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Title: Disability-based Discrimination:
Managers' Prejudices against
Workers with Psychiatric
Disabilities

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DISABILITY-BASED DISCRIMINATION: MANAGERS' PREJUDICES AGAINST WORKERS WITH PSYCHIATRIC DISABILITIES

INTRODUCTION

“Work disability is one of the most costly and prevalent health problems in Canada and the United States” (Butler, Johnson and Baldwin, 1995: 13) and it is entrenched with stigma.

The meaning of stigma includes any mark or sign for perceived or inferred conditions of deviation from a prototype or norm (Jones, Farina, Hastorf, Markus, Miller & Scott, 1984). “To be labeled a stigma the normative deviations in physical attributes, character, behavior and so forth must be undesirable qualities” (Weiner, Perry & Magnusson, 1988: 738). Dovidio, Major and Crocker (2000: 3) define stigma as a social construction involving two components: “the recognition of difference based on some distinguishing characteristic... and a consequent devaluation of the person.” Throughout history stereotypes and stigmas have surrounded people with disabilities; they have been and continue to be viewed as different. Negative response to people with disabilities, and specifically mental illness, are seen as a barrier to recovery and undermining to their self-esteem (Fink & Tasman, 1992). The Canadian Alliance for Mental Illness and Mental Health (2002) indicates that by reducing the stigma and discrimination surrounding people with mental illnesses, improvements in the overall mental health of the population will be expected. With all the current technological advances, one has to wonder why society’s behaviors and attitudes towards people with disabilities, and specifically, mental illnesses, are stuck in the past.

The purpose of this study is an investigation of managers’ perceptions toward employees with varying medical conditions during a request for workplace accommodation. Disability is a universal issue that knows no boundaries. Even though individuals may not presently be disabled, all people are confronted with the reality that they may someday be afflicted and workplace accommodation is a necessity for recovery.

Workplace accommodation is likely to be viewed as unwarranted by co-workers and supervisors when it comes to individuals with psychiatric illnesses, and companies feel that it was easier to accommodate people with physical disabilities versus those with mental and emotional problems (Combs & Omvig, 1986). Why is that?

For this study, a vignette approach was used, in which experienced managers respond to an experimentally manipulated situation. The strength of this approach lies

in the maximization of internal validity. In addition, it would be unethical and impossible to manipulate medical conditions and working situations of employees in order to evaluate the effect of managerial attitudes. The potential contribution of this research is the empirical study of mental health stigma during return to work accommodation and the practical considerations that flow from this.

Only by bringing the issue of disability-based stigmatization into the open is society going to be able to deal with it constructively and purposefully so that people can lead full and healthy lives. Managers need to recognize that they have a personal responsibility to build a sense of comfort that gives employees the confidence to live with or overcome illnesses.

RESEARCH QUESTIONS

The principal goal of this study is to use managers' self-reported perspective of a hypothetical situation involving an employee on medical leave to evaluate attitudes towards their employee based on the type of medical condition. (See appendices.)

Are managers' attitudes and perceptions affected by the type of illnesses employees have? The following section will introduce the reader to the topics addressed in this thesis to answer the above question, and the hypotheses that flow from it.

WORKPLACE ACCOMMODATION

Several provinces, including Ontario, have "duty to cooperate" requirements which require employers to promote return-to-work efforts. Employers are obliged to contact workers as soon as possible after injuries or illnesses, maintain communication and attempt to provide suitable work upon recovery. Moreover, the Supreme Court of Canada has ruled that employers are required to make every reasonable effort, short of undue hardship, to accommodate employees (Ontario Human Rights Commission & O'Malley v. Sears Ltd. [1985] 2. S.C.R. 536). This legal aspect of the duty to accommodate requires more than simple investigation of any existing jobs that may be suitable; it requires that employers examine all reasonable alternatives available to disabled individuals.

However, I argue that although there is a legal duty to accommodate employees, the stigma associated with psychiatric disabilities will reduce the likelihood that managers will accept such individuals back to work in comparison with employees off work for a physical or undiagnosed condition. The notion of potential stigma is revealed in a study by Combs and Omgvig (1986), which found that companies feel that it is easier to accommodate people with physical disabilities versus those with mental and emotional problems.

