health is understood and communicated. Ghanaian interpretations often associate psychological distress with spiritual causes such as witchcraft, curses, or divine punishment (Dako-Gyeke & Asumang, 2013). These beliefs shape workplace perceptions, where employees frequently regard mental health challenges as private, shameful, or indicative of weakness. Adom et al. (2021) found that although stress is widespread, only 17% of Ghanaian employees have ever discussed mental well-being with supervisors due to fears of stigma, gossip, or reputational damage. Lawrence et al. (2024) similarly demonstrated that employees carefully weigh the risks of disclosure—particularly in hierarchical organisations—while gendered expectations further influence communication choices. Men often fear appearing weak, while women worry about being judged as overly emotional.

Organisational communication practices in Ghana tend to reinforce silence. Workplace culture is largely formal and hierarchical, discouraging open dialogue between management and subordinates (Adjei, 2021). Communication within many organisations is instructional rather than participatory, limiting employees' ability to express concerns or seek help (Amoako & Dako-Gyeke, 2022). Asare-Doku et al. (2022) empirically showed that managerial empathy is the strongest predictor of whether employees disclose distress; where leaders are perceived as punitive or distant, silence deepens. Gender further complicates communication, as women in leadership often suppress emotional expression to protect their credibility (Mensah & Adjei,

2023). These patterns reflect Communication Privacy Management Theory, which explains how employees assess risks and manage boundaries before sharing sensitive information.

Faith-based coping and informal support networks also shape communication in Ghanaian workplaces. Many individuals turn to prayer, religious leaders, or spiritual interpretations of distress rather than formal counselling. King (2024) found that even high-profile Ghanaians often disclose distress indirectly or in “masked” forms that maintain privacy while seeking social support. Such hybrid coping strategies—merging spirituality, selective disclosure, and emotional restraint—mirror broader societal preferences for indirect communication and reflect limited trust in organisational confidentiality systems.

Recent developments indicate slow, emerging progress. The Mental Health Authority, working with NGOs such as BasicNeeds Ghana and MindIT Africa, has introduced awareness campaigns and training programmes for HR managers and line supervisors (MHA, 2023). Zuurmond et al. (2025) found that participatory peer-support initiatives in some Ghanaian organisations have enhanced openness and collective responsibility for mental well-being. However, these efforts have yet to translate into widespread organisational policy adoption or consistent communication systems. Amoako and Dako-Gyeke (2022) note that most employers still rely on annual health talks rather than ongoing participatory frameworks, limiting the sustainability of wellness culture.

Overall, the Ghanaian context is shaped by strong policy intentions but weak implementation, deep-rooted cultural stigma, hierarchical communication structures, and inadequate institutional support. Empirical studies highlight a persistent disconnect between national mental health policy and daily workplace realities. These gaps reveal the need for contextually grounded, participatory communication strategies that acknowledge stigma, incorporate

cultural and faith-based dimensions, and strengthen trust and confidentiality within organisational settings.

2.5 Gender, Stigma, and Workplace Communication

Gender significantly shapes how individuals experience and communicate about mental health in the workplace. Across global and Ghanaian contexts, gender norms influence disclosure, stigma, and access to support (WHO, 2022; Adom et al., 2021). Masculine ideals of strength and emotional control often discourage men from acknowledging distress or seeking help, as emotional expression is seen as weakness (Courtenay, 2020; Milner et al., 2019). In Ghana, men frequently conceal stress to avoid being viewed as unreliable, while managerial cultures rewarding resilience reinforce silence (Lawrence et al., 2024; Adom et al., 2021). Such pressure fosters coping through overwork, humor, or alcohol use rather than communication (Thornicroft et al., 2022). Women, conversely, face stereotypes of being “too emotional,” which undermine their credibility and career progression (Hegarty et al., 2022). Balancing professional and caregiving roles heightens stress and limits opportunities for self-care (Gould et al., 2021). Ghanaian women in leadership positions often suppress emotional expression to maintain authority, and those who seek counseling may encounter subtle discrimination (Mensah & Adjei, 2023). These dynamics reveal how institutionalized gender bias shapes communication opportunities and psychological safety. Cultural expectations also influence disclosure styles. Women tend to use expressive and relational communication, while men favor task-oriented or indirect forms (Eagly & Wood, 2019; Adjei, 2021). King (2024) found that Ghanaian women often express distress through faith-based narratives, whereas men rely on indirect advocacy or humor. Such patterns demonstrate that gendered disclosure reflects broader socio-cultural meanings of emotion, strength, and vulnerability.

Intersectionality further explains how gender interacts with age, status, and hierarchy to compound communication barriers (Crenshaw, 1991). Younger female employees in Ghanaian organisations face layered stigma and limited authority to express concerns (Amoako & Dako-Gyeke, 2022). Consequently, gender-blind workplace policies often fail to address these diverse realities (Hegarty et al., 2022).

Developing gender-sensitive communication requires promoting managerial empathy, addressing gendered stigma, and redesigning communication systems to support inclusivity. Participatory approaches such as peer-support networks and confidential storytelling can empower employees of all genders to share experiences safely (Servaes, 2008). Embedding gender analysis into workplace wellness programmes aligns with Sustainable Development Goals 3 and 5, advancing equality and well-being (United Nations, 2015).

Lawrence et al. (2024) empirically demonstrated that gender significantly mediates workplace disclosure; men tended to avoid seeking help due to fear of being labeled weak, while women faced fears of emotional stereotyping. These empirical findings support earlier conclusions that stigma, hierarchy, and gender intersect to shape communication boundaries.

2.6 Development Communication and Mental Health

Development Communication (DevComm) has evolved from a top-down, information-transfer model to an inclusive, dialogic process emphasizing participation, empowerment, and local ownership (Servaes, 2008; Melkote & Steeves, 2015). Once focused on agriculture and economic development, DevComm now extends to social issues such as health, gender, and mental well-being (Manyozo, 2022). Because mental health is integral to human development and productivity, it aligns closely with DevComm's goal of enhancing resilience through dialogue and participation.

Early diffusion models of communication, such as Rogers (2003), emphasized transmitting expert knowledge to passive audiences. These were later critiqued for neglecting cultural context. The participatory paradigm reframed communication as dialogue, mutual learning, and empowerment, positioning people as co-creators of meaning (Servaes, 2008). Applied to mental health, this perspective promotes interactive, people-centered communication that challenges stigma and builds collective understanding. Tufte and Mefalopulos (2009) argue that interventions are sustainable only when grounded in people's voices and experiences. In Ghanaian workplaces, this implies engaging employees, managers, and HR teams in co-designing communication strategies rather than adopting imported wellness templates.

Participation fosters psychological safety and inclusion, making employees more likely to disclose distress and seek help when they perceive communication as collaborative rather than evaluative (Melkote & Steeves, 2015). Adom et al. (2021) found that the absence of participatory structures in Ghanaian organisations sustains stigma and misinformation, while dialogue enables feedback and adaptation. African evidence supports this: participatory storytelling and theatre in Kenya and Uganda successfully reduced HIV/AIDS stigma, showing how collective dialogue fosters empathy and behavioural change (Tufte & Mefalopulos, 2009).

Dialogue in DevComm represents mutual respect and cultural recognition (Servaes, 2008). King (2024) showed that faith-based dialogue shapes mental health disclosure among Ghanaians, demonstrating the need to integrate spiritual and indigenous frameworks. In workplaces, participatory workshops and safe conversation spaces humanise mental health discussions, allowing employees to share experiences and co-create policy. Viewing organisations as “micro-communities of development” positions communication as both a process and goal of empowerment, aligning with Sustainable Development Goals 3 and 8 (United Nations, 2015).

2.7 Theoretical Framework

This study is guided by Communication Privacy Management Theory (CPM), developed by Sandra Petronio, which explains how individuals manage the boundaries surrounding private information. CPM posits that people consider their personal information as something they own, and they regulate disclosure through rules that are shaped by perceived risks, cultural norms, relational trust, and contextual expectations. Within workplace mental health communication, CPM provides a useful lens for understanding how employees decide whether to reveal or conceal psychological distress in professional environments.

In Ghanaian workplaces, these disclosure decisions are influenced by concerns about confidentiality, possible stigma, power distance, and organisational hierarchies. CPM helps explain why employees may rely on coded language, partial disclosure, indirect communication, or silence when navigating sensitive conversations about mental well-being. Employees weigh the potential benefits of disclosure, such as support or relief, against perceived threats, including judgment, loss of respect, or negative career implications. This balance of risk and trust becomes central to how mental health issues are communicated.

The theory also highlights the importance of co-managed boundaries, where once personal information is shared, both the discloser and the recipient become responsible for protecting or managing that information. In workplace settings, this means that managers, supervisors, and colleagues play a critical role in maintaining privacy expectations and shaping whether disclosure feels safe. Breaches of confidentiality or unsupportive responses reinforce tighter boundaries, reducing openness and sustaining stigma.

The participatory orientation of this study complements CPM by underscoring the significance of dialogue, shared understanding, and inclusive communication spaces in reshaping these boundaries. Participatory communication emphasises interaction, mutual respect, and

collective problem-solving, all of which can strengthen the trust necessary for healthier boundary negotiation. When organisations create spaces that invite contribution, encourage collaborative conversations, and legitimise employee voices, individuals are more likely to perceive disclosure as less risky. Such environments support the development of communication norms that protect privacy, reduce fear, and enhance psychological safety.

Integrating CPM with participatory principles provides a coherent lens for analysing mental health communication in Ghanaian workplaces. Boundary management explains why employees often remain silent, while participatory practices highlight how organisational culture can be transformed to support more open and supportive dialogue. Together, they illustrate how trust, shared responsibility, and inclusive communication processes can improve mental health communication and reduce stigma across diverse organisational settings.

2.8 Summary of Gaps in the Literature

The review of global, African, and Ghanaian literature reveals increasing attention to workplace mental health but also exposes major gaps in conceptual focus, theoretical grounding, and methodological diversity. These gaps justify the present study's focus and mixed-method design.

First, most existing research originates from high-income Western contexts, emphasizing corporate wellness or digital interventions that assume open communication cultures and institutional support (Thornicroft et al., 2022; LaMontagne et al., 2014). Such frameworks are poorly suited to African environments where stigma, hierarchy, and limited policy implementation persist (Atilola, 2021). While African studies have examined stigma and help-seeking behavior (Dako-Gyeke & Asumang, 2013; Odejide, 2020), few have explored the communication processes through which mental health is discussed and negotiated in

organizations. In Ghana, despite the Mental Health Act (2012), private-sector implementation remains weak, and little empirical work connects national policy with workplace realities (Aidoo & Harpham, 2021).

