

Workplace prejudice and discrimination toward individuals with mental illnesses

Zlatka Russinova^{a,*}, Shanta Griffin^b, Philippe Bloch^a, Nancy J. Wewiorski^c and Iina Rosoklija^d

^a*Center for Psychiatric Rehabilitation, Boston University, MA, USA*

^b*Formerly of Center for Psychiatric Rehabilitation, Boston University, MA, USA*

^c*MIRECC, Bedford VA Medical Center, Bedford, MA, USA*

^d*Children's Hospital Boston, MA, USA*

Abstract. Prejudice and discrimination represent a major barrier to the recovery and community integration of individuals with serious mental illnesses. Yet, little is known about the diverse ways prejudicial practices are enacted at the workplace beyond blatant discrimination. This paper presents findings about the manifestations of prejudice and discrimination at the workplace. Data were gathered from a national sample of individuals with serious mental illnesses who reported perceiving negative attitudes at work as part of their participation in a larger study on sustained employment ($n = 234$) and from a subsequent study on workplace psychiatric prejudice and discrimination ($n = 202$). Qualitative analyses of data collected through two different surveys informed the development of a comprehensive taxonomy that identified a range of prejudicial and discriminatory practices that fell within two contextual domains: work performance and collegial interactions. The specific categories within each of these domains represented a continuum of more subtle to more blatant expressions of psychiatric prejudice and discrimination that influenced workers with mental illnesses through different impact pathways. Study findings informed the development of a broader conceptual framework for understanding and combating psychiatric prejudice and discrimination in employment settings and improving the workplace inclusion and employment outcomes of individuals with serious mental illnesses.

Keywords: Serious mental illnesses, prejudice, discrimination, bullying, employment, employer attitudes, work environment

1. Introduction

People with psychiatric disabilities encounter multiple layers of prejudice and discrimination stemming from centuries' old stereotypes associated with mental illness. Such negative attitudes and behaviors have a negative impact on people living with a mental illness as they delegitimize and marginalize the individual across the familial, community and societal levels [27].

Prejudice and discrimination have been identified as major barriers to the recovery of persons with serious mental illnesses because they impede the restoration of the person's self-esteem, sense of purpose and quality of life [36]. Stronger concerns about prejudicial treatment by others tend to be associated with poorer functioning after an acute mental illness episode and with a higher avoidance of social interactions outside the person's family [37]. Traditionally, such negative attitudes and behaviors have been conceptualized and researched in the social sciences as psychiatric stigma or self-stigma when such stereotypes have been internalized [13, 39]. However, a recent trend of thought suggests that the term "stigma" is stigmatizing by itself and needs to be

*Address for correspondence: Zlatka Russinova, Ph.D., Center for Psychiatric Rehabilitation, 940 Commonwealth Avenue West, Boston, MA 02215, USA. Tel.: 617 353 3549; Fax: 617 353 7700; E-mail: zlatka@bu.edu.

suspended from use [21, 43]. In this paper we adhere to this approach.

Work is a very important dimension of people's lives and is a socially integrating force that conveys a strong sense of self-worth and social identity [49]. Employment success has the potential to reduce negative prejudicial stereotypes surrounding individuals with mental illnesses [35]. At the same time, psychiatric prejudice and discrimination have been identified as a major factor impeding the gainful employment of this population [49]. Evidence exists that prejudice and discrimination limit employment by contributing to longer periods of unemployment, by restricting access to higher paying jobs with benefits, and by resulting in lower wages for people with psychiatric disabilities [7, 44, 49]. There is also emerging evidence that prejudice and discrimination represent an important environmental barrier to the job acquisition and work integration of this population [12]. People with mental illnesses are denied employment, fired when their psychiatric disability is revealed, and encounter negative attitudes, behaviors and comments by co-workers and employers [46]. Thus, the need to address workplace prejudice and discrimination in a systematic and aggressive way has been identified as one of the key principles in promoting the workplace integration of individuals with psychiatric disabilities [28].

Surveys of employers' attitudes have provided consistent evidence that employers hold a range of negative attitudes toward persons with mental illnesses [11, 25, 44, 48, 49]. Employers tend to perceive individuals with mental illnesses as aggressive, dangerous, unpredictable, unintelligent, unreasonable, unreliable, lacking self-control, and frightening, and as a result question their work performance, quality of work, work attendance and tenure, and need for excessive and expensive accommodations [4, 14, 17, 18, 25, 32, 44]. Employers are also less confident about their work skills, their ability to socialize with others, and their capacity to handle stress at work [44]. Given such concerns, employers tend to be less willing to hire individuals with mental illnesses compared to individuals with physical disabilities [23, 48, 49].