Hypothesis 1: Type of illness will have an effect on managers' willingness to accommodate an employee back to work; specifically, managers will be less likely to accommodate an employee with a psychiatric diagnosis versus a physical or undiagnosed condition.

COMMITMENT

Over the past several decades attempts have been made to define and conceptualize commitment and, as a result, literature connecting commitment in organizations to work behaviors has been obtained (e.g. Becker, 1992; O'Reilly & Chatman, 1986; Porter, Steers, Mowday & Boulian, 1974). Commitment binds people to the organization for which they work. Employees who stay with an organization regardless of the companies' employment outlook, those who attend work on a regular basis and are dedicated to the organization are employees who are considered committed to the organization.

Meyer and Allen (1991) indicated that "the view that commitment is a psychological state that (a) characterizes the employee's relationship with the organization, and (b) has implications for the decision to continue membership in the organization" (67). With regards to the psychological state of commitment Meyer and Allen's research reveals that it consists of three components: affective, continuance and normative. Affective commitment refers to the employee's emotional attachment to, identification with, and involvement in the organization. Employees with a strong affective commitment continue employment with the organization because they want to do so (...) (Meyer & Allen, 1991: 67).

The focus of this study will be on the affective component of commitment within the workplace. Studies to date have revealed that affective commitment is negatively correlated with the measure of voluntary absences (Meyer, Allen, & Smith, 1993), individuals with strong affective commitment appear protected from the impact of stress on displeasure, and they work harder in their positions than employees with weak commitment (Meyer & Allen, 1997). "Affective commitment is arguably the most desirable form of commitment and the one that organizations are most likely to want to instill in their employees (Meyer & Allen, 1997:67). The role of perceptions is key to the development of employees' commitment, since it lies in a belief that their organizations are supportive (Meyer & Allen, 1997). Acceptance is critical for the socialization process and affects the commitment and satisfaction displayed by disabled employees (McLaughlin, Bell, & Stringer, 2004).

Employees with psychiatric disabilities may not receive acceptance given that mental-behavioral stigmas are perceived as onset-controllable, elicit little pity, much anger, and judgments to neglect disabled individuals (Weiner, Perry, & Magnusson,

1988). For the purpose of this study, I was interested in examining the perception of levels of affective commitment depending on the type of medical condition presented. I argue that the level of perceived affective commitment will be higher for employees with physical conditions than an undiagnosed condition because of its ambiguity, and that the lowest perceived level will be for employees with psychiatric conditions because of the stigma against them.

Hypothesis 2: The level of perceived affective commitment by managers will vary depending on the type of medical condition the employee has.

Hypothesis 2a: An employee returning from a psychiatric medical leave will be perceived by managers to be less affectively committed to an organization, in comparison with an employee returning from a medical leave following an undiagnosed condition.

Hypothesis 2b: An employee returning from a psychiatric medical leave will be perceived by managers to be less affectively committed to an organization, in comparison with an employee returning from a medical leave following a physical condition.

Hypothesis 2c: An employee returning from an undiagnosed condition medical leave will be perceived by managers to be less affectively committed to an organization, in comparison with an employee returning from a medical leave following a physical condition.

Trust

Trust has been a relevant topic of research in psychology and sociology since the late 1950s. “Recent developments in the organizational sciences reflect the importance of interpersonal trust relationships for sustaining individual and organizational effectiveness” (McAllister, 1995). Affect-based trust relates to the emotional bonds between people and cognition-based trust relates to the choosing of whom we will trust and under what circumstances (McAllister, 1995). Trust in subordinates is important in order for managers to supervise efficiently and effectively, and is the reason why it was decided to examine cognition-based trust for this study. Given that affect-based trust is the emotional bonds and this study consisted of a hypothetical employee, it was felt that this type of trust would be more difficult to illicit.