Second, communication is rarely treated as a central analytical lens. African research tends to focus on clinical or attitudinal outcomes, neglecting how communication shapes disclosure, trust, and stigma (Asare-Doku et al., 2022). Theoretical integration is limited, with few studies applying frameworks like Communication Privacy Management or Participatory Communication to explain behavior.

Third, gender and culture—critical determinants of workplace dialogue—are often treated as secondary variables (Courtenay, 2020; Hegarty et al., 2022). Cultural interpretations linking mental illness to spirituality or weakness (Adom et al., 2021) and gendered expectations about emotional expression remain underexplored in workplace contexts.

Methodologically, most Ghanaian studies employ single-method designs, either quantitative or descriptive qualitative, offering limited depth (Adjei, 2021; Lawrence et al., 2024). The absence of mixed-method explanatory approaches constrains understanding of both patterns and lived experiences.

Finally, Development Communication principles, though central to participatory social change, have been scarcely applied to workplace mental health (Servaes, 2008; Melkote & Steeves, 2015). Existing initiatives remain top-down, with minimal employee participation. This study addresses these gaps by applying participatory communication to explore how inclusive dialogue can reduce stigma and enhance mental well-being in Ghanaian workplaces.

2.9 Chapter Summary

This chapter reviewed global, African, and Ghanaian literature on workplace mental health communication. The global evidence shows that open dialogue, leadership support, and stigma reduction improve employee well-being. African studies highlight persistent cultural beliefs, hierarchical communication systems, and limited institutional capacity, which restrict open conversations about mental health. In Ghana, despite the Mental Health Act, organisational communication remains formal and top-down. Stigma, confidentiality concerns, gender norms, and reliance on informal coping mechanisms continue to shape communication practices.

The chapter also showed that development communication principles, especially participation, can strengthen workplace dialogue by promoting inclusion and shared responsibility. Although Communication Privacy Management offers a useful lens for understanding disclosure and boundary negotiation, these processes are influenced by broader organisational and cultural dynamics that participatory communication can help address. The reviewed studies reveal significant gaps in Ghana regarding communication strategies, participatory approaches, and contextual evidence from the private sector. These gaps justify the present study.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter outlines the methodology adopted to investigate workplace mental health communication in Ghana. Methodology provides the structural framework through which research questions are systematically explored and answered. Given the sensitive and multifaceted nature of mental health in organizational settings, it is crucial to adopt a coherent plan that ensures reliability, validity, and contextual relevance.

The chapter presents the design of the study, including the sampling strategies, data collection methods, and procedures for data analysis. Each of these methodological components is discussed to highlight how they contribute to achieving the research objectives. In doing so, the chapter not only establishes the rigor of the study but also demonstrates the alignment between research questions, methodological choices, and the Ghanaian workplace context. By laying out these procedures, the chapter provides a roadmap that ensures transparency and replicability, while positioning the study to generate insights capable of informing effective and inclusive workplace mental health policies.

3.2 Research Philosophy

This study is guided by the philosophical paradigm of pragmatism, which supports the use of mixed methods to explore complex social phenomena like workplace mental health communication. Pragmatism allows the researcher to focus on the research problem rather than being confined to a single system of philosophy or reality (Creswell & Plano Clark, 2018). It acknowledges that both quantitative and qualitative data offer valuable insights and that combining them provides a richer and more comprehensive understanding. In this context,

pragmatism justifies the integration of numerical data on communication practices with in-depth qualitative narratives about lived experiences, cultural dynamics, and stigma. This paradigm is particularly relevant for studies aiming to produce actionable, context-specific knowledge that can inform both policy and practice.

3.3 Research Approach

This study adopted a mixed methods approach, integrating both quantitative and qualitative research methods to provide a comprehensive understanding of workplace mental health communication in Ghana. Mixed methods research combines the strengths of qualitative and quantitative approaches, enabling researchers to capture both measurable trends and the deeper meanings, perceptions, and contexts behind them (Creswell & Plano Clark, 2018; Johnson et al., 2007). The quantitative component generated empirical evidence on the prevalence, forms, and patterns of workplace mental health communication, as well as the influence of gender differences and stigma on disclosure behaviors. This allowed statistical comparisons between demographic groups and identifying factors that predict mental health communication preferences (Bryman, 2016). The qualitative component captured contextualized insights into lived experiences, organizational cultures, and the socio-cultural dynamics that influence how mental health is discussed or silenced in Ghanaian workplaces. This integration is particularly suitable for the research problem because mental health communication is shaped by both structural factors (e.g., organizational policies, resource allocation, communication systems) and social factors (e.g., stigma, gender norms, interpersonal relationships). By combining the two, the study provided both breadth and depth of understanding.

3.4 Research Design

This study employed a mixed-method research design, specifically an explanatory sequential design, beginning with a quantitative phase followed by a qualitative phase. The purpose of this design is to elaborate on the quantitative findings by using qualitative methods (Creswell & Plano Clark, 2018). In this design, quantitative findings provided an initial overview of workplace mental health communication patterns, which were then explored in greater depth through qualitative inquiry (Ivankova, Creswell, & Stick, 2006). The quantitative overview focused on mapping the prevalence and nature of mental health communication practices within Ghanaian workplaces, identifying preferred communication channels, and examining potential gender-based differences in disclosure and stigma experiences. The qualitative phase built on the quantitative results by exploring the social, cultural, and organizational dynamics that shape mental health communication.

3.5 Study Area

The study was conducted in Accra, Ghana, within a private financial technology (FinTech) organization operating in the micro-lending and digital financial services sector, with a workforce of about two hundred staff. This organization was selected because it represents a rapidly expanding area of Ghana's private sector, characterized by high work demands, performance-driven cultures, and limited psychosocial support systems. Such environments often influence how employees communicate about mental health, manage workplace stress, and perceive stigma around disclosure.

The choice of this setting is justified by its relevance to emerging workplace mental health challenges in Ghana's modern digital economy. Employees in FinTech organizations frequently

face tight deadlines, technology-related stress, and communication pressures in highly competitive environments. Exploring mental health communication in this context offers valuable insights that can inform the design of more inclusive mental health policies and practices across similar private workplaces in Ghana.

3.6 Population

The population of this study was made up of employees and managers working in the selected FinTech organisation. The study specifically targeted individuals who have been employed in their current workplace for at least six months, as this ensures adequate exposure to workplace culture and communication practices. Management-level staff were included to capture organizational perspectives on policy and communication, while non-managerial employees were included to reflect lived experiences of disclosure, stigma, and support. By focusing on this population, the study aimed to provide a holistic understanding of how mental health is communicated within corporate organizations in Ghana.

3.7 Sampling

Given the sequential explanatory mixed methods design, sampling was conducted in two distinct but interconnected phases. The quantitative phase used simple random sampling of staff in the selected FinTech. This random selection was utilized to aim for a spread of responses across different departments. A target sample of 50 respondents was anticipated, with a key requirement being people in the workforce for at least six months. For the qualitative phase, participants were recruited from among survey respondents who voluntarily expressed interest in taking part in follow-up interviews. To maintain the anonymity of the questionnaire,

respondents were asked, at the end of the survey, if they wish to be contacted for an interview. Those who agreed provided their contact details on a separate, unlinked response form to ensure that their survey responses remained anonymous. From this volunteer pool, a purposive selection was made to ensure variation in gender, management level, and experience with mental health communication. Approximately 5 participants were selected for interviews.

If no survey respondents volunteered for follow-up interviews, the researcher would have recruited additional participants who met similar inclusion criteria through professional networks within the same industry. This approach would have ensured that the qualitative phase was still conducted within comparable organizational contexts, maintaining the integrity of the research design. These participants would not have formed part of the survey dataset but would help explain and contextualize the quantitative findings, consistent with the explanatory sequential mixed-method approach.

The target sample size for the quantitative phase was fifty (50) participants. This number is appropriate for an explanatory mixed-method study of this nature, where the objective is to identify key trends and relationships rather than to make statistical generalizations (Neuman, 2014; Bryman, 2016). Given the organizational context and time constraints of the study, this sample size was considered both manageable and sufficient to generate meaningful insights.

For the qualitative phase, approximately five (5) participants were interviewed. This number aligns with the recommendations of Creswell and Plano Clark (2018), who note that qualitative follow-up samples in explanatory or mixed-method designs are typically small because their purpose is to provide depth and explanation rather than representativeness. Guest et al., (2020) further suggest that thematic saturation is often achieved between four and six interviews when the topic is well-focused. Accordingly, five interviews were deemed adequate to capture diverse perspectives across gender, role, and communication comfort while maintaining

feasibility within the study timeframe. This approach was guided by the study's pragmatic philosophy, which focuses on using practical methods and appropriate sample sizes to generate useful, real-world insights rather than statistical generalizations.

3.8 Data Collection Methods

In the context of research, data collection methods can include surveys, interviews, observations, experiments, content analysis, document analysis, among others (Creswell & Creswell, 2017; Neuman, 2014). These methods are selected based on their suitability for addressing the research questions, the type of data required (quantitative or qualitative), and the available resources. For this research, data collection was conducted in two sequential phases. The first phase involved administering a structured questionnaire to the random sample of employees and managers identified during the sampling stage. The survey captured:

- Current mental health communication practices in workplaces.
- Perceptions of stigma, organizational support, and disclosure norms.
- Preferences for different communication channels and approaches.
- Demographic and workplace characteristics (sector, size, gender, role, etc.).

The questionnaire was distributed online and was adapted to the context through pre-testing and review.

The second phase commenced after preliminary analysis of the quantitative data. After analyzing the quantitative data, qualitative interviews were conducted with participants who volunteered separately to be contacted for this phase. The follow-up recruitment did not compromise survey anonymity, as identifying information was not linked to individual survey

responses. The interview participants were purposively selected from the volunteer list to reflect variation in gender, role, and workplace experiences.

These interviews explored in greater depth:

- Personal experiences of mental health communication at work.
- How gender, organizational culture, and stigma influence disclosure and help-seeking.
- Perceptions of inclusivity in existing practices.
- Preferred approaches for workplace mental health communication and policy design.

Interviews were conducted either in person or via secure online platforms, depending on participant preference and logistical feasibility. They were carried out in English and were audio-recorded with informed consent.

3.9 Data Collection Instrument

The study employed two main instruments for data collection, consistent with its mixed methods design.

