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This is a preliminary, unedited version of a manuscript that has been accepted for publication in the Brazilian Journal of Psychiatry. As a service to our readers, we are providing this early version of the manuscript. The manuscript will still undergo copyediting, typesetting, and review of the resulting proof before it is published in final form. The final version may present slight differences in relation to the present version.

# Beyond “Best Places to Work”: The Hidden Weight of Stigma in Corporate Mental Health - A mixed-methods study in Brazil

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## Abstract

**Background**: Workplace mental health initiatives often overlook stigma, which may function as a "hidden demand", undermining psychological safety and help-seeking.

**Objective**: To assess psychosocial factors and perceived public stigma among employees related to mental-health programs in companies rated as the best workplaces in Brazil.

**Methods:** We surveyed 166 professionals from 36 companies using three Guarding Minds at Work (GM@W) domains and the Perceived Devaluation–Discrimination Questionnaire. Generalized linear models were used for quantitative data, and thematical analysis qualitative data originated from three mixed-role focus groups plus GM@W open-ended responses.

**Results:** Most respondents endorsed companies' effective response to identified psychological risks (81.5%) and that companies support employees with mental

health problems (84.1%). However, only 59.2% reported employees are free from mental-illness stigma at work, and fewer endorsed adequate stress-coping support. Public stigma perception was correlated with worse GM@W scores. National companies and mental-health professionals reported poorer perceptions in key domains. Qualitative themes converged on leadership strain, uneven program quality/scale, return-to-work friction, stigma, and the need to embed mental health into strategy and prevention.

**Conclusions:** Even in companies rated as the best workplaces in Brazil, psychosocial protection and stigma remain an issue. Strengthening leadership capability, governance, confidentiality safeguards, and evaluation is essential.

**Keywords:** psychosocial factors; organizational culture; leadership; social discrimination; occupational health psychology; Brazil

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## Introduction

Workplace strongly shapes mental health [1]. For Karl Jaspers, “a profession is not merely a job, it is rooted in the totality of a person´s being”[2]. The Job Demands-Resources (JD-R) theory explains that resources motivate employees extrinsically by helping them to achieve goals and intrinsically by fulfilling needs for belonging, competence, and autonomy[3,4]. It posits that every occupation has its own specific risk factors associated with job stress, which can be categorized as demands (e.g., workload, emotional strain, time pressure) and resources (e.g., autonomy, social support, trust). While demands exhaust employees’ mental and physical resources and may lead to burnout, resources buffer these effects and foster engagement, motivation, and resilience. In this sense, workplace balance within the JD-R framework, considering further issues such as sense of coherence,[5] injustice, low support, and limited decision latitude, is an important factor influencing mental health[6]. Since COVID-19 forced widespread remote work, work-related mental health gained more attention[7,8], though post-pandemic evidence remains emerging.

A recent systematic review of 38 studies confirmed that poor mental health is strongly associated with significant productivity loss in the workplace[9]. This

finding highlights the importance of timely awareness and effective treatment pathways, as leaving mental disorders untreated not only worsens their outcome but also reinforces existing negative stereotypes. Employees with untreated conditions may be perceived as less efficient and productive than their colleagues without mental illness, a dynamic that perpetuates stigma[10]. On the other hand, stigma remains a central barrier that prevents individuals from acknowledging their difficulties and from seeking professional help[11,12]. Thus, stigma can be conceptualized as a hidden demand that undermines psychological safety and depletes social resources, creating a cumulative risk for distress. Despite its critical role, many workplace mental health initiatives worldwide still fail to address stigma directly, limiting their effectiveness or reducing them to superficial "window dressing"[13].

From an organizational and management perspective, promoting workplace mental health should not be treated as an isolated set of initiatives, but as the product of strategic alignment between organizational systems (work design, resources, and policies) and people-management practices. Psychological contract theory emphasizes that realistic mutual expectations reduce uncertainty and stress and strengthen employee–organization trust[14]. In this sense, trust stands out as a particularly important mediator for jobs resources. Recent data from 220 employees demonstrated that positive relationships with leadership and colleagues not only foster job satisfaction but also enhance organizational commitment, both directly and indirectly[9]. Classic job-stress models highlight how social support and control buffer the impact of high demands on strain[15,16]. Leadership—particularly transformational leadership—can shape resources, meaning, and psychological safety and is repeatedly implicated in employee wellbeing[17,18]. At the policy level, international guidance recommends integrating psychosocial risk management into occupational health and safety systems[19], as well as using standards such as ISO 45003[20].

More recently, integrative "healthy organization" frameworks have gained prominence by emphasizing that workplace mental health depends on the alignment between leadership practices, psychosocial resources, and organizational systems. The Healthy and Resilient Organization (HERO) model proposed by Salanova and colleagues[21] highlights how organizational resources

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and practices can foster both wellbeing and performance. Within this perspective, leadership emerges as a central leverage point for shaping psychosocial safety and sustaining prevention and support at scale[22], while the mental health challenges faced by leaders themselves have also been increasingly recognized[23]. In parallel, the expansion of remote and hybrid work has renewed attention to social support, isolation, and new pathways for managing mental health in distributed teams[24]. Finally, workplace health promotion research has increasingly emphasized the ethical and practical relevance of meeting workers' expectations, linking this to organizational reputation and productivity[25,26].

Accordingly, evidence supports multicomponent mental health and psychosocial programs, as well as targeted, disorder-specific interventions, particularly when adapted to the realities of each workplace[27,28]. However, tailoring interventions to organizational contexts introduces challenges, especially in research, since individualized approaches hinder comparability across studies. Moreover, stigma and potential legal liabilities can limit open discussions of sensitive topics such as employee mental wellbeing, further complicating implementation. For interventions to succeed, they must therefore combine evidence-informed practices with the lived experiences of workers, ensuring that toolkits and programs are relevant, adaptable, and truly integrated into workplace dynamics[13]. As such, it is also important in research to employ mixed methods designs, to gain a deeper understanding of issues related to mental health in the workplace that are only brought up through qualitative methods.