Under conditions of uncertainty and complexity (such as return to work accommodation) willingness to be trustful is of importance (Becker, 1996). People who trust others are more likely to provide others with a “second chance” and to respect the rights of others (Rotter, 1980). Trust and empathy have been claimed to be closely

related (Ickes, Stinson, Bissonnette & Garcia, 1990). Given the logic underlying hypothesis 1 - which is that a psychiatric ill employee will be less likely to receive a second chance due to stigma - it is argued that this employee will also be less inclined to be trusted in comparison with the other two conditions. In addition, differences between the undiagnosed and the physical condition are expected, as hypothesized below.

Hypothesis 3: Managers' perceptions of cognition-based trust will be influenced by the type of medical condition the employee has.

Hypothesis 3a: Managers will have less cognition-based trust in an employee with a psychiatric condition than in an employee with an undiagnosed condition.

Hypothesis 3b: Managers will have less cognition-based trust in an employee with a psychiatric condition than an employee with a physical condition.

Hypothesis 3c: Managers will have less cognition-based trust in an employee with an undiagnosed condition than an employee with a physical condition.

Fear

The perceptual distortion aspect of stigma was brought to light in a study conducted by the Ontario Division of the Canadian Mental Health Association in 1993-1994. This study showed that the most prevalent misconception about mental illness was that the majority of the general population believed that mental patients were dangerous and violent. However, results from epidemiological data in the U.S. Department of Health and Human Services 1981 found that mental illness rates were not proportional to violent rates (Canadian Mental Health Association, 1994). Individuals with a history of psychiatric disorder elicited fear in others based on Riskind and Wahl's 1992 study. If this misconception surrounding violence is still present then it is expected that perceptions of fear of future violence by psychiatrically ill employees will be present. In addition, fear of the unknown may result in greater perceptions of fear of future violence by employees with undiagnosed conditions in comparison with physical conditions.

Hypothesis 4: Managers' perceptions of fear of future violence by an employee will be influenced by the type of medical condition the employee has.

Hypothesis 4a: An employee with a psychiatric condition will elicit a higher level of fear of future violence toward others than an employee with an undiagnosed condition based on the perception of managers.

Hypothesis 4b: An employee with a psychiatric condition will elicit a higher level of fear of future violence towards others than an employee with a physical condition based on the perception of managers.

Hypothesis 4c: An employee with an undiagnosed condition will elicit a higher level of fear of future violence toward others than an employee with a physical condition based on the perception of managers.

Moreover, the perception of fear of future violence toward the employee based on medical condition is also examined. I argue that if stigma and discrimination is present in society then aggression against the stigmatized individuals may occur, in this case, against the psychiatrically ill.

Hypothesis 5: Managers' perceptions of fear of future violence towards an employee will be influenced by the type of medical condition the employee has.

Hypothesis 5a: Managers' perceptions of fear of future violence towards an employee with a psychiatric condition will be greater than for an employee with an undiagnosed condition.

Hypothesis 5b: Managers' perceptions of fear of future violence toward an employee with a psychiatric condition will be greater than for an employee with a physical condition.

Hypothesis 5c: Managers' perceptions of fear of future violence towards an employee with an undiagnosed condition will be greater than for an employee with a physical condition.

RELEVANT RESEARCH

Managers in general still have unfounded assumptions concerning the job-related abilities of persons with disabilities, their performance levels, absenteeism, turnover rates, and the cost of accommodation (Braddock & Bachelder, 1994).

Misconceptions surrounding disability and work are held by managers: ideas such as that the ability of disabled persons to perform work duties depends solely on the nature of the impairment and the quality of medical care received are not accurate. In reality, factors such as the characteristics of workers, their usual jobs, attitudes of employers, labor market conditions, and the availability of workplace accommodations are important determinants of employment outcomes for disabled workers (Baldwin & Johnson, 1998).

Unfounded assumptions can result in discrimination in employment. These can be expressed as refusals to hire someone, job terminations of disabled employees prior to those not disabled in response to reductions in the demand for labor, poorer job evaluations, failure to promote, refusals to rehire workers after they are absent because of an illness or injury, and so forth. "The failure to take the needs of the disabled into account and the insurmountable barriers to equality presented by such failure typify disability-based discrimination" (Molloy, 1992: 26). For the purpose of this study, the evaluation of disability-based discrimination based on types of condition was examined during workplace accommodation.