Findings from survey research with employers have been corroborated by studies that examined psychiatric prejudice and discrimination from the perspective of individuals with mental illnesses themselves [3, 45, 51]. Wahl [51] reported that one third of the participants in a U.S. national survey of 1,301 individuals with serious mental illnesses indicated that they have been turned down for a job once their psychiatric background became known. A quarter of the

participants in this study described encountering an unfriendly work environment when they had a job and later revealed their mental health issues. Individuals with schizophrenia who participated in focus groups conducted by Schulze and Angermeyer [45] described facing challenges with both access to employment and return to work after a period of psychiatric treatment. These challenges included critical remarks, mistrust and denial of skills previously proven. Another study [3] found that individuals with schizophrenia who were entering or returning to the workplace anticipated prejudicial and discriminatory treatment by employers more frequently than they actually experienced it, thus providing empirical evidence that perceptions of negative attitudes and behaviors may have even greater repercussions for the recovery of persons with serious mental illnesses than actual experiences of discrimination [36].

The anticipation of psychiatric prejudice and discrimination impacts decisions to disclose one's psychiatric disability at the workplace [31]. Among those who disclose after gaining employment, many report being demoted, having hours or responsibilities reduced, being harassed, being isolated from coworkers, being asked to quit, or being terminated [7, 11, 16]. Those who remain employed often report being denied transfers, promotions, or training opportunities due to having a mental illness [7, 11, 16]. They also report that taking time off from work for psychiatric treatment has led to concerns about their trustworthiness and to doubts about their skills and abilities [45].

In summary, there is substantial evidence about the existence of workplace prejudice and discrimination toward persons with serious mental illnesses. Negative attitudes and discriminatory behaviors enacted by employers and anticipated by individuals with mental illnesses limit their chance of getting a job, keeping the job, or advancing in the job. At the same time, little is known about the specific ways in which psychiatric prejudice and discrimination are enacted at the workplace since no study has yet examined in depth this issue from the perspective of workers with mental illnesses.

The purpose of this study was to identify and classify discrete manifestations of prejudice and discrimination in the work environment as experienced by individuals with serious mental illnesses. The development of a taxonomy of psychiatric prejudice and discrimination at the contemporary workplace offers a blueprint for guidelines to direct future efforts aimed at increasing the social inclusion of workers with mental health conditions.

2. Methods

2.1. Study overview

This paper presents the results of a qualitative study based on data collected as part of two larger studies. One study longitudinally examined sustained employment among a national sample of 529 individuals with serious mental illnesses who, at the time of study enrollment, were employed and had been gainfully employed for at least 12 of the past 24 months [41]. Longitudinal data were collected through a mail survey administered at baseline and subsequent 12-month intervals over the five years of the study. The first follow-up survey, which was completed by 482 participants between May 2000 and April 2002, included questions about their experience of psychiatric prejudice and discrimination in the job they had at the time.

A subset of the participants in the longitudinal study ($n = 232$) contributed to a spin-off study that focused on the relationship between vocational recovery and workplace psychiatric prejudice and discrimination [40]. As part of a survey designed specifically for the purposes of this study and completed between July 2006 and March 2007, participants were asked to describe the worst instance of prejudice and discrimination they had ever experienced within the context of employment. Thus, findings presented in this paper capture varying degrees of intensity in participants' experience of psychiatric prejudice and discrimination at work.

2.2. Sample

The current qualitative study was based on data collected from two partially overlapping sets of participants in the two previous studies. The first set (designated as Study 1) consists of 234 individuals who reported negative attitudes toward mental illness at the job they had at the time they completed the first annual follow-up survey.¹ The second set of 202 individuals (designated as Study 2) includes participants who reported on their worst experience of workplace psychiatric prejudice and discrimination as part of their involvement in the spin-off study described above.²

¹ A total of 482 individuals completed the first follow-up sustained employment survey. Of them 73 (15%) reported not observing negative attitudes at their current job; 2 (0.4%) reported observing only positive attitudes; 33 (7%) stated that the question was not applicable to their work situation, and 140 (29%) did not provide any response.