3.9.1 Structured Questionnaire (Quantitative Phase)

A structured questionnaire was developed to capture information on employees' experiences and perceptions of workplace mental health communication. The instrument included both closed-ended and Likert-scale questions covering current practices, perceptions of stigma, disclosure norms, and preferred communication approaches. The questionnaire also captured demographic information (gender, sector, role, organizational size) to allow for comparative analysis. Pre-testing was conducted with a small group of employees to refine question clarity and ensure contextual relevance.

3.9.2 Semi-Structured Interview Guide (Qualitative Phase)

An interview guide was designed for use during the qualitative phase to generate deeper insights into employees' and employers' experiences. The guide contained open-ended questions that allowed participants to elaborate on workplace communication, stigma, gender dynamics, and policy gaps. Flexibility was maintained to allow the interviewer to probe further based on responses. The guide was developed in consultation with communication and mental health experts to ensure cultural appropriateness and ethical sensitivity.

Together, these instruments enable systematic collection of both quantitative and qualitative data, ensuring that the study's research questions were comprehensively addressed.

3.10 Data Analysis

Data analysis was conducted in line with the sequential explanatory mixed methods design, with separate procedures for the quantitative and qualitative phases, followed by integration of findings. The integration of the two phases occurred at both the design and interpretation stages. Quantitative findings were used to identify key patterns and variables—such as differences in disclosure comfort, stigma perception, and gender-based communication experiences—that informed the focus of the qualitative interviews. During interpretation, the qualitative insights were compared and connected with the quantitative trends to explain underlying reasons for the observed patterns, thereby ensuring that both data sets complement and validate each other. Survey responses were coded and entered into a statistical software package such as SPSS for analysis. Given the time-constrained nature of the study, the analysis focused primarily on descriptive statistics to identify patterns in workplace mental health communication practices, levels of stigma, and disclosure preferences. From a qualitative perspective, interview

transcripts were transcribed verbatim and analyzed using thematic analysis (Braun & Clarke, 2006). An inductive coding approach was employed to allow themes to emerge from the data, while also paying attention to issues highlighted in the research questions, such as stigma, gender dynamics, and preferred communication strategies. Coding was carried out manually with structured coding frameworks. Thematic analysis is particularly well-suited for capturing the lived experiences of participants and for identifying nuanced patterns of meaning across diverse workplaces.

3.11 Ethical Consideration

This study was conducted in strict adherence to the ethical standards governing human subject research at the University of Media, Arts and Communication (UNIMAC). All research activities prioritized the dignity, rights, and well-being of participants, in accordance with UNIMAC's guidelines. Participants were fully informed about the study's purpose, procedures, potential risks and benefits, and their rights as participants. Written informed consent was obtained from all participants, who indicated their agreement by ticking a consent checkbox on the form, after the study's purpose, procedures, and their right to withdraw at any time without penalty have been clearly explained. For participants completing the questionnaire, anonymity was maintained, and any contact information for follow-up interviews was collected through a separate form to prevent linkage between survey responses and identities.

All data was treated confidentially, meaning it was not disclosed to unauthorised third parties. Interview data could not be fully anonymous due to the interactive nature of interviews; however, pseudonyms were used in transcripts and reports, and indirect identifiers were generalised where necessary to prevent deductive disclosure. Given the sensitivity of mental health, participants' privacy was protected by allowing them to skip any question, pause or stop

the interview at any time, and choose not to be audio-recorded; only information they voluntarily provided was collected.

The study also upheld the principles of academic integrity as prescribed by UNIMAC. To avoid plagiarism, all sources were properly cited using APA (7th edition) referencing style. The researcher used plagiarism detection tools, including Turnitin, and ethical writing practices to ensure originality, honesty, and academic quality.

Finally, cultural sensitivity guided all interactions, particularly in addressing stigma and gender-related dynamics. By upholding these principles, the study ensured that participants' rights, dignity, and well-being were fully protected.

3.12 Chapter Summary

This chapter has outlined the methodological framework adopted for the study. A mixed methods approach, using an explanatory sequential design, was employed to examine workplace mental health communication in Ghana. The study population, sampling strategies, and data collection methods were described, alongside the instruments used to generate quantitative and qualitative data. Procedures for data analysis were explained, emphasizing both descriptive statistical techniques and thematic analysis. Ethical considerations were highlighted to ensure participant safety, confidentiality, and cultural sensitivity. This methodological roadmap positions the study to provide valid and reliable insights into how mental health is communicated in Ghanaian workplaces and how participatory approaches can inform inclusive policy and practice.

CHAPTER FOUR

DATA ANALYSIS, PRESENTATION OF FINDINGS AND DISCUSSIONS

4.0 Introduction

This chapter presents, analyses, and discusses the study's findings based on the adopted mixed-methods design. Consistent with the explanatory sequential design, this chapter presents the quantitative findings alongside the qualitative insights, integrating both data sources within each objective to provide a comprehensive understanding of mental health communication in the selected FinTech organisation.

The chapter opens with the demographic characteristics of the 51 respondents who provided valid, consented survey data. It then presents findings organised according to the study's four objectives: current workplace mental health communication practices; gender differences in communication experiences; preferred communication channels and formats; and implications of these patterns for more inclusive and participatory mental health communication strategies.

In presenting the results, the chapter moves beyond descriptive reporting by analysing emerging patterns, highlighting notable trends, and interpreting them within the organisational and broader Ghanaian socio-cultural context. Quantitative patterns are complemented by qualitative insights that deepen understanding of employees' lived experiences, perceptions, and communication challenges. Together, these analyses provide a comprehensive picture of workplace mental health communication in Ghana's FinTech sector.

4.1 Demographic Characteristics of Respondents

A total of 51 employees participated in the study. With respect to sex, two-thirds of the respondents were male (66.7%, n = 34), while females constituted 33.3% (n = 17). In terms of age distribution, most participants were between 25 and 34 years (64.7%, n = 33). This was followed by respondents aged 35–44 years (23.5%, n = 12). Smaller proportions fell within the 18–24-year age group (7.8%, n = 4) and the 45–54-year category (3.9%, n = 2). Regarding tenure within the organisation, the largest group had worked for less than 12 months, representing 35.3% (n = 18) of the sample. Employees with 12–23 months and 2–4 years of service each accounted for 29.4% (n = 15) of respondents. The least represented group comprised employees who had been with the organisation for 5–9 years, making up 5.9% (n = 3).

Table 1: Demographic Characteristics of Respondents

		Frequency	Percent
Number of years in organisation	12 - 23 months	15	29.4
	2 - 4 years	15	29.4
	5 - 9 years	3	5.9
	less than 12 months	18	35.3
Age group	18 - 24	4	7.8
	25 - 34	33	64.7
	35 - 44	12	23.5
	45 - 54	2	3.9
Sex	Female	17	33.3

	Male	34	66.7
	Total	51	100.0

Source: Field Data, 2025

These characteristics are important for understanding patterns in workplace mental health communication, as they shape how employees engage with organisational messages, perceive confidentiality, and participate in conversations about wellbeing. A youthful workforce may be more open to digital communication channels, while a male-dominated environment may influence disclosure norms and perceptions of stigma. Similarly, the high proportion of employees with fewer than five years of tenure has implications for trust-building, openness, and familiarity with organisational policies. The subsequent figures present the distribution of gender, age, and organisational tenure among respondents.

4.2 Perceptions of Workplace Mental Health Communication

This section presents employees' perceptions of how mental health communication operates within the organisation. Rather than assessing policies or management-level practices, the analysis focuses on employees' awareness, experiences, and interpretations of the communication environment surrounding mental health issues at work. The results reflect how staff understand the availability of support, the clarity of communication channels, and the extent to which they feel comfortable discussing mental health concerns within the organisation.

The results demonstrate that while the organisation recognises mental health as part of staff wellbeing, communication structures remain inconsistent. A majority of employees (34, 66.7%) agreed or strongly agreed that the organisation acknowledges mental health as part of wellbeing. However, 12 employees (23.6%) agreed that there were clear channels for

communication about mental health concerns, while a substantial 20 employees, (39.2%), neither agreed nor disagreed, indicating uncertainty or inconsistency in communication clarity.

Managerial engagement presented a mixed picture. While 20 employees (39.2%) agreed their managers encourage open conversations, 16 employees (31.4%) were neutral, and 16 employees (31.4%) disagreed or strongly disagreed. This suggests that the quality of supervisory communication varies across departments.

Confidentiality appears to be one of the strongest areas of employee confidence. 27 employees (53%) believed mental health information is treated confidentially, although 21 employees (41.2%) remained neutral. This neutrality signals awareness gaps rather than distrust.

Internal awareness initiatives are limited. Only 11 employees (21.5%) reported receiving periodic information or campaigns related to mental health, while 19 employees (37.3%) disagreed and 21 employees (41.2%) were neutral. This indicates an absence of sustained communication efforts.

A notable concern is the absence of designated mental health support structures. Only 14 employees (27.5%) indicated the presence of a focal person or support office (such as HR or an Employee Assistance Programme), while 30 employees (58.9%) disagreed. Similarly, awareness of how to access professional help externally was low: 18 employees (35.3%) disagreed they knew how to obtain help if needed.

On a more positive note, team platforms were perceived as respectful spaces for wellbeing conversations, with 32 employees (62.7%) agreeing or strongly agreeing. However, only 19 employees (37.3%) felt safe raising concerns to their supervisors, with 21 employees (41.2%) reporting uncertainty.

Finally, mechanisms for reporting psychosocial risks such as bullying or harassment were relatively clear, with 29 employees (56.9%) confirming they knew where to report such issues.

Commenting on the absence of an explicit policy on mental health, Daniel, a non-managerial staff said:

“We all know mental health matters, but there is no clear structure or policy in the company. It’s mostly left to individuals.”

Insights from management also confirmed the absence of formal structures. Adjoa, an assistant HR Manager, noted, *“We have not formalised any mental health process yet, so there is no clear procedure for reporting or follow-up.”* She also acknowledged that although the organisation has a whistleblower portal on its website, it is rarely used for mental health concerns because staff are unsure whether it guarantees confidentiality.

This mirrors organisational communication literature showing that awareness without structured policy frameworks often results in inconsistent practices and limited employee confidence in mental health systems. The disconnect between awareness and structured practice demonstrates weak organisational boundary management, a central concern of Communication Privacy Management theory, which predicts hesitation when rules for privacy governance are unclear or unspecified.