"The accommodation procedure should be an interactive process between the requestor and employer and the outcome should be determined on an individual basis (Beck v. University of Wisconsin Regents, 1996, Taylor v. Phoenixville school district). Accommodations can include flexible hours, limiting distraction, part-time scheduling, more frequent breaks, and time off for scheduled clinical services.

It is important to note that when employees experience an inability to work due to sickness or injury, drastic disturbances in their personal and occupational lives occur and as a result they are vulnerable (Quebec, 1999). Employees' turmoil and sense of alienation may be enhanced if their organizations fail to communicate or are disorganized in their workplace accommodation practices, or simply terminate those who take disability leave. Individuals who stop working because of their disability indicate that their employment problem lies in obtaining the right to return to work after their illnesses or injuries have occurred (Baldwin & Johnson, 1998: 47). Employees' perceptions of fairness and control are affected by organizations' willingness and extent of workplace accommodation (Colella, 2001).

Persons with disabilities make up a large and growing proportion of the workforce when compared with other aspects of diversity such as gender and ethnicity. As a result corporate adherence to misconceptions and myths about disabled workers constitutes one of the biggest barriers to employment of disabled workers and a serious issue in the corporate world in general. Misconceptions and myths are the root of stigma.

ATTRIBUTES OF DISABILITIES

"The nature of the disability is one of the most important determinants of how disabled persons are viewed and treated within the organization, especially to the extent that they invoke negative responses from co-workers" (Colella, Paetzold, & Belliveau, 2004).

It has been proposed by Stone and Colella (1996) that the attributes of people with disabilities can affect how they are perceived within organizations. The three characteristics of disabilities that produce offensive responses are invisibility, social

undesirability and the belief that the disability is self-caused. The lack of visible symptoms in conditions such as depression, back pain, and chronic fatigue syndrome result in disbelief by others of impairment. The social undesirability associated with conditions such as psychological disorders are prone to be reacted to more negatively than physical or sensory disabilities (such as blindness). This is also true of disabilities perceived to be self-caused, which evoke more negative reactions (Colella, Paetzold, and Belliveau, 2004). The issue with respect to causality is not whether people are actually responsible for the onset of the stigma but rather the perception of responsibility. When physical disabilities are attributed to factors beyond people's control, individuals are viewed to have more positive effect, personality attributes, and skills in comparison with people who are perceived to have onset controllable conditions (Hebl & Kleck, 2002). This notion was further supported in a study by Weiner, Perry, and Magnusson in 1988. They found that physically-based medical conditions were perceived as onset-uncontrollable and as a result elicited pity and judgments to help and did not result in feelings of anger. On the other hand, mental-behavioral stigmas were perceived as onset-controllable, elicited little pity, much anger, and judgments to neglect disabled individuals. The controllability element of stigma appears to be related to the social ideas of entitlement.

As can be seen from the above findings, characteristics of psychiatric illnesses are viewed far more negatively and induce less sympathy than physical conditions. As a result of these misconceptions, individuals with mental illness were rated as the least desirable group of individuals with disabilities: people with alcoholism and mental retardation rated higher (Tringo 1970).

PARTICIPANTS AND PROCEDURE

Participants were recruited via a mass mailing of a recruiting message with an accompanying link to the online study. A total of 1,065 employed individuals over the age of 18 and working in managerial positions who had volunteered to participate in web-based research received the recruiting message. Seven days following the release of the recruiting message a reminder was sent to those who had not already responded. Participants received raffle-type incentives in the form of five prizes valued at \$46.00 (Canadian). In addition, a recruiting message was sent out to members of a university research team to forward to individuals who were managers.

Two hundred and seventy two individuals opened the consent page of the online survey; out of those participants, one did not consent to participate and six indicated that they were not eligible based on the recruiting message. Two hundred and sixty five continued on to the questionnaire. Respondents worked in a wide variety of countries, however the majority (53.3 per cent) worked in the United States, 18.4 per cent in Canada, 20.6 per cent worked in various other countries, and 7.7 percent did

not indicate the country they were working in. Of all the respondents, 54.4 per cent were female, 38.6 per cent were male, and 7 per cent did not indicate their gender. The average age of the participants was 39 years. Respondents had a variety of length in tenure with a mean of 10 years. Eighty six individuals had previously been on a medical leave themselves out of which 10.3 per cent required accommodation upon their return.