One comprehensive instrument that has gained prominence is the *Guarding Minds at Work* (GM@W) survey, originally developed by Samra et al. and recently updated under Dr. Heather Stuart's leadership (2022–2023)[29]. Commissioned by Canada's Workplace Strategies for Mental Health, GM@W assesses 13 psychosocial workplace factors associated with employee wellbeing[30]. Its mixed-methods design—combining multiple-choice and open-ended questions—allows both structured data collection and space for more nuanced, unconstrained feedback. While validated in a large sample of 3,077 employees, publications applying GM@W remain scarce[31–33], and none to date have explicitly examined its relationship with stigma.

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Recognizing this gap, our study set out to explore the intersection of workplace practices and stigma by surveying employees connected to mental health programs in Brazil's 150 top-ranked companies, as identified by an international certification. By targeting organizations already committed to mental health initiatives, the study seeks to uncover how workplace culture, leadership, and stigma interact in shaping mental wellbeing, and whether organizational strategies are effectively addressing barriers to care. An explanatory sequential mixed-methods design was adopted for the aims of the study[34].

## Methods

### *Sample*

We initially targeted 150 companies ranked as the best workplaces in Brazil by the *Great Places To Work* 2023 international ranking[35], plus 13 members of the Einstein Reference Center for Mental Health (CRESM), totaling 163 companies. The *Great Place to Work* (GPTW) ranking is an international certification system that annually evaluates companies' organizational culture through the *Trust Index* (employee survey on credibility, respect, fairness, pride, and camaraderie) and the *Culture Audit* (assessment of management practices)[35]. The Einstein Reference Center for Mental Health (CRESM) is a collaborative platform coordinated by the Hospital Israelita Albert Einstein that integrates corporations, universities, and public-sector institutions to promote evidence-based strategies for mental-health prevention and psychosocial-risk management. We chose the GPTW list as a pragmatic sampling frame of organizations with high-rated organizational culture (a "best-case" setting in which barriers related to stigma and psychosocial-risk management might still be observable). We added CRESM member companies because they represent organizations explicitly engaged with evidence-based workplace mental-health initiatives, broadening variability in program maturity and providing a policy-relevant contrast group. Of this pool, 122 companies were contacted via email, phone, or LinkedIn—the remaining 41 companies could not be reached, i.e., did not answer messages or e-mails. Fifty-three companies responded positively to our call, and actually fifty attended a formal presentation of the research project, with 36 agreeing to participate, yielding a refusal rate of 70%. Among these

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companies, 7 were CRESM members, 28 were GPTW-only, and 1 pertained to both groups. The main reasons for refusal were legal hurdles (n=4), restructuring (n=3), no response (n=3), lack of time (n=2), and other reasons (n=2).

After agreeing to participate, the companies were invited to formalize their involvement by signing a letter of agreement. Next, the research team asked each company to appoint 3 to 5 participants to complete the online survey, to ensure variability and response anonymity. These participants had to be HR directors or managers, mental health professionals, occupational medicine practitioners, or occupational health specialists involved in mental health management initiatives within the organizations.

Participating companies signed a letter of agreement and nominated 3–5 representatives—HR managers, mental health professionals, or occupational health specialists—to complete an online survey anonymously. After providing informed consent, 186 participants were invited; 166 (89.3%) completed the questionnaire and were considered for analysis.

*Surveys*

Two surveys were used in this study. The first comes from the *Guarding Minds at Work* (GM@W) initiative[29,36]. This evidence-based initiative aims to assess how well a company supports psychological health and safety, to develop a tailored plan for each organization. For the purposes of our study, and not to take too much time from participants, we selected three dimensions of the survey: Psychological and Social Support, Psychological Demands and Competencies, and Psychological Protection. These sections of the questionnaire contained 16 statements related to these themes, to be rated on a scale from 1 (“Always occurs”—positive view on workplace) to 5 (“Never occurs”— negative view on workplace). In addition, there were 9 open-ended questions also related to these three themes. These three domains were selected because they represent a parsimonious set that maps onto core mechanisms emphasized by major occupational health frameworks (demands/resources and support), are highly actionable for organizational stakeholders, and are conceptually proximal to stigma, disclosure, and help-seeking dynamics in the workplace. They also align with the international shift toward psychosocial risk management embedded in occupational health and safety systems[19].

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The GM@W survey has a European Portuguese version, which was adapted into Brazilian Portuguese. It was backtranslated into English by a proficient speaker and compared to the original English version to ensure the quality of the adaptation. A pilot test was subsequently conducted with 10 employees from the Einstein Reference Center for Mental Health (CRESM) to assess the fluency and clarity of the survey. Sample items of the GM@W include "People in my workplace understand the importance of protecting employees' psychological safety" (Psychological and Social Support) and "Management makes an effort to prevent harm to employees due to discrimination" (Psychological Protection). The research team obtained formal written consent from the GM@W authors for its use in the current study.

The second survey used was the Perceived Devaluation and Discrimination Questionnaire (PDDQ)[37]. This widely used tool in the international literature assesses perceived stigma—it asks respondents what they believe society thinks about mental illness in general and about specific situations such as employment, friendship, or disclosure. Several other studies in Brazil have used this questionnaire[11,38]. The scale is divided into three sections. The first (Perceived Discrimination) contains twelve statements and explores the respondent's perception of how most people would think or act toward someone with a mental illness. The second section (Secrecy) includes nine items and addresses treatment, relationships with others, and mental illness. The third section (Contact) contains eight items and asks how the respondent thinks and acts in situations involving a person with mental illness (e.g., being friends with, working with, etc.). Responses are scored on a scale from 1 ("Strongly disagree") to 6 ("Strongly agree"). Typical PDDQ items are "Most people would not hire a person who has been hospitalized for mental illness" (Perceived Discrimination) and "I would not reveal a history of mental illness to coworkers" (Secrecy).