Overall, these findings depict an organisation that acknowledges mental health conceptually but lacks systematic communication strategies, consistent structures, and visible support systems. These uncertainties reflect what Communication Privacy Management (CPM) theory identifies as weak organisational boundary coordination, where employees cannot clearly identify how private information is managed (Petronio, 2002). The absence of formalised channels also contradicts participatory communication principles, which emphasise clarity, inclusion, and accessibility of information flows within organisational systems. Further, these findings are consistent with previous studies showing that many organisations recognise mental health conceptually but struggle to translate this awareness into structured communication

systems and clear support architecture. For example, research in similar African corporate contexts indicates that while wellbeing is increasingly acknowledged, formal communication frameworks, mental health focal persons, and routinised awareness programmes remain underdeveloped (Appiah et al., 2022; Oppong & Asampong, 2021). International studies also highlight that the absence of clear communication channels and visible policy guidelines often leads to employee uncertainty and low utilisation of mental health resources (WHO, 2022; Harvey et al., 2017). Thus, the present findings reflect broader organisational patterns where awareness exceeds institutionalisation.

Table 2: Employees’ Perceptions of Mental Health Communication

Statement	Response Category	Frequency	Percent (%)
Q1. Our organization acknowledges mental health as part of staff wellbeing.	Strongly Disagree	1	2.0
	Disagree	7	13.7
	Neutral	9	17.6
	Agree	28	54.9
	Strongly Agree	6	11.8
Q2. There are clear channels to communicate about mental health concerns.	Strongly Disagree	5	9.8
	Disagree	12	23.5

	Neutral	20	39.2
	Agree	9	17.6
	Strongly Agree	5	9.8
Q3. Managers encourage open conversations about mental health.	Strongly Disagree	3	5.9
	Disagree	13	25.5
	Neutral	15	29.4
	Agree	16	31.4
	Strongly Agree	4	7.8
Q4. Information shared about mental health is treated confidentially.	Strongly Disagree	0	0.0
	Disagree	3	5.9
	Neutral	21	41.2
	Agree	24	47.1
	Strongly Agree	3	5.9
Q5. We receive periodic information/campaigns on mental health.	Strongly Disagree	8	15.7

	Disagree	11	21.6
	Neutral	21	41.2
	Agree	9	17.6
	Strongly Agree	2	3.9
Q6. There is a designated person/office (e.g., HR/EAP) for mental health support.	Strongly Disagree	14	27.5
	Disagree	16	31.4
	Neutral	7	13.7
	Agree	11	21.6
	Strongly Agree	3	5.9
Q7. Staff know how to get professional help for mental health if needed.	Strongly Disagree	6	11.8
	Disagree	12	23.5
	Neutral	20	39.2
	Agree	11	21.6
	Strongly Agree	2	3.9

Q8. Team meetings/platforms allow respectful discussion on wellbeing.	Strongly Disagree	1	2.0
	Disagree	5	9.8
	Neutral	13	25.5
	Agree	28	54.9
	Strongly Agree	4	7.8
Q9. I feel safe raising mental health concerns to my supervisor.	Strongly Disagree	4	7.8
	Disagree	7	13.7
	Neutral	21	41.2
	Agree	16	31.4
	Strongly Agree	3	5.9
Q10. I know where to report bullying/harassment or psychosocial risks.	Strongly Disagree	3	5.9
	Disagree	10	19.6
	Neutral	9	17.6
	Agree	21	41.2

	Strongly	8	15.7
	Agree		

Source: Field Data, 2025

4.3 Gender Differences in Mental Health Communication

As its second objective, the study looked at the influence of gender differences on employees' experiences with mental health communication at work

An independent-samples t-test was conducted to examine gender differences in employees' mental health communication experiences. Results showed no significant difference between males (M = 3.09, SD = 0.90) and females (M = 3.12, SD = 0.93), $t(49) = -0.109$, $p = .914$. This indicates that gender does not significantly influence employees' experiences with mental health communication at the workplace.

Table 3: Group Statistics for Gender Differences in Composite Mental Health Communication Scores

	Gender	N	Mean	Std. Deviation	Std. Error Mean
Mental health communication	Male	34	3.09	.900	.154
	Female	17	3.12	.928	.225

Source: Field Data, 2025

The findings of this study showed no significant gender differences in employees' mental health communication experiences, $t(49) = -0.11$, $p = .914$, with an extremely small effect size

(Cohen's $d = 0.03$). This indicates that male and female employees perceive mental health communication in similar ways and show comparable levels of willingness to discuss or disclose mental health concerns within the organisation.

This result suggests that, within the organisation studied, men and women communicate about mental health in very similar ways, showing comparable levels of comfort, hesitation, and willingness to disclose concerns. This observation is consistent with emerging literature indicating that gender gaps in workplace mental health communication are narrowing as organizations adopt more inclusive mental health policies and awareness campaigns (Birch et al., 2021; Oliver et al., 2020). Previous studies have noted that while women historically reported higher willingness to discuss emotional concerns, contemporary workplaces with structured mental health frameworks reduce these differences by providing equal communication channels and support systems (Smith & Mahoney, 2019). Thus, the present findings imply that gender may no longer be a primary determinant of mental health communication in modern work environments. The interview data supports this pattern, as both male and female participants expressed similar concerns about trust, confidentiality, stigma, and emotional safety, rather than highlighting gender specific barriers. This suggests that, in this organisational context, shared workplace norms and culture shape communication experiences more strongly than gender differences. The limited gender differences observed align with Communication Privacy Management (CPM) theory's assertion that privacy-rule decisions are shaped more by relational trust and workplace norms than by demographic variables. This finding also supports participatory communication perspectives, which argue that communication experiences equalise when systems are transparent, inclusive, and supportive.

Table 4: Independent Samples t-Test for Gender Differences in Mental Health Communication

Variable	Gender	N	Mean	SD	t(df)	p-value
Mental Health Communication	Male	34	3.09	0.90	-0.11 (49)	0.914
	Female	17	3.12	0.93		

Source: Field Data, 2025

4.4 Preferred Communication Approaches

Objective three aimed to identify the communication approaches employees consider most comfortable, trustworthy, and appropriate for discussing mental health concerns in the workplace. The goal was to understand which channels employees prefer to use, why they prefer them, and how these preferences reflect issues of trust, confidentiality, organisational culture, and psychological safety. By examining preferred communication approaches, this objective helps to reveal how employees navigate sensitive conversations and what forms of communication are most likely to encourage or discourage disclosure.

The results indicate strong employee caution toward formal disclosure channels. Nearly half, 25 employees (49%), disagreed that they would disclose a mental health concern to HR, whereas 19 employees (37.3%) indicated they would. Disclosure to line managers was slightly higher, with 22 employees (43.1%) indicating they would disclose, though 14 employees (27.5%) disagreed and 15 employees (29.4%) remained neutral.

Peer-based communication emerged as the most trusted channel. A total of 40 employees (78.5%) stated they would disclose concerns to a trusted colleague or peer. This preference reflects the interpersonal and relational communication patterns typical of Ghanaian workplaces, where horizontal trust networks often function more reliably than formal structures. This pattern is strongly consistent with Communication Privacy Management

theory, which posits that individuals disclose sensitive information only within relational contexts where boundary turbulence feels minimal and trust is high. The dominance of peer communication further reflects participatory communication ideals, which position horizontal dialogue and shared meaning-making as safer and more empowering than top-down formal structures.

A strong and consistent pattern across interviews was the centrality of trust in determining disclosure behaviour. Employees were significantly more comfortable speaking with colleagues or friends within the workplace than with HR or supervisors. The relationship-oriented nature of the organisation appears to anchor disclosure decisions.

Ama, a non-managerial staff stated:

“If I’m stressed or overwhelmed, I usually talk to one colleague who understands me. Going to HR is the last thing I’d do.”

She expressed concern about being labelled, judged, or misunderstood, particularly by supervisors:

“Managers are more focused on targets; I’m not sure they will take it well if I start talking about emotional issues.”

Some supervisors also noted that while they try to be approachable, they do not feel fully equipped to handle mental health conversations. This suggests that managerial support may exist but requires further training to be effective.

This finding strongly supports Communication Privacy Management theory, showing that employees establish personal “privacy boundaries” based on trust, relational closeness, and perceived risk. It also reflects participatory principles—employees prefer communication spaces that feel human, empathetic, and non-hierarchical. The findings further align with

Communication Privacy Management scholarship, which emphasises that disclosure decisions are shaped by perceived privacy boundaries, trust levels, and relational closeness (Petronio, 2002). Similar studies in African workplaces report that peer support frequently outweighs formal disclosure channels due to fears of stigma and organisational repercussions (Oppong, 2021).

Further, confidentiality concerns were prevalent. A majority, 35 employees (68.7%), agreed that such concerns would discourage disclosure, reaffirming trust deficits in formal structures. Gender norms were perceived as influential by 18 employees (35.3%), though neutrality levels of 15 employees (29.4%) indicate varied experiences.

Workload pressures were found to significantly hinder mental health communication. A substantial 32 employees (62.7%) agreed that pressure reduces openness among employees, indicating that high performance expectations limit the time and emotional capacity needed for meaningful conversations about wellbeing. In fast-paced FinTech environments, employees often prioritise meeting targets and deadlines over discussing personal challenges, even when they are distressed. Heavy workloads may also create a culture where admitting difficulty is perceived as a sign of weakness or inefficiency, which further discourages disclosure. This suggests that organisational demands can unintentionally reinforce silence around mental health, making it harder for employees to seek support when they need it.

Participants frequently described the organisation as fast-paced, target-driven, and demanding. This high-pressure environment was cited as a major barrier to discussing mental health. Employees felt that the organisational culture prioritises productivity and speed, leaving little room for vulnerability.

Edinam, a female senior staff observed:

“The pressure is intense. Sometimes you’re afraid to even admit you’re struggling because it might be seen as weakness.”

Kofi, another senior staff added:

“There are days where you don’t even have time to think. In such an environment, it’s difficult to have emotional conversations.”

Thus, the organisation’s culture inadvertently discourages openness by creating a climate where vulnerability may be perceived as incompetence. This is particularly critical in a FinTech context defined by speed, innovation, and high performance. This supports longstanding evidence that high-pressure environments undermine psychological safety and reduce willingness to discuss mental health (Edmondson, 2019). Research in fast-paced and target-driven sectors similarly highlights workload as a major inhibitor of wellbeing communication (Carroll & Chung, 2021).

Despite the barriers identified, participants described clear conditions under which they would feel more comfortable discussing mental health. These included confidentiality assurance, managerial empathy, reasonable adjustments, and alternative reporting channels.

Firstly, assurance of confidentiality emerged as a major enabling factor. Akosua, a non-managerial female staff member, explained that, *“If confidentiality is guaranteed, people will talk. The fear is that it may be used against you.”* Her reflection underscores how perceived privacy risk discourages disclosure.