MEASURES AND THE VIGNETTE

As part of the mass mailing, participants received a link to the online survey which contained a letter of introduction with a request for consent, a questionnaire, and a vignette with accompanying medical notes (see Appendices).

The questionnaire consisted of two main sections. In the first section respondents were asked seven demographic questions (age, gender, country they work in, years as manager, whether they have been on medical leave and if they had been did they required workplace accommodation).

Vignette

To assess the attitudes of management to workplace accommodation, the medical conditions were experimentally manipulated to determine their effect on managers' perspectives. The manipulation was administered in the form of a vignette and accompanying medical notes. The focus was on the possible general categories of medical conditions, namely physical, psychiatric and undiagnosed conditions. As a manipulation check, respondents were requested to confirm what type of medical condition Pat (the androgynous name of the hypothetical employee) had prior to continuing on with remainder of the questionnaire. The vignette began with a short description about Pat's company, job characteristics, work history, and symptoms prior to the medical leave. The symptoms used consisted of ones that could be present in both physical and psychiatric conditions. The type of illness was manipulated, resulting in three experimental conditions: namely psychiatric, physical and undiagnosed. Each participant read only a single version of the story and participants were randomly assigned a version of the vignette by the online survey. Out of those participants who completed the survey, 29.4 per cent received the physical condition, 33.9 per cent received the diagnosis pending condition, and 36.7 per cent received the psychiatric condition.

Scales evaluating managers' perceptions

The second section of the questionnaire requested that participants' rate their attitudes towards the person described in the vignette. This section was separated from the preceding sections by instructions that asked participants to respond to questions from

the view point that they were Pat's supervisor. Participants were asked a series of yes or no questions, including whether they would accept the employee back to work and whether they would trust the employee to complete tasks.

The three measures described below which were part of the second section of the questionnaire, used a 7-point response scale (1 = strongly disagree, 7 = strongly agree) and scores were obtained by calculating the average of the responses to the items.

A modification of the affective commitment scale items of Meyer et al. 1993 was used to evaluate managers' attitudes towards the level of affective commitment they felt that the employee (Pat) would display. The scale was reduced from 8-items down to 4-items and modified to fit the context of the vignette (e.g. "I believe that Pat would be very happy to spend the rest of a career with Conexpro [the name of the hypothetical company]"; or "I believe that Pat enjoys discussing Conexpro with people outside of the company").

The fear of future violence was then assessed with an 6-item scale with 3-items related to fear of violence caused by the employee (e.g. "I am afraid that Pat will shout or swear while at work"; or "I am afraid that Pat will be violent in the workplace") and 3-items related to fear of violence towards the employee (e.g. "I am afraid that employees will shout or swear at Pat while at work"; or "I am afraid that Pat will be a victim of workplace violence"). This scale was created based on the fear of future violence scale created by Rogers and Kelloway (1997) which assessed the fearfulness of becoming a victim of workplace violence.

A measure to assess affect- and cognition-based trust levels was developed by McAllister in his 1995 study. The measure consisted of 11 items, 6 assessing levels of affect-based trust which relates to the emotional bonds between people and 6 assessing levels of cognition-based trust which relates to the choosing of whom we will trust and under what circumstances (McAllister, 1995). Cognitive-based trust was used to evaluate perceived competence rather than integrity. The 6-items assessing levels of cognition-based trust levels were modified slightly in order to make them applicable to the vignette (e.g. "I feel that Pat will approach the job with professionalism and dedication"; or "Given Pat's track record, I see no reason to doubt Pat's competence and preparation for the job").

DISCUSSION

Managers' behaviors are saying yes to workplace accommodation but their attitudes are saying no. While managers say they would not discriminate in terms of their willingness to accommodate they do discriminate in terms of perceived attitudes. Their attitudes in the accommodation of their disabled employees are a limiting factor on the success of return to work accommodation. Although managers in this study did

agree to accommodate the employee back to work regardless of medical condition, they failed to remove attitudinal barrier when dealing with psychiatric conditions.