*Focus group sessions*

After the quantitative phase, a qualitative stage was conducted to deepen understanding of workplace mental health issues. Three online focus groups were organized (each with 6 to 8 participants), allowing only one randomly-chosen participant per company to avoid colleagues from the same organization in the same group. Thus, groups were mixed across respondent roles (e.g.,

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managers/HR and occupational health or mental-health professionals) to encourage cross-functional discussion about program implementation and barriers. Five general topics were extracted from the survey's answers and moderated by three CRESM psychologists who used open-ended questions to stimulate interaction and collective reflection. The discussions lasted 120-minutes. They were recorded, then transcribed verbatim, and analyzed using thematic analysis[39]. Researchers systematically coded the transcripts to identify recurring patterns, themes, and shared or divergent viewpoints. As such, statements derived from the transcripts were first grouped according to keywords/codes, and then each code was grouped into themes.

*Statistical analysis*

Data were described as number and percentage (categorical) and mean±SD (continuous). Normality of continuous data was tested with Shapiro–Wilk. GM@W scores were averaged per dimension, so higher values indicated more negative perceptions of workplace mental health resources. PDDQ scores were averaged within subscales (perceived discrimination: 12 items; secrecy: 9; contact: 8), with higher values reflecting higher stigma. Three generalized linear models (GLMs) were run, each with a GM@W dimension mean as the dependent variable, and respondent's area of work, respondent's job title, company's area, and company type (national /multinational) as predictors. National companies refer to firms headquartered and operating primarily within Brazil (privately held), whereas multinational companies denote corporations with international headquarters or operations in multiple countries. GM@W and PDDQ scores were compared using Spearman correlations. Analyses were conducted in SPSS v29 (OS). Data are available from the authors upon request.

## Results

The characteristics of our sample are described in Table 1. Among the 166 participants, the average age was 41.7 years, and the majority were female (66.9%). Participants were almost evenly split between national (53%) and multinational (47%) companies. Most respondents were either HR managers

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(40.4%) or occupational health professionals (39.2%), working primarily in companies from the services (42.8%) and industrial (37.3%) sectors.

**Table 1** – Sample characteristics (n=166)

| | | |
|---|---|---|
| Age (mean, SD) | | 41.7 (8.5) |
| Sex (female) | | 111 (66,9%) |
| Company category | National | 88 (53.0%) |
| | Multinational | 78 (47.0%) |
| Participant's area of work | Human resources | 67 (40.4%) |
| | Occupational health | 65 (39.2%) |
| | Mental health | 6 (3.6%) |
| | Other | 25 (16.9%) |
| Company's area | Provision of services | 71 (42.8%) |
| | Industry | 62 (37.3%) |
| | Commerce | 6 (3.6%) |
| | Other | 27 (16.3%) |
| Line of business | Health | 22 (13.3%) |
| | Financial services | 19 (11.4%) |
| | Mining & Metals | 17 (10.2%) |
| | Technology / IT | 14 (8.4%) |
| | Food & Beverage | 12 (7.2%) |
| | Insurance | 11 (6.6%) |
| | Others | 71 (42.7%) |
| Size of the company | Small | 1 (0.6%) |
| | Medium | 1 (0.6%) |
| | Large | 164 (98.8%) |
| Participant´s job title | Manager | 55 (33.1%) |
| | Specialist | 33 (19.9%) |
| | Coordinator / Supervisor | 29 (17.5%) |
| | Analyst | 17 (10.2%) |
| | Director | 20 (12.0%) |
| | Other | 12 (7.2%) |

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Almost all companies were large enterprises (98.8%). In terms of job position, 33.1% were managers, 19.9% were specialists, and 17.5% were coordinators/supervisors. Twenty out of the 166 participants did not complete the full questionnaire. They differed from survey completers regarding the "job position" variable, non-respondents being significantly more likely to hold the position of "Director" (37% vs 0-20%, p=0.014).

*Quantitative results from the GM@W*

*Psychological and Social Support*: In this GM@W domain, when asked about the statement "When psychological risks are identified, management responds effectively", 81.5% of respondents answered "always" or "often" (Table 2). For the statement "People in my workplace understand the importance of protecting employees' psychological safety", 77.7% responded "always" or "often". Regarding "People with mental health problems are supported to perform their work effectively", the percentage was 84.1%. For "People with physical health issues are supported to do their jobs effectively", 92.4% responded "always" or "often."

**Table 2** – GM@W domains and item answers

| | **Always / Often** | **Sometimes** | **Rarely / Never** |
|---|---|---|---|
| **Psychological and social support** | | | |
| 1. When psychological risks are identified, management responds effectively. | 81.5% | 14% | 1.6% |
| 2. People in my workplace understand the importance of protecting employee psychological safety | 77.7% | 17.8% | 4.5% |
| 3. People with mental health issues are supported to do their jobs effectively. | 84.1% | 13.4% | 2.5% |
| 4. People with physical health issues are supported to do their jobs effectively. | 92.4% | 7.6% | 0% |
| 5. Management helps employees cope with workplace stress. | 61.1% | 31.3% | 7.6% |
| 6. No employee feels lonely at work, including when working remotely. | 59.2% | 31.2% | 9.6% |
| **Psychological Competencies and Demands** | | | |
| 1. Management appointments consider the "people skills" necessary for specific positions. | 79.0% | 17.2% | 3.8% |
| 2. Work does not present a threat to any employee's psychological health. | 49.0% | 35.0% | 15.9% |
| 3. Work does not compromise the values or morals of any employee. | 70.7% | 15.3% | 14.0% |
| **Psychological Protection** | | | |
| 1. Management makes efforts to prevent harm to employees from discrimination. | 90.4% | 7.0% | 2.5% |