Managerial empathy was also highlighted. Kwame, a male supervisor, noted, *“If managers are trained to handle these conversations, it will change everything.”* His account suggests that the manner in which managers respond plays a significant role in shaping employees’ willingness to speak up.

Reasonable adjustments were also repeatedly mentioned as important. Ama, a mid-level officer, described how *“Knowing that the company can adjust workload when you are struggling will make people more open.”* This indicates that structural flexibility signals care and reduces the emotional cost associated with disclosure.

Lastly, participants emphasised the need for alternative or private reporting channels. Yao, a non-managerial male employee, stated, *“Sometimes you want a private way to talk, not necessarily face to face with HR.”* This reflects a desire for discretion and reduced power dynamics in help-seeking interactions.

Finally, the availability of reasonable accommodations strongly influenced employees’ willingness to communicate mental health concerns. A total of 42 respondents (84.3%) indicated that they would be more likely to disclose if the organisation provided supportive adjustments such as flexible work arrangements, modified deadlines, or temporary reductions in workload. This suggests that when employees know they will not be penalised or overwhelmed after disclosing a mental health difficulty, they feel safer and more supported to speak up. Reasonable accommodations signal organisational care and create conditions that reduce fear, enabling more open conversations about mental health.

The survey also showed openness to seeking professional help, with 30 respondents (58.8%) indicating they would do so when distressed. Qualitative accounts revealed a preference for external therapists because they are seen as neutral and more confidential than internal options. However, some participants were unsure how to access such services or whether the organisation facilitates them. This gap between willingness and access highlights the need for clearer information and structured linkages to external support.

These findings suggest that employees prefer communication channels that feel supportive, relational, and confidential, such as speaking to trusted colleagues or peer supporters. These

channels are viewed as safe because they rely on familiarity, empathy, and the expectation of discretion. In contrast, formal or managerial pathways such as reporting directly to supervisors or approaching the Human Resource office are seen as more structured and authoritative, where disclosure may feel risky because of concerns about judgement, documentation, or possible career implications. The difference between the two categories is therefore grounded in the degree of trust, emotional safety, and perceived consequences that each type of communication pathway presents.

These disclosure patterns closely align with existing research indicating that employees across various contexts place greater trust in informal or peer-based communication structures than in formal HR-led mechanisms, especially when discussing sensitive psychological concerns (Bowers et al., 2020; Carroll & Chung, 2021). Literature from Ghana and other African settings underscores that confidentiality concerns, power distance, and fear of stigma frequently discourage employees from using formal channels (Appiah-Agyekum & Asibey, 2020). Similarly, studies show that reasonable work adjustments significantly increase psychological safety and willingness to disclose mental health challenges (Harvey et al., 2017). The findings show that communication behaviours are strongly shaped by trust, relational closeness, and perceptions of organisational support.

Table 5: Frequency and Percentage Distribution of Responses to Preferred Mental Health Communication Approaches

Statement	Response Category	Frequency	Percent (%)
Q1. I would disclose a mental health concern to HR if needed.	Strongly Disagree	7	13.7
	Disagree	18	35.3

	Neutral	7	13.7
	Agree	14	27.5
	Strongly Agree	5	9.8
Q2. I would disclose to my line manager if needed.	Strongly Disagree	3	5.9
	Disagree	11	21.6
	Neutral	15	29.4
	Agree	17	33.3
	Strongly Agree	5	9.8
Q3. I would disclose to a trusted colleague/peer.	Strongly Disagree	2	3.9
	Disagree	4	7.8
	Neutral	5	9.8
	Agree	34	66.7
	Strongly Agree	6	11.8
Q4. I would seek professional help if experiencing distress.	Strongly Disagree	1	2.0

	Disagree	12	23.5
	Neutral	8	15.7
	Agree	20	39.2
	Strongly Agree	10	19.6
Q5. Confidentiality concerns would discourage me from disclosing.	Strongly Disagree	3	5.9
	Disagree	8	15.7
	Neutral	5	9.8
	Agree	21	41.2
	Strongly Agree	14	27.5
Q6. Gender norms at my workplace affect whether I would disclose.	Strongly Disagree	4	7.8
	Disagree	14	27.5
	Neutral	15	29.4
	Agree	15	29.4
	Strongly Agree	3	5.9

Q7. Workload or pressure affects whether employees discuss mental health openly.	Strongly Disagree	3	5.9
	Disagree	3	5.9
	Neutral	13	25.5
	Agree	28	54.9
	Strongly Agree	4	7.8
Q8. If reasonable adjustments were available, I'd be more likely to disclose.	Strongly Disagree	0	0.0
	Disagree	0	0.0
	Neutral	8	15.7
	Agree	23	45.1
	Strongly Agree	20	39.2

Source: Field Data, 2025

4.5 Development Communication Strategies for Inclusive Mental Health Policies

The findings show that development communication principles can play a central role in shaping inclusive workplace mental health policies in Ghana. The strong reliance on peer networks demonstrates the need for policies that recognise and formalise informal support systems. Policies could therefore incorporate peer-support structures, participatory feedback

mechanisms, and safe spaces for dialogue, ensuring that communication channels reflect employees' relational preferences.

The absence of clear mental health communication processes in the organisation suggests that workplace policies must prioritise transparency, openness, and accessibility. Development communication emphasises inclusive information flows, and policies informed by this approach should outline clear procedures for disclosure, confidentiality, and referral. Such policies would reduce uncertainty and strengthen employee confidence in organisational systems.

The findings further show that managerial capacity is crucial for enabling open communication, yet supervisors often feel unprepared for these conversations. Policies guided by development communication principles should therefore mandate basic training in empathetic communication, supportive leadership, and boundary management. This would ensure consistent and inclusive responses across departments.

The organisational culture of high workload and pressure indicates that inclusive policies must also address environmental barriers to communication. Development communication recognises the importance of enabling environments; therefore, policies should include provisions for reasonable accommodations, psychological safety, and stigma reduction to ensure employees feel safe to disclose concerns.

Finally, employees' willingness to seek professional help but uncertainty about accessing it reveals the need for policies that clearly communicate available internal and external support. Policies should formalise partnerships with mental health professionals and outline structured linkages so that employees receive consistent and understandable information.

Together, these insights show that development communication strategies can directly inform inclusive workplace mental health policies that are participatory, transparent, supportive, and responsive to employee needs.

4.5 Chapter Summary

This chapter presented and analysed the study's findings by integrating both quantitative and qualitative evidence. The demographic profile revealed a young, predominantly male workforce with relatively short organisational tenure. Quantitative results outlined existing communication practices, gender-related patterns, preferred disclosure channels, and organisational factors influencing mental health communication. The qualitative insights deepened these patterns by illustrating how trust, workplace culture, managerial attitudes, confidentiality concerns, and workload pressures shape employees' willingness to discuss mental health. The integrated analysis showed how both data strands complement each other and jointly explain the communication dynamics within the organisation. These findings provide the foundation for the conclusions and recommendations presented in the next chapter.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.0 Introduction

This chapter brings together main insights from the study and presents the summary of findings, recommendations, suggestions for future research, and the concluding reflections. Drawing on both the quantitative patterns and the qualitative perspectives reported in the previous chapter, it provides an overall interpretation of workplace mental health communication in the selected FinTech organisation.

The chapter summarises the findings according to the four research objectives, highlighting how the organisation's communication practices, interpersonal dynamics, and structural conditions shape employees' willingness to discuss mental health. It then presents recommendations informed by the study's evidence, followed by areas for further research where additional inquiry is needed to strengthen the understanding of mental health communication in Ghanaian workplaces. The chapter concludes with final reflections on the broader implications of the study.

5.1 Summary of Key Findings

This section summarises the study's major findings in line with the four research objectives. The findings integrate insights from both the quantitative survey and the qualitative interviews, providing a nuanced understanding of how mental health is communicated within the selected workplace.

5.1.1 Perceptions of Workplace Mental Health Communication

The study found that while the organisation conceptually acknowledges mental health as part of staff wellbeing, there is a significant gap between recognition and structured practice. Employees reported limited awareness of formal mental health communication systems, as well as inconsistent or unclear channels for discussing psychological concerns. Many respondents were unsure about existing policies, focal persons, or procedures for raising mental health issues.

Confidentiality was one of the few areas that employees perceived relatively positively, although many also indicated uncertainty about how confidential information is managed. Awareness campaigns and proactive communication efforts were minimal, and there were no routine programmes or structured activities promoting mental health. This creates an environment where mental health is understood to be important but is not systematically embedded into organisational communication practices.

Qualitative insights reinforced these findings, showing that employees rely heavily on personal knowledge and external sources rather than institutional communications. Participants described organisational communication on mental health as informal, reactive, and often invisible. Workload pressure and the fast-paced nature of the FinTech environment further constrained opportunities to discuss mental health openly.

5.1.2 Gender Differences in Mental Health Communication

The study found no significant gender differences in employees' overall experiences of mental health communication. Quantitative analysis showed almost identical mean scores for men and

women, while qualitative narratives suggested that both genders navigate similar concerns in disclosure and help-seeking.

Both men and women expressed caution when discussing mental health at work, mainly due to confidentiality fears, stigma, and the perceived risk of judgement. Although gender norms shape emotional expression in Ghanaian society, within this organisational context, these norms did not translate into substantially different communication patterns. Instead, organisational culture, communication climate, and trust emerged as the dominant influences on employees' willingness to disclose or seek help.

This finding suggests that at least in this workplace, structural and cultural organisational factors overshadow gendered expectations, equalising men and women's experiences of risk, uncertainty, and hesitation around mental health communication.

5.1.3 Preferred Communication Approaches for Addressing Mental Health

The study revealed a strong preference for peer-based communication as the primary channel for discussing mental health concerns. Employees overwhelmingly reported that they were more comfortable confiding in trusted colleagues than in HR personnel, supervisors, or formal reporting structures. This preference was rooted in perceptions of relational trust, empathy, and reduced likelihood of judgement or negative consequences.

Disclosure to HR or line managers was significantly lower, and a substantial proportion of employees expressed fear that such disclosures could affect job security, career progression, or professional reputation. Confidentiality concerns were a major deterrent, with many employees indicating that the risk of information spreading or being misinterpreted discouraged them from using formal channels.

Despite these concerns, employees demonstrated a strong willingness to seek professional psychological help, especially if they experienced significant stress or distress. However, many were uncertain about how to access such services or whether the organisation supported these efforts.

Importantly, employees indicated that the availability of reasonable work adjustments—such as flexible schedules or temporary workload reduction—would make them far more likely to disclose mental health concerns. This suggests that structural support mechanisms not only aid wellbeing but also influence communication behaviour.