It is important to note that when discussing workplace accommodation, the managers in this study may have simply been acknowledging that they are required to accommodate. For employers to reject employees' requests for return to work accommodation, the costs of accommodation must be so significantly large that they "alter the essential nature or substantially affect the viability of the enterprise" (Gunderson & Hyatt, 1996: 92). This clearly does not leave much room for employers to refuse workplace accommodation. Accommodation is not a courtesy, it's the law. Failure to provide accommodation short of undue hardship may be found to be discrimination on the basis of disability. Perhaps this is why no differences between medical conditions and the willingness to accommodation were revealed in this study? Had the question been prefaced by "legal obligation aside would you accommodate the employee back to work?", different results may have been obtained.

Managers play a key role in the recovery of their employees from illness or injury through the accommodation of the persons with disabilities back to work and the creation of a welcoming work environment. Unfortunately, a welcoming environment is not what people returning to work after a psychiatric illness appear to receive. Managers had less cognition-based trust and viewed employees with psychiatric illnesses as having less affectively commitment than employees with physical conditions.

This study also revealed that it is more beneficial for employees to have undiagnosed medical conditions than to have the label of a psychiatric illness. The lack of significant differences between the undiagnosed condition and the other two conditions reveal that a lack of diagnosis is ambiguous.

Stigma, prejudice, and discrimination are interrelated and this study confirms that they remain present in the corporate world when dealing with the ever present psychiatric conditions. When evaluating psychiatric disabilities it is important to step back and look at the prevalence of these conditions. In one day, 10 per cent to 15 per cent of Canadians experience a mental disorder; in one year, the number is 20 per cent-25 per cent and 70 per cent of these people are in the labor force (Roundtable Roadmap 2004). It has been estimated that mental health problems are the primary or secondary issues in 60 per cent-65 per cent of disability insurance claims in Canada (Roundtable Roadmap 2004). A recent study indicated that 77 per cent of employers surveyed said more workers were using group benefit plans because of mental illness issues and 75 per cent saw an increase in short-term disability claims for that same reason (Roundtable Roadmap 2004). Overall, in Canada, the impact of clinically diagnosed mental illnesses is in excess of \$11 billion per year in productivity losses and \$33 billion if the indirect costs of health and social services or sub clinical conditions were considered (Burton 2004).

Consequences of Stigmatization

The consequences of disability based stigmatization are of great importance in the corporate world given the prevalence of psychiatric conditions. Regardless of the merit of the evaluation we negatively evaluate those who are the holder of the stigmatized characteristic. Stigmatization leads to stereotyping, status loss and discrimination for the targeted individuals, which leads to being devalued by society (Link & Phelan 2001).

Acceptance is critical for the socialization process and impacts the commitment and satisfaction displayed by the disabled employees (McLaughlin, Bell & Stringer 2004). Therefore, by managers viewing employees with psychiatric illnesses as having less affective commitment and thereby reducing their level of acceptance, employees with these conditions will display less commitment. Consequently, this stigmatization can impact the likelihood of advancement and personal development opportunities (Cox 1993).

Stigma creates unique demands on the targeted individuals because of the ever-present prospect of prejudice and discrimination. For instance, Parker and Griffin (2002) investigated gender harassment in traditionally male occupations and found that it caused overperformance demands which resulted in psychological distress. The potential impact of possessing a socially devalued identity in terms of social interactions may be considered unique from conventional stressors (Miller & Major, 2000). Stigma can impact the development of work relationships for networking purposes (Day & Schoenrade 1997), can foster a climate that exacerbates stress, and may trigger or worsen people's conditions. As a result of the above, individuals who are the target of stigma can experience social isolation (Cox 1993) which is supported in my finding that they are less trusted. As a consequence, stigmatized individuals have poorer job performance (Stephan & Stephan, 1985).