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| | | | |
|---|---|---|---|
| 2. Every employee feels safe to speak up at work. | 67.5% | 26.8% | 5.7% |
| 3. Management makes efforts to prevent harm to employees from bullying. | 90.4% | 7.6% | 1.9% |
| 4. All employees are free from stigma related to having a mental illness at work. | 59.2% | 30.6% | 10.2% |
| 5. All employees are free from bullying at work. | 72.0% | 19.1% | 8.9% |
| 6. All employees are free from harassment (verbal, physical, or sexual) at work. | 71.3% | 21.0% | 7.6% |
| 7. All employees are free from discrimination at work. | 75.8% | 18.5% | 5.7% |

On the other hand, only 61.1% responded “always” or “often” to the statement “Management helps employees cope with workplace stress”. In other words, 38.9% responded “sometimes”, “rarely”, or “never.” Similarly, only 59.2% answered “always” or “often” to the statement that “No employee feels lonely at work, including when working remotely”.

Employees from national companies had significantly higher scores (worse perception) in this GM@W dimension (B=0.245, SE=0.096, p=0.011) compared to those from international companies, as did mental health professionals (B=0.656, SE=0.289, p=0.023) (Table S1).

*Psychological Competencies and Demands*: In this dimension, when asked whether “Management appointments consider the 'people skills' necessary for specific positions”, 79% responded “always” or “often” (Table 2). However, only 49% answered “always” or “often” to the statement “Work does not present a threat to any employee’s psychological health” (Table S2).

*Psychological Protection*: In this GM@W domain, 90.4% of participants responded “always” or “often” to the statement “Management makes efforts to prevent harm to employees from discrimination” (Table 2). For the statement “Management makes efforts to prevent harm to employees from bullying”, this percentage was also 90.4%. However, only 59.2% responded “always” or “often” to the statement “All employees are free from stigma related to having a mental illness at work”. For “All employees are free from bullying at work”, the figure was 72%, and for “All employees are free from harassment (verbal, physical, or

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sexual) at work", it was 71.3%. Employees from national companies had significantly higher scores (worse perception) in this dimension (B=0.246, SE=0.114, p=0.032) as did mental health professionals (B=0.735, SE=0.325, p=0.024) (Table S3).

*Results from the PDDQ and correlation between scales*

In the Perceived Public Stigma Questionnaire, the mean score for the Perceived Discrimination dimension was 3.896 (SE=0.056)(with 1 indicating lower stigma and 6 indicating higher stigma). The mean score for the Secrecy dimension was 3.374 (SE= 0.059), and for Avoidance, it was 3.653 (SE=0.039).

Scores from the Psychological and Social Support dimension of the GM@W were significantly correlated with the Perceived Discrimination (p<0.001) and Secrecy (p<0.001) scales of the PDDQ (Table 3). Scores from the Psychological Demands and Competencies dimension of the GM@W were significantly correlated with all PDDQ scales: Perceived Discrimination (p<0.001), Secrecy (p=0.033), and Withdrawal (p<0.001). Likewise, scores from the Psychological Protection dimension of the GM@W were significantly correlated with all PDDQ scales: Perceived Discrimination (p<0.001)(Figure 1), Secrecy (p<0.001), and Withdrawal (p=0.007). All these correlations point to the following: the higher the perceived public stigma, the worse the perception of mental health wellbeing in the company.

**Table 3** – Correlation between mean values in GM@W domains and in PDDQ domains

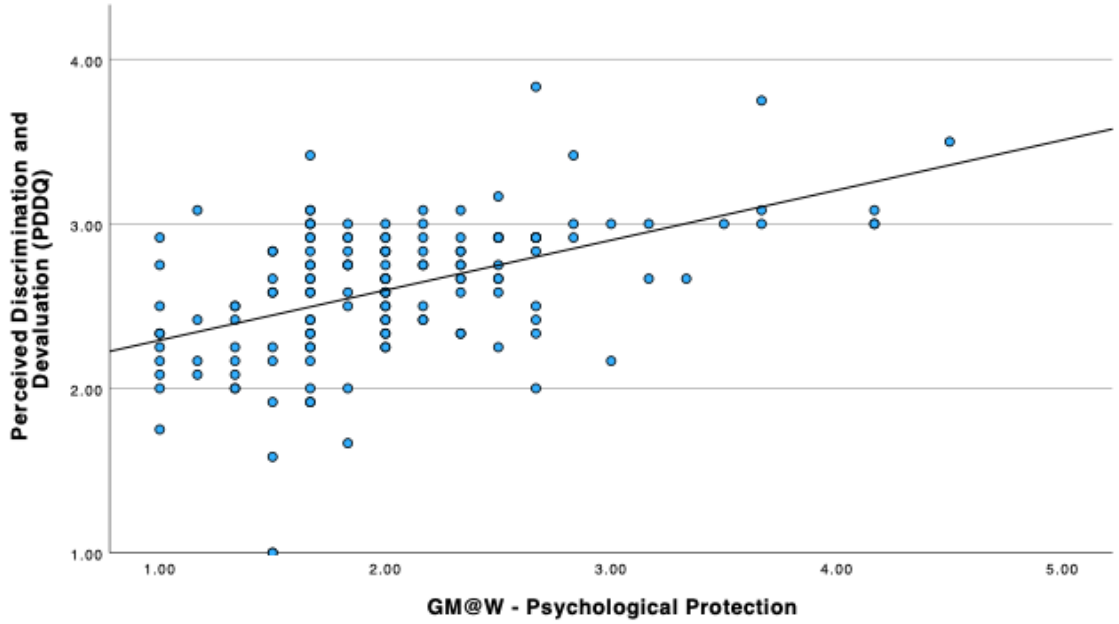
| | PDDQ | PDDQ - Secrecy | PDDQ - Withdrawal | GM@W - Psychological and Social Support | GM@W - Competencies and Demands | GM@W - Psychological Protection |
|---|---|---|---|---|---|---|
| PDDQ | - | | | | | |
| PDDQ - Secrecy | 0.394** | - | | | | |
| PDDQ - Withdrawal | 0.161 | 0.224** | - | | | |
| GM@W - Psychological | 0.415** | 0.279** | 0.134 | - | | |