5.1.4 Development Communication Strategies for Inclusive Mental Health Policies

The study demonstrated that employees desire communication approaches that are participatory, inclusive, and dialogic. The findings show that top-down or policy-driven communication alone is insufficient for building trust or reducing stigma. Instead, employees prefer communication systems that encourage genuine dialogue, enable shared decision-making, and include safe spaces for expression.

The strong reliance on peer networks indicates that horizontal communication already exists informally and is functioning as the most trusted mechanism within the organisation. This creates an opportunity for the organisation to formalise and strengthen these participatory spaces through structured peer-support systems, co-created wellness initiatives, and more responsive feedback mechanisms.

Overall, the findings suggest that participatory communication principles—dialogue, inclusion, trust-building, and co-creation—are essential for designing workplace mental health strategies that employees perceive as credible, safe, and supportive. These insights highlight

the central role communication can play in shaping organisational culture and advancing mental health as a workplace development issue.

5.2 Recommendations

The findings of this study show that workplace mental health communication in Ghana requires deliberate improvement to promote openness, confidentiality, and psychological safety. The recommendations presented below draw together all identified policy, organisational, academic, and managerial actions needed to strengthen wellbeing support and communication systems. They are arranged as numbered sub-sections for clarity.

5.2.1 Development of Clear and Comprehensive Workplace Mental Health Policies

The organisation studied should design and implement a comprehensive mental health policy that outlines how concerns can be raised, the communication pathways available, and the specific roles and responsibilities of managers and support personnel. The policy should clearly explain confidentiality procedures, referral options, and the types of reasonable adjustments that can be offered. This will reduce uncertainty and ensure that employees understand what to expect when seeking help.

5.2.2 Creation of Confidential and Accessible Communication Channels

There is a need for secure and confidential communication channels through which employees can disclose psychological distress. The organisation studied should consider using a designated mental health focal person, a dedicated confidential phone or email line, or formal partnerships with external counsellors. Clear communication about privacy rules is essential to building trust in these systems.

5.2.3 Institutionalisation of Peer Support and Employee Wellbeing Structures

Employees expressed strong confidence in peer-based communication. The organisation studied should formalise this by training selected staff as wellbeing champions or peer supporters equipped to offer basic psychosocial support. Structured peer support groups, safe discussion circles, and team-based wellbeing activities can help normalise mental health conversations and strengthen trust.

5.2.4 Integration of Mental Health Communication into Organisational Culture

Workplace mental health communication should be a routine part of organisational life. The organisation studied should integrate wellbeing messages into staff meetings, onboarding processes, newsletters, review sessions, and internal platforms. Regular, open communication will help reduce stigma and build a culture that supports early help seeking.

5.2.5 Strengthening Managerial Empathy and Communication Competence

Managers should receive training in empathetic communication, active listening, confidentiality management, and ethical handling of sensitive information. Their responses directly shape employees' willingness to disclose mental health concerns. Consistent, ethical, and non-punitive leadership communication helps build trust and reduces fears associated with disclosure.

5.2.6 Introduction of Reasonable Work Adjustments for Staff Experiencing Distress

When employees experience psychological distress, temporary adjustments such as flexible scheduling, modified workloads, or adjusted deadlines should be available. These accommodations demonstrate organisational care, reduce pressure, and encourage employees to seek support at an early stage.

Managers should create opportunities for collective reflection through brief check ins, wellness discussions, or team-based dialogue. These safe spaces promote openness, build community, and encourage employees to express concerns without fear of judgement.

5.2.7 Promotion of Awareness of the Mental Health Act within Workplaces

Both employees and managers should be sensitised to the provisions of the Mental Health Act. This sensitisation can be coordinated by the HR unit and management, drawing on support from qualified mental health professionals. Such awareness efforts will help strengthen compliance, reinforce confidentiality expectations, and promote recognition of mental health as an essential workplace wellbeing issue.

5.3 Limitations of the Study

This study has some limitations. First, the research was conducted in one organisation. Although this provided detailed, context-specific insights, it limits the generalisability of the findings to other workplaces in Ghana, which may have different communication cultures and mental health policies.

Second, the study relied on self-reported data from surveys and interviews. Because mental health is sensitive, participants may have withheld information or provided socially desirable responses despite assurances of confidentiality.

Third, the qualitative sample was relatively small. While the interviews offered depth and helped explain the quantitative results, a larger sample might have revealed additional perspectives and variations in communication behaviour.

Finally, the study examined communication patterns rather than clinical mental health assessment. It did not evaluate diagnostic issues, the severity of mental health conditions, or

treatment outcomes, and external influences such as family or community stigma were not examined in detail.

Despite these limitations, the study provides valuable insights into how employees navigate mental health communication in Ghanaian workplaces and establishes a foundation for future research.

5.4 Suggestions for Future Research

The study identifies several important directions for future inquiry that can strengthen understanding of workplace mental health communication in Ghana.

5.4.1 Broadening Contexts and Theoretical Exploration

Future research should examine workplace mental health communication across different organisational settings, including private companies, public institutions, and informal sector workplaces. Such studies would help clarify how culture, hierarchy, and organisational structures influence employees' disclosure and support-seeking behaviours. Researchers should also expand work on Communication Privacy Management Theory by exploring how employees form, adjust, and negotiate privacy rules in Ghanaian workplaces, and how cultural expectations shape boundary management. Intersectional factors, such as age, gender, seniority, and organisational status, should be considered to understand how different groups experience communication challenges or barriers.

5.4.2 Methodological and Intervention-Focused Studies

Future research should adopt longitudinal and mixed methods designs to capture changes in communication patterns over time and to integrate broad trends with lived experience. There

is also a need to explore how digital and remote work communication affects trust, confidentiality, and willingness to disclose mental health concerns.

Researchers should additionally assess the impact of workplace interventions, such as manager training, peer support programmes, or awareness initiatives, to determine which strategies are most effective in reducing stigma and supporting employee wellbeing.

5.5 Conclusion

This study set out to examine how mental health is communicated within a Ghanaian workplace and to understand the factors that shape employees' willingness to discuss psychological concerns. The findings demonstrate that while employees recognise mental health as an important aspect of wellbeing, communication around it remains limited, informal, and strongly influenced by concerns about confidentiality, trust, and organisational culture. Employees carefully manage what they disclose and rely heavily on peers because formal communication channels are not yet perceived as safe or supportive.

The study also shows that organisational structures, leadership behaviour, and communication climates play a more decisive role in shaping disclosure than demographic factors such as gender. When supportive responses, confidentiality, and reasonable adjustments are unclear or inconsistent, employees tend to remain silent, even when they experience distress. These findings confirm that communication is central to the creation of psychologically safe workplaces.

The recommendations presented in this chapter highlight the need for organisations to develop structured communication systems, strengthen managerial capacity, and create participatory spaces where employees can express concerns without fear of judgement. At the policy level, stronger national guidelines and workplace-focused mental health literacy efforts are needed to complement organisational initiatives. Academically, future research should continue to

explore workplace mental health communication across diverse contexts and through deeper engagement with communication theory.

Overall, the study concludes that improving workplace mental health in Ghana requires more than awareness creation. It requires intentional and sustained communication practices that build trust, reduce stigma, and empower employees to seek support. By understanding how people negotiate privacy, vulnerability, and organisational expectations, workplaces can develop environments that promote both wellbeing and productivity.

REFERENCES

- Adjei, M. (2021). Organizational communication patterns and employee engagement in Ghanaian firms. *Ghana Journal of Communication Studies*, 12(2), 35–52.
- Adom, D., Mensah, J., & Osei, M. (2021). Workplace communication and employee well-being in Ghana: Exploring stigma and disclosure. *Journal of Organizational Studies*, 18(2), 45–59.
- Aidoo, M., & Harpham, T. (2021). Policy implementation of the Mental Health Act in Ghana: Challenges and prospects. *BMC Health Services Research*, 21(1), 120–133.
- Amoako, S., & Dako-Gyeke, M. (2022). Hierarchy and dialogue: Communication cultures in Ghanaian organizations. *African Communication Research*, 15(3), 89–107.
- Amoateng, S., & Kalichman, S. (2020). Occupational stress and mental health literacy in African workplaces. *African Journal of Psychology*, 8(1), 54–68.
- Appiah, R., Ofori, E., & Oppong, S. (2022). Workplace mental health policies in Ghana: Assessing organizational preparedness. *Ghana Medical Journal*, 56(3), 211–223.
- Asare-Doku, F., Badu, E., & Osei, C. (2022). Managerial empathy and employee disclosure of mental distress in Ghanaian workplaces. *International Journal of Mental Health Systems*, 16(1), 1–12.
- Atilola, O. (2021). Mental health services and systems in sub-Saharan Africa: Challenges and prospects. *Current Opinion in Psychiatry*, 34(4), 389–395.
- Becker, M. H., & Maiman, L. A. (1975). Sociobehavioral determinants of compliance with health and medical care recommendations. *Medical Care*, 13(1), 10–24.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101.
- Bryman, A. (2016). *Social research methods* (5th ed.). Oxford University Press.

- Carpenter, C. J. (2010). A meta-analysis of the effectiveness of health belief model variables in predicting behavior. *Health Communication, 25*(8), 661–669.
- Courtenay, W. H. (2020). Constructions of masculinity and their influence on men's well-being: A theory of gender and health. *Social Science & Medicine, 50*(10), 1385–1401.
- Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review, 43*(6), 1241–1299.
- Dako-Gyeke, M., & Asumang, E. S. (2013). The cultural interpretation of mental illness and health-seeking behavior in Ghana. *Journal of Health, Population and Nutrition, 31*(3), 383–391.
- Deloitte. (2022). *Mental health and employers: Refreshing the case for investment*. Deloitte Insights.
- Eagly, A. H., & Wood, W. (2019). Gender identity and communication styles in organizations. *Annual Review of Organizational Psychology and Organizational Behavior, 6*, 191–215.
- Eaton, J., et al. (2018). Addressing the treatment gap in mental health in Africa: Task sharing and social inclusion. *International Journal of Mental Health Systems, 12*(1), 1–10.
- Fadeyi, O., & Afolabi, R. (2023). Mental health stigma among Nigerian civil servants: Communication and disclosure challenges. *African Journal of Psychology, 9*(2), 33–47.
- Freire, P. (1970). *Pedagogy of the oppressed*. Continuum.
- Gould, D., Williams, L., & Davidson, P. (2021). Gender, stress, and emotional labor in modern workplaces. *Gender, Work and Organization, 28*(5), 1550–1567.
- Government of Ghana. (2012). *Mental Health Act, 2012 (Act 846)*. Accra: Assembly Press.