"Whether stereotypes develop through social learning, influence, and communication, or as rationalizers of the status quo, stereotypes may set in motion biased attentional and interpretational processing of information about stigmatized persons; trigger affective responses such as disgust, anger, anxiety and fear; and contribute to discriminatory actions" (Biernat & Dovidio 2000, 111). Although this study's findings did reveal perceptual differences when dealing with a psychiatric condition, no affective responses of fear were revealed. This is an encouraging finding given that the Ontario Division of the Canadian Mental Health Association in 1993-1994 revealed that the most prevalent misconception about mental illness was that mental patients are dangerous and violent. Perhaps misconceptions about mental illnesses are being reduced but unfortunately people with them are perceived more negatively than others in the corporate world.

MANAGERIAL AND CORPORATE IMPLICATIONS —STIGMATIZATION-REDUCTION STRATEGIES

Based on the finding of this study I support a recommendation made by McLaughlin and his associates (2004) that organizational or managerial interventions could be designed to reduce social stigma associated with a specific disability, or disabilities. These interventions could incorporate the following components. Have people with disabilities work with employees on cooperative tasks in positions of equal status (Greig & Bell, 2000). Alexander and Link's (2003) study indicated that there was strong evidence for the importance of contact in reducing stigmatizing attitudes and the potential usefulness of incorporating contact into any stigma reduction intervention. This supports the growing body of research that suggests that personal experience with people who have a mental illness can reduce stigmatizing attitudes towards mental illness. Interventions can also incorporate the straightforward presentation of information about disabilities. However, traditional campaigns that highlight discrimination may have a negative impact on the mentally ill because they highlight the prevalence of hostile attitudes, and in so doing the stigmatized stereotype is perpetuated (Green, Hayes, Dickinson, Whittaker, & Gillheaney, 2003).

Mary Ann Bayton, director of Mental Health Works, an initiative of the Canadian Mental Health Association, provides the following guidance: "Increased communication between managers and employees can help remove the stigma surrounding mental health." She said "it really comes down to managers understanding mental illness so that they're not afraid of it and then applying the communication skills that exist anyway." (Mental Health Roundtable website).

There is no need to come up with new intricate strategies to implement the following recommendations. The intervention methods can be modeled after successful interventions designed to improve employee attitudes toward ethnic, racial and gender diversity.

Roundtable to Mental Disability Management 2004-2005 Senior Chairman Michael Wilson suggests that it is not life expectancy but disability that is the principal public health issue of the 21st century. This study supports the need for companies to incorporate mental health in their corporate health and safety policies. Disability awareness, de-stigmatization, and accommodation for disability should be a priority within organizations. This is further echoed by the national action plan of 2002 prepared by The Canadian Alliance for Mental Illness and Mental Health, which had as one of its main goals reducing the stigma associated with mental illnesses in Canadian society through public education and awareness.

The retention of experienced skilled workers is a benefit to all parties involved and in the long run can have a positive impact on the bottom line. Prejudice and discrimination are difficult issues to alter but if the community works together to

advocate better treatment improvement in the quality of life of individuals with disabilities and mental illness in particular may occur and perhaps in the long term stigma will be eradicated.

CONCLUSION

In conclusion, this study contributes to the workplace accommodation and mental health literatures. While these findings require replication with actual medical leave cases, the results of the present study suggest that employees with psychiatric disabilities continue to be viewed more negatively than workers with physical disabilities. More specifically, managers have differing perspectives when it comes to an employee depending on the type of medical condition. An employee with a psychiatric disability is viewed as having less affective commitment to the organization and managers have less cognition-based trust in them in comparison with employees with physical disabilities. Within the corporate world this type of stigmatization can impact the career growth of psychiatrically ill employees.

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Appendix: Questionnaire

Please respond to all of the following:

What country are you working in? Canada, United States, Other

How old are you?

How long have you been working as manager (either for your current organization or other organizations)?

What is your gender? Female__ Male__

Have you ever been on a medical leave of absence (excluding parental leave)? Yes__ No__ (If yes please answer the following.)

If you answered **Yes** to the previous question upon your return from medical leave did you require workplace accommodation (i.e., altering the nature of your work or work schedule to accommodate your medical condition(s))? Yes__ No__

You are almost half way done this survey.

Please click on the link below and keep the separate window open until you have completed the remainder of the survey. This link contains a short description of a hypothetical situation. Once you have read this please continue the study.

[Click: The Situation](#)

Respond to the following survey from the perspective of you being Pat's supervisor.