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| | | | | | | |
|---|---|---|---|---|---|---|
| and Social Support | | | | | | |
| GM@W - Competencies and Demands | 0.301** | 0.177* | 0.282** | 0.473** | - | |
| GM@W - Psychological Protection | 0.490** | 0.274** | 0.220** | 0.706** | 0.547** | - |

* p<0.05
** p<0.01

**Figure 1 —** Spearman correlation between perceived discrimination (higher values=more stigma) and psychological protection (higher values=worse perception of workplace's protection)(p<0.001)




*Qualitative analysis*

Both the qualitative analysis of the themes generated by the focus groups and the open-ended responses from the GM@W questionnaire elicited five major themes (Table 4). This suggests that even if the sample was expanded, new themes would not emerge, as the qualitative phase of the study had already reached saturation. The main themes identified by the participants were: 1) leadership, 2) expansion and quality of mental health programs, 3) stigma, 4) mental health as part of the company's culture and strategy, 5) need for prevention and support. To address potential differences by respondent role, we

paid specific attention during coding reflect whether statements were voiced from a managerial/HR perspective or from an occupational health/mental-health perspective (based on participants' self-identification and the content of their comments). In general, managers emphasized feasibility, resourcing, and leadership constraints, whereas health professionals emphasized confidentiality, care pathways, and stigma-related barriers to help-seeking. Each of the 5 themes from qualitative analysis is discussed below.

**Table 4** – Themes in qualitative analysis

| Statements' Examples | Codes | Themes |
|---|---|---|
| "Improvement of support from the top leaders of the organization"<br>"Increasingly train leaders on the topic"<br>"Ensure the topic (of mental health) is increasingly brought up by senior leadership"<br>"Strategic discussions together with top management" | Engage with leadership | Leadership |
| "Managers should be better prepared for mental health issues"<br>"More frequent training with human resources and leadership is needed"<br>"Train leaders to address the topic as something normal" | Leadership training | |
| "Continuously expand the programs already in place"<br>"Listen to the specific demands and needs of each group"<br>"Bring mental health campaigns into daily life more frequently, consistently promoting the employee assistance program and other available tools for prevention and treatment"<br>"Implement a structured program for this purpose (of mental healthcare)" | Program expansion | Expansion and quality of mental health programs |
| "Strengthen reporting channels for psychological monitoring"<br>"Intensify campaigns that engage employees to seek professional help for psychosocial issues, aiming to reduce stress and pressure at work"<br>"Develop people in psychological safety"<br>"Expand the accredited network and referred professionals in the health insurance" | Expansion of services | |

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| | | |
|---|---|---|
| "...with stricter monitoring not only of reports but also of areas considered 'at risk' due to mental health issues"<br>"Further facilitate access to the support network"<br>"Improve the management of work–life balance"<br>"Have more clearly defined strategies and not act only in response to demand" | Quality | |
| "Create a committee or affinity group for the topic"<br>"Support networks, social worker"<br>"Have employees serve as mental health ambassadors"<br>"Create a health committee to monitor indicators and figures"<br>"Further promote the topic internally" | Specialized services | |
| "Awareness and understanding of the subject"<br>"Further intensify … the interventions so that everyone (leaders and operational staff) reaches the same level of awareness, establishes more open communication, and seeks help more naturally"<br>"Increase awareness across all areas, as well as periodic monitoring and evaluations"<br>"Literacy/training for all employees and effective promotion of the use of the mental health app, which offers psychological and psychiatric support" | Mental Health Literacy | Stigma |
| "Reduce tolerance for misconduct"<br>"Reduce discrimination"<br>"Continue closely mapping sensitivity within teams and do not accept any type of discrimination, regardless of the hierarchical level it comes from, enabling punitive measures and even termination if necessary" | Prejudice | |
| "Improve the culture regarding psychosocial factors"<br>"Promote a culture of respect and inclusion (expand and reinforce)"<br>"Encourage open communication, tolerance for mistakes"<br>"Work on stress prevention, ensure breaks during working hours"<br>"Recognize and celebrate efforts and achievements" | Culture | Mental health as part of the company's culture and strategy |
| "There are already actions in place that protect and contribute to a good environment"<br>"I believe that, for me, everything the company could be doing is already being done in the best possible way"<br>"Maintain what is already being done" | Sufficiency | |

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| | | |
|---|---|---|
| "Maintain existing organizational practices" | | |
| "…continue listening to people, gathering information, and analyzing it"<br>"Rely on subject matter experts to support us"<br>"Dedicated discussion groups"<br>"Adopt a humanized approach to employee support"<br>"Training for difficult conversations" | Active listening | Need for prevention and support |
| "Prevention, anticipation of cases"<br>"Mental health screening"<br>"Better identify cases and prevent them"<br>"Work in a preventive rather than reactive manner" | Prevention | |

1) *Leadership*: Managers frequently described burnout among leaders and multilateral pressures, while health professionals emphasized leadership mental-health literacy as a bottleneck. Leadership was frequently mentioned as the weakest link. Many leaders are perceived as overwhelmed and unprepared: "Leadership is the most sensitive point. Many managers are unwell and unprepared." "Many leaders are also struggling. The (mental health) movement needs to come from the top." "Older leaders see overload as a virtue. The new generation wants balance. There's a lack of mental health literacy." One particularly insightful comment referred to mid-level leaders who are caught between the demands of upper management and the needs of their teams—the so-called "sandwich manager": "There's pressure from upper management for results and pressure from the operational base."