- Greene, K. (2020). Communication privacy management theory: Understanding people's communication choices about health. *Journal of Social and Personal Relationships*, 37(1), 1–23.
- Guest, G., Namey, E., & Chen, M. (2020). A simple method to assess and report thematic saturation in qualitative research. *PLOS ONE*, 15(5), e0232076.
- Hegarty, P., Mitchell, M., & Khan, A. (2022). Gender, emotion, and workplace stigma in health communication. *Journal of Applied Communication Research*, 50(4), 289–305.
- Henderson, C., Noblett, J., Parke, H., Clement, S., Caffrey, A., Gale-Grant, O., & Thornicroft, G. (2020). Mental health-related stigma in the workplace. *Social Psychiatry and Psychiatric Epidemiology*, 55(3), 285–293.
- Hochschild, A. R. (2012). *The managed heart: Commercialization of human feeling*. University of California Press.
- Ivankova, N. V., Creswell, J. W., & Stick, S. L. (2006). Using mixed-methods sequential explanatory design: From theory to practice. *Field Methods*, 18(1), 3–20.
- Johnson, R. B., Onwuegbuzie, A. J., & Turner, L. A. (2007). Toward a definition of mixed methods research. *Journal of Mixed Methods Research*, 1(2), 112–133.
- King, L. (2024). *Disclosing mental health in public life: A study of Ghanaian public figures*. University of Ghana Thesis Repository.
- LaMontagne, A. D., Martin, A., Page, K. M., Reavley, N. J., Noblet, A. J., Milner, A., & Smith, P. M. (2014). Workplace mental health: Developing an integrated intervention approach. *BMC Psychiatry*, 14(1), 131–145.

- Lawrence, J., Mensah, D., & Nartey, R. (2024). Stigma, disclosure, and workplace communication among Ghanaian employees. *Journal of African Organizational Psychology*, 12(1), 55–70.
- Manyozo, L. (2022). *Development communication: People, participation and change*. Routledge.
- Melkote, S. R., & Steeves, H. L. (2015). *Communication for development: Theory and practice for empowerment and social justice* (3rd ed.). SAGE.
- Mensah, D., & Adjei, M. (2023). Women in leadership and emotional resilience in Ghanaian organizations. *Gender and Development Studies*, 19(1), 78–92.
- Milner, A., King, T. L., & LaMontagne, A. D. (2019). Managerial support and mental health: A systematic review. *Occupational Health Science*, 3(2), 227–248.
- Mkhize, N., & Kometsi, K. (2020). African conceptions of mental disorder: Toward culturally informed mental health policies. *South African Journal of Psychology*, 50(1), 3–15.
- Neuman, W. L. (2014). *Social research methods: Qualitative and quantitative approaches* (7th ed.). Pearson.
- Odejide, O. (2020). Rethinking mental health promotion in African workplaces: Policy gaps and cultural realities. *African Journal of Social Sciences*, 12(2), 67–82.
- OECD. (2021). *Fostering mental health in the workplace: The role of communication and leadership*. OECD Publishing.
- Osei, P. (2023). Understanding mental health literacy among Ghanaian professionals. *Ghana Social Science Review*, 9(1), 21–37.
- Petronio, S. (2002). *Boundaries of privacy: Dialectics of disclosure*. SUNY Press.

- Roberts, J., Asare, K., & Kpodo, F. (2020). Implementation of the Mental Health Act in Ghana: Progress and challenges. *Health Policy and Planning*, 35(6), 678–687.
- Rogers, E. M. (2003). *Diffusion of innovations* (5th ed.). Free Press.
- Rosenstock, I. M. (1974). The health belief model and preventive health behavior. *Health Education Monographs*, 2(4), 354–386.
- Servaes, J. (2008). *Communication for development and social change*. SAGE Publications.
- Silverman, D. (2020). *Qualitative research* (5th ed.). SAGE Publications.
- Tashakkori, A., & Teddlie, C. (2010). *SAGE handbook of mixed methods in social & behavioral research* (2nd ed.). SAGE Publications.
- Thornicroft, G., Henderson, C., & Evans-Lacko, S. (2022). Reducing stigma and discrimination associated with mental illness in workplaces. *World Psychiatry*, 21(2), 104–119.
- Tufte, T., & Mefalopulos, P. (2009). *Participatory communication: A practical guide*. World Bank.
- United Nations. (2015). *Transforming our world: The 2030 Agenda for Sustainable Development*. United Nations Publications.
- WHO. (2022). *World mental health report: Transforming mental health for all*. World Health Organization.
- WHO Africa Regional Office. (2021). *Mental health in the African Region: Status report 2021*. WHO.
- Wu, T., Chang, C., & Ling, C. (2021). Leadership empathy and mental health communication in workplaces. *Journal of Organizational Behavior*, 42(3), 412–429.

Zuurmond, M., Osei, P., & Drah, M. (2025). Participatory peer support and mental health promotion in Ghanaian organizations. *African Journal of Development Communication*, 6(2), 23–39.

APPENDICES

Appendix A: Survey Form

You are invited to participate in a study titled:

“Improving Mental Health Communication in Ghanaian Workplaces: A Participatory Approach to Policy and Practice.”

This study explores how mental health is currently communicated in Ghanaian workplaces. It aims to understand employees' and employers' experiences, perceptions, and preferences related to mental health discussions, stigma, disclosure, and available support systems.

Across many organizations, mental health issues such as stress, burnout, and anxiety are common but often difficult to talk about. Communication plays a key role in reducing stigma, encouraging openness, and building supportive environments where people feel safe seeking help.

Your participation will help identify the barriers and opportunities for improving mental health communication at work. Insights from this survey will inform recommendations for more inclusive and responsive workplace policies.

The survey is anonymous and confidential. No identifying information will be collected, and your responses will only be used for academic purposes. Participation is entirely voluntary, and you may skip any question or stop the survey at any time without any consequence.

Thank you for contributing to this important research.

Consent & Eligibility

To continue, please confirm that:

- You understand the purpose of the study
- You have worked in your current organization for at least six months
- You consent to participate in the survey

Please read and tick as applicable. Your responses are confidential.

Consent: I have read the information and willingly agree to participate. Yes

A1. How long have you worked in your current organization? <12 months 12–23 months 2–4 yrs 5–9 yrs 10+ yrs

A2. Age band: 18–24 25–34 35–44 45–54 55+

A3. Gender: Female Male

B. Workplace Mental Health Communication Practices

Tick one box per statement. Scale: 1=Strongly Disagree ... 5=Strongly Agree.

Statement	1	2	3	4	5
Please tick one option per row	Strongly Disagree	Disagree	Neither	Agree	Strongly Agree

B1. Our organization acknowledges mental health as part of staff wellbeing.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B2. There are clear channels to communicate about mental health concerns.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B3. Managers encourage open conversations about mental health.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B4. Information shared about mental health is treated confidentially.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B5. We receive periodic information/campaigns on mental health.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B6. There is a designated person/office (e.g., HR/EAP) for mental health support.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B7. Staff know how to access external support (hotlines, clinics, NGOs).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B8. Team meetings/platforms allow respectful discussion on wellbeing.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B9. I feel safe raising mental health concerns to my supervisor.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B10. I know where to report bullying/harassment or psychosocial risks.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C. Stigma & Climate

Tick one box per statement. Scale: 1=Strongly Disagree ... 5=Strongly Agree. Items marked (R) are positive and reversed in analysis.

Statement	1	2	3	4	5
-----------	---	---	---	---	---

Please tick one option per row	Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
C1. People here think colleagues with mental health challenges are less competent.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C2. Talking about mental health hurts one's reputation at my workplace.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C3. Staff fear negative career consequences if they disclose.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C4. Jokes/remarks that stigmatize mental health happen at work.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C5. Leadership models positive attitudes toward mental health. (R)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C6. I would feel embarrassed seeking help for mental health.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C7. I would be comfortable using employer-	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

provided mental health resources. (R)					
C8. I believe mental health issues are common and manageable. (R)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D. Disclosure & Help-Seeking

Tick one box per statement. Scale: 1=Strongly Disagree ... 5=Strongly Agree.

Statement	1	2	3	4	5
Please tick one option per row	Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
D1. I would disclose a mental health concern to HR if needed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D2. I would disclose to my line manager if needed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D3. I would disclose to a trusted colleague/peer.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D4. I would seek professional help if experiencing distress.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D5. Confidentiality concerns would discourage me from disclosing.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D6. Gender norms at my workplace affect whether I would disclose.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D7. Workload/pressure affects whether I would disclose.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D8. If reasonable adjustments were available, I'd be	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

more likely to disclose.					
--------------------------	--	--	--	--	--

E. Channels & Preferences

E1. Which channels exist at your workplace? (Tick all that apply)

HR focal person Line manager Anonymous reporting form Staff clinic/EAP Union representative

Peer support group Suggestion box Email/online helpline None Other:

E2. Preferred channels if you needed support? (Tick up to 3)

HR focal person Line manager Anonymous reporting External hotline Peer support Faith/traditional leader

Family/friends Other: _____

E3. Preferred formats for information/training? (Tick up to 3)

Short talks at work Webinars Posters/infographics WhatsApp messages Manager briefings

E-learning modules Policy handbook Other: _____

F. Policies, Training & Resources

Tick one box per statement. Scale: 1=Strongly Disagree ... 5=Strongly Agree.

Statement	1	2	3	4	5
Please tick one option per row	Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
F1. My organization has a written policy on mental health/wellbeing.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F2. I received training/briefing on mental health at work in the last 12 months.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F3. Managers receive specific guidance on responding to staff mental health needs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F4. The organization offers an Employee Assistance Programme (EAP) or referrals.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F5. There are clear procedures for reasonable accommodation/adjustments.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

F6. Mental health initiatives are inclusive and gender-sensitive.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F7. Monitoring of staff wellbeing (e.g., surveys) happens at least annually.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

G. Mental Health Literacy & Psychosocial Risks

G1. Confidence to recognize signs in self/others: 1 Very low 2 Low 3 Moderate 4 High 5 Very high

G2. In the past 12 months, have you experienced any of the following at work? (Tick all that apply)

Excessive workload Long hours Role ambiguity Job insecurity Bullying/harassment

Discrimination Traumatic incidents None Prefer not to say

G3. If yes to any, did you seek support? Yes No Prefer not to say

G4. Main barrier to seeking support (choose one):

Confidentiality concerns Stigma Didn't know where to go Cost Time Manager unsupportive

Didn't think it was serious Other: _____ Not applicable

H. Role

H1. Role level: Non-management Supervisor Middle management Senior management Executive

H2. Employment type: Permanent Contract Intern Other: _____

H3. Sector: Public Private Non-profit State-owned enterprise Other: _____

H4. Industry: Banking/Finance Education Health Telecom/ICT Manufacturing Public administration Media/Comms Other: _____

H5. Organization size: <10 10–49 50–249 250–999 1,000+

H6. Work arrangement: On-site Hybrid Remote

H7. Tenure in current organization: 12–23 months 2–4 years 5–9 years 10+ years

H8. Highest education: SHS Diploma Bachelor's Master's Doctorate Other: _____

H11. (Optional) In one or two sentences, what would most improve mental health communication at your workplace? _____

H12. What do you think is the biggest reason employees hesitate to talk about mental health issues at work?