According to the medical note what type of condition does Pat have? Diagnosis pending, physical condition, psychiatric condition.

As Pat's supervisor, you have authority to accept or reject Pat's request to return to work. Based on the information in the story you read, would you accept Pat back to work? Yes__ No__

Would you trust Pat to complete the required job tasks? Yes__ No__

Keep the separate window containing the hypothetical situation open until you have completed the survey.

You have only one more section of the survey left.

**Dear Participants, this is the final page of the survey.
Respond to the following questions from the perspective of you being Pat's supervisor.**

For the following items, please indicate your level of agreement or disagreement with the statements.

Use a ranking system as follows:

1. Strongly disagree
 2. Disagree
 3. Somewhat disagree
 4. Neutral
 5. Somewhat agree
 6. Agree
 7. Strongly Agree
- I believe that Pat would be very happy to spend the rest of a career with Conexpro.
 - I believe that Pat enjoys discussing Conexpro with people outside of the company.
 - I believe that Pat feels that a problem for Conexpro is a problem for Pat.
 - Conexpro has a great deal of personal meaning for Pat.

For the following items, please indicate your level of agreement or disagreement with the statements by checking off the appropriate number.

Use a ranking system as follows:

1. Strongly disagree
 2. Disagree
 3. Somewhat disagree
 4. Neutral
 5. Somewhat agree
 6. Agree
 7. Strongly Agree
- I am afraid that Pat will shout or swear while at work.
 - I am afraid that Pat will be violent in the workplace.
 - In general, I am afraid that Pat will display some form of aggression, violence, or threat of aggression or violence at work.
 - I am afraid that employees will shout or swear at Pat while at work.

- I am afraid that Pat will be a victim of workplace violence.
- In general, I am afraid that employees will display some form of aggression, violence, or threat of aggression or violence towards Pat at work.

For the following items, please indicate your level of agreement or disagreement with the statements by checking off the appropriate number.

Use a ranking system as follows:

1. Strongly disagree
 2. Disagree
 3. Somewhat disagree
 4. Neutral
 5. Somewhat agree
 6. Agree
 7. Strongly Agree
- I feel that Pat will approach the job with professionalism and dedication.
 - Given Pat's track record, I see no reason to doubt Pat's competence and preparation for the job.
 - I will be able to rely on Pat not to make my job more difficult by careless work.
 - I feel that most people, even those who aren't close friends of Pat, trust and respect Pat as a coworker.
 - Work associates who interact with Pat consider Pat to be trustworthy.
 - If people knew more about Pat and Pat's background, they would be more concerned and monitor Pat's performance more closely.

Thank you for your participation in this survey.

Your responses have been successfully collected.

Please pick one of the links below to navigate away from this site.

Queen's University
Queen's School of Business

Appendix: The structure of the vignette's experimental manipulations

Pat is an employee of Conexpro, a medium-sized non-unionized organization. During the course of employment, Pat has enjoyed an acceptable level of performance and has no history of extended medical leave. Pat holds an office job with light physical demands and works in an environment with moderate noise levels. The job requires some solitary work and some interaction with others, and discrete tasks that can be performed by any member of the department. If there is a sudden increase in workload, it is divided among the employees and overtime is often necessary in these situations.

Pat has had noticeable weight loss, has appeared generally fatigued, and has often seemed out of breath and distracted.

Shortly after Pat's colleagues noticed these symptoms, a medical certificate signed by a specialist physician arrived at the Human Resources department, stating that Pat was unable to work for an indefinite period of time due to a *physical condition*. According to the medical certificate, no psychiatric condition was present.

The Human Resources department then received a medical certificate stating that Pat can gradually return to work over a period of 6 weeks. Please see attached copies of the medical certificates.

Where * is the passages below were inserted for the various conditions:

Version 1 – Diagnosis Pending

... an undiagnosed condition. It is unclear from the note whether the specialist physician is leaning toward a physical or psychiatric diagnosis.

Version 2 – Physical Condition

... a physical condition. According to the medical certificate, no psychiatric condition was present.

Version 3 – Psychiatric Condition

... a psychiatric condition. According to the medical certificate, no physical condition was present.