2) *Expansion and Quality of Mental Health Programs*: Managers mostly highlighted scaling challenges; health professionals highlighted clinical adequacy and confidentiality. Companies have made progress in mental health, with structured programs and dedicated psychological support spaces: "The company offers a channel with clinical psychologists; the service is confidential." "We created mental health 'brigadiers'. They are team members who receive basic listening training." However, the increasing demand for mental health support is exceeding companies' capacity to respond: "The demand has grown so much that we can't reach everyone who needs help." "We created programs, but we don't have the time or structure to handle all the cases. It's a reality challenge."

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“We used to have in-person psychologists, but we switched to app-based services to meet the demand across all branches.” There is also concern about the effectiveness of the programs: “Having resources doesn’t guarantee quality. Short, spaced-out sessions are not enough.” A shift in the pattern of mental health conditions was also noted. While depression was once the most common issue, anxiety and stress have now become more prevalent: “Depression used to be the most common. Now, anxiety and stress are the main complaints.”

3) *Stigma*: Stigma was described as pervasive across all organizational levels: “Some managers prefer not to hire someone who’s had depression.” (Recruitment) “Even with a help channel, some people don’t seek support out of fear.” (Work routine) “Sometimes HR discloses the reason for a leave to the manager, breaking confidentiality.” (sick leaves) “If someone doesn’t quickly readapt upon returning to work, they’re seen as a burden.” (Return to work) Despite advances, prejudice and resistance toward mental health persist in the corporate environment: “There is prejudice and resistance around mental health at work. Open, empathetic communication with leadership and the creation of safe spaces are seen as fundamental strategies for progress.” “There is stigma. HR needs to be better prepared to deal with it. Sometimes people are dismissed as early as in recruitment (because of mental health stigma).” “Returning to work is challenging. Sometimes the position is already filled, and leadership resists reintegration.” “Reintegration should include the employee in the planning process. Often, they feel exposed (by their disclosed mental disorder).” “If you don’t play by the rules, you’re out.” Managers often cited reintegration issues; health professionals cited confidentiality breaches and help-seeking avoidance.

4) *Mental Health as part of the company’s Culture and Strategy*: Mental health must be part of the company’s strategic agenda: “Mental health should be connected to the company’s strategy.” “Institutions label people. Cultural change is needed, and that takes time.” “There’s a lot going on, but nothing is connected. It’s all scattered initiatives.” “If it’s not embedded in the culture, it becomes just a feel-good action. People can tell when it’s not genuine.” “HR is taking up the fight, but upper management still treats it as an individual problem.”

A more strategic and systemic perspective on the issue is clearly needed: “It’s not always prejudice when people with a mental health history aren’t hired—sometimes there’s just no structure to support them.” “Mental suffering is

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multifactorial. It involves factors both internal and external to the workplace." "People don't have (financial) backups—they're in debt, and that causes a lot of suffering." (Financial strain) "It's not just work. There's also family and social pressure. We carry those burdens too." (Social and family pressure) "We have a high-performance culture that pushes everyone to the limit." (High-performance culture) "It's constant information overload. Notifications, demands, meetings. The body doesn't shut down." (Overstimulation and lack of rest)

5) *Need for Prevention and Support*: There is a pressing need for prevention and early detection of mental health conditions: "If someone is already vulnerable and faces an unprepared counterpart, it makes everything worse." "We are applying the *mental health questionnaire* monthly to detect psychological distress early." "We added a mental health scale to routine health checks and questions about suicide risk." The company has a responsibility to shelter, support, and follow up with employees facing mental health issues. However, this support has limits: "We follow up with a multidisciplinary team, but if there's no improvement (in performance), we move toward dismissal with HR support." "When there's no progress even with proper support, termination may be necessary." "It's not just about wanting to support. You have to be able to deliver. If performance isn't there, the department doesn't want the person back."

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## Discussion

In this mixed-methods study conducted in Brazilian "best workplaces," respondents generally reported the presence of workplace mental-health initiatives and some favorable perceptions of psychosocial resources, yet persistent vulnerabilities emerged—most notably around psychological protection and stigma.[40] Productivity-oriented arguments for investing in mental health are well established,[9] but our findings suggest that even organizations perceived as high-performing can struggle to translate "program presence" into day-to-day psychological safety. Qualitative themes helped explain this gap: participants described uneven implementation maturity, limited evaluative capacity, and enduring fears around disclosure and reputational consequences,

consistent with stigma acting as a “hidden demand” that drains social resources and undermines help-seeking.[10–12]

Concerning the Guarding Minds at Work modules, results were mixed. In all three modules, while some answers showed positive views on how companies address workplace’s mental health, other answers pointed towards a concern in this topic. Our pattern of results aligns with core premises of the Job Demands–Resources framework: demands deplete and resources buffer strain, while resource-rich environments promote engagement and resilience.[41,42] At the same time, classic job-stress models emphasize that strain depends not only on demands but also on decision latitude and social support.[15,16] In our data, perceptions of supportive elements were relatively stronger than perceptions of protection from psychosocial harm—suggesting that organizations may more readily provide instrumental support than consistently secure psychosocial safety in everyday interactions. This is consistent with the view that “healthy workplaces” require strategic alignment between work design, leadership behavior, and organizational systems, rather than isolated initiatives.[14–16,18,43] Accordingly, future studies should examine how classic demand-control-support mechanisms can be integrated with newer job demands-resources models, including team-level and organizational conditions that shape autonomy, communication, and social support at work. Such research may help clarify which modifiable work resources protect employees under high demand and inform organizational interventions targeting workload, schedule, teamwork, and participatory job redesign.[44]