(Please write your response in a few words or a sentence.)

H13. Would you be willing to participate in a short follow-up interview about these topics?

Yes (Please complete separate volunteer form)

No

Thank you.

Appendix B: Volunteer Form for Follow-Up Interview Participation

Title of Study: Improving Mental Health Communication in Ghanaian Workplaces: A Participatory Approach to Policy and Practice

Researcher: Esenam Agyekumhene

Institution: University of Media, Arts and Communication (UNIMAC)

Purpose of this Form:
You have completed a questionnaire about workplace mental health communication. The researcher is conducting follow-up interviews with a few volunteers to gain a deeper understanding of the issues identified in the survey. Your participation is entirely voluntary. Completing this form does **not** link your identity to your survey responses — the two are completely separate.

If you are willing to be contacted for a short interview (about 30–45 minutes), please complete the following section. Your details will only be used for the purpose of arranging the interview.

Section A: Consent and Contact Details

1. **Name (optional):** _____
2. **Phone number or email address:** _____
3. **Do you agree to be contacted for a follow-up interview?**
 - Yes
 - No
4. **Preferred interview mode:**
 - In-person
 - Online (Zoom, Google Meet, or Teams)
 - Telephone

5. Preferred day and time for interview (if any):

Section B: Background Information

6. Gender:

- Male
- Female

7. Role in organization:

- Management / Supervisory
- Non-management / Staff

8. How long have you worked in your current organization?

- Less than 1 year
- 1–3 years
- 4–6 years
- More than 6 years

Section C: Workplace Experiences (Self-Report)

The following questions help ensure that participants selected for follow-up interviews represent a range of perspectives and experiences. These questions will help the researcher select a diverse group of interviewees. Your answers are confidential and will not be linked to your earlier questionnaire responses.

9. How comfortable do you feel discussing mental health concerns at work?

- 1 Very uncomfortable
- 2 Somewhat uncomfortable
- 3 Neutral
- 4 Somewhat comfortable
- 5 Very comfortable

10. How supportive do you think your organization is when employees talk about mental health?

- 1 Not supportive at all
- 2 Slightly supportive

- 3 Neutral
- 4 Supportive
- 5 Very supportive

11. **Have you ever discussed or disclosed a mental health concern at work?**

- Yes
- No
- Prefer not to say

12. **Would you describe your workplace as open about mental health issues?**

- Yes
- No
- Not sure

13. **Why are you interested in taking part in this interview?**

- _____
- _____

Section D: Consent Declaration

All interview data will be anonymized in transcripts and reports, and no individual will be identifiable in any publication or presentation.

I understand that participation in this interview is voluntary and that I may withdraw at any time without any penalty. I also understand that my information on this form will be used only for scheduling purposes and will not be connected to my questionnaire responses.

Signature (or tick box if online): I agree to participate

Appendix C: Semi-Structured Interview Guide

Study: Workplace Mental Health Communication in Accra, Ghana

Qualitative Phase – Explanatory Sequential Mixed Methods

1) Purpose & Interview Flow

Purpose: To deepen understanding of how mental health is communicated in workplaces, and to explain patterns observed in the survey (communication practices, stigma, disclosure,

policies, and inclusive approaches) The qualitative interviews will help explain specific trends observed in the survey, such as differences in comfort levels with disclosure or variations in perceived organizational support.

Duration: 45 minutes – 1 hour. Mode: In-person or secure online. Language: English or local language with interpretation as needed.

Flow: Warm-up → Workplace communication → Experiences & disclosure → Stigma & culture → Policy/support → Gender & inclusion → Psychosocial risks → Improvements → Closing.

2) Ethics & Consent Script (Read Verbatim)

Thank you for meeting with me. We're conducting research on workplace mental health communication in Accra. Your participation is voluntary. You may skip any question or stop at any time without any consequence. With your permission, I'd like to audio-record so I don't miss anything; recordings will be stored securely and de-identified in reports. Your name or organization will not appear in any publication. Do you have any questions? Do I have your consent to proceed and to audio-record?

Distress Protocol: If at any point you feel uncomfortable, please tell me and we will pause or stop. I can share information on support services if helpful.

3) Interviewee Details (Interviewer to Complete)

Date/Time: _____ Interviewer ID: _____ Interview Mode: In-person / Online

Participant ID: _____ Role Level: Management / Non-management
Sector/Industry: _____

Tenure in current organization (years): _____ Gender: _____

4) Core Questions & Probes

Note: Use open-ended prompts. Follow relevant probes. Tailor a few probes to explain specific survey patterns if known (e.g., low disclosure comfort, high workload).

A. Warm-up & Role Context

A1. Can you briefly describe your role and typical workday?

A2. How is staff wellbeing generally handled in your workplace? (e.g., HR, line managers, informal practices)

B. Workplace Communication Practices

B1. In your experience, how are mental health topics communicated at work? (e.g., meetings, emails, posters, WhatsApp)

B2. What channels exist if someone needs to raise a mental health concern? Which do people actually use?

B3. How is confidentiality handled when someone seeks help?

Probes: clarity of channels; trust in HR/manager; examples of effective or ineffective communication; anonymous options; frequency of communications.

C. Experiences & Disclosure

In the survey, many participants mentioned confidentiality and manager response as important factors. How do these play out in your workplace experience

C1. Without naming anyone, can you share an example of a time someone (including yourself) discussed a mental health concern at work? What happened next?

C2. What makes people more or less comfortable disclosing? (e.g., confidentiality, team culture)

C3. If reasonable adjustments were available (e.g., flexible time), would that change disclosure comfort? How?

Probes: outcomes after disclosure; perceived risks/benefits; differences across teams or levels; manager response quality.

D. Stigma & Organizational Culture

D1. How do people at your workplace view colleagues who talk about mental health?

D2. Do you notice jokes or remarks that stigmatize mental health? How are they handled?

D3. What attitudes do leaders/managers model regarding mental health?

Probes: fear of career consequences; competence perceptions; reputation concerns; examples of positive leadership.

E. Gender, Inclusion & Safety

F1. Do gender norms affect whether people talk about mental health or seek help? In what ways?

F2. Are mental health initiatives inclusive for different groups (e.g., women/men, non-binary staff, younger/older staff)?

F3. What would make the environment feel safer and more inclusive for disclosure?

Probes: intersectional issues (age, role level, contract type); confidentiality concerns specific to gender; privacy needs.

F. Policies, Training & Support

E1. Are there any written policies or guidance on mental health and reasonable accommodations? How well are they known?

E2. What support exists (Employee Assistance Programmes, referrals, focal persons)? How accessible and useful are they?

E3. Have you (or colleagues) received any training or briefing on mental health in the past year?

Probes: barriers to access; awareness vs. use; policy-practice gaps; suggestions for training content.

G. Psychosocial Risks & Work Design

G1. Which work-related factors most affect mental health where you work? (e.g., workload, long hours, job insecurity, bullying)

workload

G2. How are these issues identified and addressed, if at all?

Probes: reporting routes; effectiveness of responses; examples of improvements or unresolved concerns.

H. Improvements & Preferred Channels

H1. What would most improve mental health communication and support at your workplace?

H2. Which channels or formats would you find most useful? (e.g., anonymized helpline, manager briefings, short talks, WhatsApp tips)

H3. If you could change one policy or practice tomorrow, what would it be and why?

I. (If Management) Supervisory Perspective

I1. What guidance or tools would help managers respond appropriately to mental health concerns?

I2. How do you balance confidentiality with team performance needs?

I3. What metrics or feedback would help you track wellbeing and communication without breaching privacy?

5) Closing & Debrief (Read Verbatim)

Thank you for your time and openness. Is there anything important we haven't covered? Do you have any questions for me? If you would like, I can share a brief list of support resources.

6) Field Notes (Interviewer Use)

Context/Setting: _____

Key themes emerging: _____

Notable quotes (non-identifying): _____

Reflections/Follow-ups: _____

Appendix D: Coding Matrix of Emerging Themes

Main Theme	Sub-Themes	Codes (Examples)	Illustrative Quotes
Theme 1: Mental Health Awareness but Limited Formal Structures	<ul style="list-style-type: none"> – General awareness of mental health – Lack of formal MH initiatives – Informal learning and personal understanding 	<p>“Mental health is important”, “people go through things”, “we don’t have structured support”, “nothing formal from HR”</p>	<p><i>“Mental health is important, but to be honest, we don’t really have any formal system in place. Most of what we know is from our own experience or social media.”</i></p>
Theme 2: Communication Climate Shaped by Trust and	<ul style="list-style-type: none"> – Prefer peers and trusted colleagues – Cautious 	<p>“I’ll talk to a friend”, “I don’t trust HR with this”, “my manager</p>	<p><i>“If anything was troubling me mentally, I’d rather speak to a colleague I trust than</i></p>

<p>Relational Proximity</p>	<p>disclosure to HR/supervisors – Fear of judgement or repercussions</p>	<p>can judge”, “I don’t want to be labelled”</p>	<p><i>HR. With HR, I’m not sure where the information will end up.”</i></p>
<p>Theme 3: Workload, Pressure, and Organisational Culture as Barriers</p>	<p>– High pressure culture – Fast-paced targets – Low psychological safety</p>	<p>“The pressure is too much”, “no time to talk about these things”, “the culture is stressful”, “you can’t show weakness”</p>	<p><i>“The workload is heavy. Some days you can’t even breathe. In that environment, opening up about mental health makes you feel exposed.”</i></p>
<p>Theme 4: Enablers of Mental Health Communication</p>	<p>– Confidentiality assurance – Manager empathy – Reasonable adjustments – Private channels</p>	<p>“Confidentiality will help”, “if managers showed concern”, “flexible hours”, “anonymous reporting”</p>	<p><i>“If the company showed that conversations will stay confidential and managers are trained to listen, more people would open up.”</i></p>