That both participants’ area of work and company category remained significantly associated with GM@W domains suggests that mental-health outcomes are shaped not only by individual experiences, but also by the occupational and organizational contexts in which employees are embedded[45,46]. This is broadly consistent with previous studies showing differences in common mental disorders across sectors and occupations, as well as with evidence that organizational conditions such as workplace culture and coworker support are associated with psychological distress[45,47]. At the same time, because psychosocial job characteristics do not always fully explain occupational differences, our findings may indicate that area of work and company category also capture broader contextual factors—such as emotional demands,

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institutional culture, and work organization—supporting the need for tailored rather than uniform workplace mental-health strategies

As for the perceived discrimination and devaluation, stigma remained a major explanatory factor for why mental-health needs stay partially hidden at work. Untreated mental disorders are associated with productivity losses,[9] and stigma is a well-documented barrier that prevents employees from acknowledging difficulties and seeking professional help.[12] In our study, perceived devaluation/discrimination captured a broader social climate that appears to "enter" the workplace, shaping whether mental health programs are trusted, whether leaders feel safe engaging proactively, and whether employees anticipate negative consequences of disclosure.[11] This helps clarify why some workplace initiatives risk becoming superficial "window dressing": if stigma is not addressed explicitly, the very conditions required for uptake (psychological safety, trust, confidentiality) remain fragile.[48]

*Practical and theoretical implications and the value of integrating quantitative and qualitative evidence*

For leaders and HR, the central implication is that workplace mental health should be embedded into strategy and psychosocial-risk governance, not treated as an add-on.[14–16,18,43] A recently published document from the European Agency for Safety and Health at Work mentions several multilevel key strategies to put mental health policy into practice[49]. For instance, promoting protective factors at a team and organizational level to maximize resilience, a proactive prevention approach, promoting inclusive ways of working, and a respectful work culture where workers are treated fairly, difference is acknowledged and valued, communication is open and civil, conflict is addressed early, and there is a culture of empowerment and cooperation. Numerous studies have shown that effective leadership predicts higher psychological safety, lower burnout, and improved well-being[5,50]. International guidance recommends integrating psychosocial risk management into occupational health and safety systems[19] and operationalizing this through standards such as ISO 45003.[20] Practically, this means (i) building leader capability (mental-health literacy, psychologically safe management, and role clarity)[18,43,50], (ii) ensuring program accountability with clear metrics (uptake, timeliness, return-to-work quality, and employee experience), and (iii) proactively

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addressing emerging stressors in remote/hybrid work (isolation, weakened support structures, and unclear boundaries)[7,8,24]. In addition, aligning interventions with workers' expectations is not merely a communication issue—it is an ethical and reputational driver that can influence engagement and perceived legitimacy.[25,26]

For occupational health and mental-health professionals, the findings underscore the importance of trustworthy, confidential pathways and clear care navigation. A key barrier described qualitatively was the fear that disclosure could lead to subtle penalties or loss of status, reinforcing avoidance and late presentation.[10–13] Programs should therefore prioritize confidentiality safeguards, transparent referral routes, and stepped-care or triage models that reduce friction to early access, especially when line managers are uncertain or overloaded.[19,20] In parallel, occupational health teams can strengthen program credibility by partnering with management to define outcomes, evaluate implementation quality (not only availability), and ensure that preventive and supportive practices are integrated into everyday work processes rather than delivered as occasional campaigns.[21,50]

Theoretically, our findings support the move toward integrative "healthy organization" models (e.g., HERO), in which wellbeing depends on the alignment between leadership practices, psychosocial resources, and organizational systems.[21] Within this perspective, leadership is not merely another correlate of wellbeing but a key mechanism shaping psychosocial safety climate and sustaining support at scale.[18,43,50,51] Our mixed-methods approach adds value by showing how similar "headline" commitments to workplace mental health can coexist with implementation bottlenecks and persistent stigma-related dynamics that are not fully captured by scale means alone. By combining quantitative ratings with implementation narratives, we clarify not just whether resources are perceived to exist, but why they may fail to translate into psychological protection and trusted help-seeking.

This study has limitations that should be considered. First, the cross-sectional design precludes causal inference. Second, data were self-reported by professionals directly involved in corporate mental-health management, which may have introduced social-desirability bias despite assurances of anonymity. Third, only three GM@W dimensions were selected to minimize respondent

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burden, potentially omitting relevant psychosocial factors. Fourth, the sample was limited to large companies that voluntarily participated, reducing generalizability. In this sense, participation bias cannot be ruled out, as the factors assessed in the survey (e.g. stigma) could be differentially present in companies which refused to participate. Fifth, attrition rate was relatively high and should be considered while interpreting the results. Future research should employ longitudinal and multilevel designs including employees from various organizational levels, integrate objective indicators (e.g., absenteeism, turnover), and test multicomponent anti-stigma interventions tailored to different corporate contexts. Such multicomponent interventions should target stigma at its various levels, addressing, for instance, return to work after a mental health related sick leave, workers recovery from mental health problems, awareness of mental health and stigma among all levels of employees, mental health literacy, proactive prevention, discrimination at the selection and hiring level.[52] At last, another limitation concerns the qualitative quotations from group interviews. Because individual speakers were not systematically coded, it is not possible to determine whether quotations came from the same or different participants. This limits their use as evidence of the distribution of views across individuals. However, as the qualitative component aimed to identify themes rather than individual perspectives, quotations should be interpreted as illustrative of thematic patterns rather than as independent personal accounts.

## Conclusion

In Brazilian “best workplaces,” the presence of mental-health initiatives coexisted with clear fragilities in psychosocial protection—especially around stigma—suggesting that program availability does not automatically translate into day-to-day psychological safety. This calls for the need of more implementation research, to evaluate if initiatives proposed by the company are effectively occurring and being adopted. Across GM@W domains, respondents reported strong managerial responsiveness to identified risks and support for employees with difficulties, yet sizeable minorities described limited stress-coping support, persistent loneliness in remote work, and, most strikingly, a lack of freedom from mental-illness stigma at work. The consistent association between higher

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perceived public stigma and worse perceptions of workplace psychosocial conditions supports the view of stigma as a “hidden demand” that erodes trust, discourages disclosure, and undermines timely access to care—even in high-culture settings. Qualitative findings explain how these dynamics operate in practice: leaders under multilateral pressures, uneven program maturity and evaluation, confidentiality breaches, and return-to-work frictions. Together, the results imply that effective workplace mental-health strategy requires more than isolated interventions: it must be embedded into organizational governance and psychosocial-risk management, with explicit anti-stigma actions, leadership capability building, confidential care pathways, and measurable quality indicators for prevention and support. Future research should test these mechanisms longitudinally and with multilevel designs, while evaluating whether integrated governance approaches reduce stigma and improve psychological protection and early help-seeking outcomes.

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**Competing interests**

The authors have no relevant financial or non-financial interests to disclose.

**Ethics Approval**

The research was approved by the ethical committee of the Albert Einstein Israeli Hospital (77770723.6.1001.0071).

**Consent to participate**

Informed consent was obtained from all individual participants included in the study.

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## Author Contributions

AAL, LGVZ and FAN conceptualized the work and designed the methodology; AAL and CH curated the data and performed formal analysis; all authors contributed to project administration, supervision, review & editing the original draft and final version. All authors have read and approved the submitted manuscript.

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## Supplementary material

**Table S1 –** Generalized linear model - Psychological and Social Support

| Parameter | | B | SE | p |
|---|---|---|---|---|
| Company category | National | 0.245 | 0.096 | **0.011** |
| | Multinational | (ref.) | | |
| Participant's area of work | Human resources | 0.181 | 0.153 | 0.237 |
| | Mental health | 0.656 | 0.289 | **0.023** |
| | Occupational health | 0.139 | 0.161 | 0.389 |
| | Other | (ref.) | | |
| Company's area | Commerce | -0.046 | 0.267 | 0.864 |
| | Provision of services | 0.114 | 0.143 | 0.425 |
| | Industry | 0.061 | 0.141 | 0.665 |
| | Other | (ref.) | | |
| Participant´s job title | Director | 0.355 | 0.253 | 0.161 |
| | Manager | 0.283 | 0.212 | 0.182 |
| | Coordinator / Supervisor | 0.267 | 0.225 | 0.235 |
| | Specialist | 0.405 | 0.222 | 0.069 |
| | Analyst | 0.349 | 0.245 | 0.154 |
| | Other | (ref.) | | |

**SE:** Standard error
**Bold:** statistically significant

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**Table S2 –** Generalized linear model - Psychological Competencies and Demands

| **Parameter** | | **B** | **SE** | **p** |
|---|---|---|---|---|
| Company category | National | 0.095 | 0.136 | 0.484 |
| | Multinational | (ref.) | | |
| Participant's area of work | Human resources | -0.111 | 0.216 | 0.609 |
| | Mental health | 0.040 | 0.409 | 0.922 |
| | Occupational health | -0.045 | 0.228 | 0.844 |
| | Other | (ref.) | | |
| Company's area | Commerce | -0.461 | 0.377 | 0.222 |
| | Provision of services | -0.166 | 0.202 | 0.411 |
| | Industry | -0.274 | 0.199 | 0.169 |
| | Other | (ref.) | | |
| Participant´s job title | Director | -0.836 | 0.357 | **0.019** |
| | Manager | -0.481 | 0.299 | 0.108 |
| | Coordinator / Supervisor | -0.380 | 0.318 | 0.233 |
| | Specialist | -0.272 | 0.314 | 0.386 |
| | Analyst | 0.045 | 0.346 | 0.896 |
| | Other | (ref.) | | |

**SE:** Standard error
**Bold:** statistically significant

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**Table S3 –** Generalized linear model - Psychological Protection

| **Parameter** | | **B** | **SE** | **p** |
|---|---|---|---|---|
| Company category | National | 0.246 | 0.114 | **0.032** |
| | Multinational | (ref.) | | |
| Participant's area of work | Human resources | 0.160 | 0.181 | 0.379 |
| | Mental health | 0.735 | 0.325 | **0.024** |
| | Occupational health | 0.139 | 0.193 | 0.473 |
| | Other | (ref.) | | |
| Company's area | Commerce | -0.089 | 0.322 | 0.782 |
| | Provision of services | -0.027 | 0.167 | 0.872 |
| | Industry | 0.024 | 0.168 | 0.473 |
| | Other | (ref.) | | |
| Participant´s job title | Director | -0.019 | 0.302 | 0.951 |
| | Manager | 0.097 | 0.255 | 0.705 |
| | Coordinator / Supervisor | 0.043 | 0.270 | 0.875 |
| | Specialist | 0.306 | 0.269 | 0.255 |
| | Analyst | 0.482 | 0.291 | 0.097 |
| | Other | (ref.) | | |

**SE:** Standard error
**Bold:** statistically significant

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