² Thirty (13%) of the 232 individuals who contributed to the spin-off study did not provide a response about their worst experience of psychiatric prejudice and discrimination at work.

By virtue of their involvement in the original longitudinal study all participants in the current study met established eligibility criteria for both lifetime presence of serious mental illness and sustained competitive employment [41]. Determination of lifetime serious mental illness was based on meeting at least one of the following criteria: a) receipt of disability benefits for psychiatric disability at any time, and/or b) at least one psychiatric hospitalization. Presence of sustained employment was determined by meeting all of the following criteria: a) current competitive employment of at least 10 hours per week; b) at least 12 months of employment in the two years prior to study enrollment, including at least 6 months of employment during each of these two years; and c) at least 6 months of continuous employment during the last year. Participants were recruited from various regions of the United States through consumer advocacy organizations, mental health and rehabilitation providers, Internet and newsletter announcements. The demographic, clinical and occupational characteristics of the two sets of participants contributing to the current qualitative study are presented in Table 1. In summary, participants who contributed to this study were predominantly white females in their 40s. Two-thirds of the sample was either currently or previously married. Respondents were well educated: half of the sample had a master's or doctoral degree and another third had a bachelors degree. The majority of the study participants had mood disorders with bipolar disorder being reported by half of the sample.

2.3. Measures

Data pertinent to the current study were collected based on two open-ended questions. The first question, "If you have noticed negative attitudes about mental illness in your current work environment, please describe them below," was part of the first follow-up survey in the longitudinal study (Study 1). The second question, "Please describe in your own words the worst stigmatizing experience you ever had at work due to your psychiatric condition," was part of the survey developed for the spin-off study on workplace psychiatric prejudice and discrimination (Study 2).

2.4. Data analysis

We implemented a complex multi-layer iterative process of analyzing collected data. First, we used an open coding process to develop categories representing discrete manifestations of psychiatric prejudice and

Table 1
Demographic characteristics of study participants

Variables	Study 1 (N=234)	Study 2 (N=202)
Age	43.30 ± 8.27	42.59 ± 7.85
Gender (female)	180 (77%)	154 (79%)
Ethnicity (Caucasian)	223 (95%)	189 (98%)
Marital status		
Single, never married	58 (25%)	71 (35%)
Married or in serious relationship	97 (42%)	69 (34%)
Divorced, separated, or widowed	78 (33%)	61 (30%)
Education		
Graduate degree	118 (50%)	111 (55%)
B.A. degree	76 (33%)	64 (32%)
Some college	31 (13%)	20 (10%)
High school diploma	6 (3%)	5 (3%)
Less than 12th grade	2 (1%)	1 (1%)
Income		
Less than \$10,000	17 (7%)	10 (5%)
\$10,000–\$19,999	49 (21%)	31 (15%)
\$20,000–\$29,999	52 (22%)	25 (12%)
\$30,000–\$39,999	41 (18%)	28 (14%)
\$40,000–\$49,999	28 (12%)	37 (18%)
\$50,000 or more	45 (19%)	70 (35%)
Psychiatric diagnosis		
Schizophrenia spectrum	37 (16%)	25 (13%)
Bipolar	120 (51%)	106 (55%)
Major depression	67 (29%)	50 (26%)
Other	10 (4%)	12 (6%)
Age of first diagnosis	25.24 ± 8.50	25.15 ± 8.31
Lifetime receipt of disability benefits	105 (45%)	111 (56%)
Hollingshead occupational status	6.65 ± 1.51	6.59 ± 1.67
Occupational setting		
Self-help/advocacy	15 (6%)	12 (6%)
Mental health	72 (31%)	43 (21%)
Health/human services	43 (18%)	37 (18%)
Non-helping settings	104 (44%)	110 (55%)

discrimination at the workplace based on data collected as part of Study 1. The initial set of categories was established based on consensus among the first, third, fourth and fifth authors who worked together at the earlier stages of the data analysis process. These authors independently coded the entire text in consecutive segments. Group meetings were held after each segment of text had been coded to formulate and review categories. During this process, these authors also noticed that study participants described different pathways through which prejudicial practices were manifest: those they experienced themselves, those they observed with regard to co-workers, and those they anticipated or perceived to be happening. We then also coded participants' responses for these three pathways. After the initial list of codes was established, the third and the fifth author independently coded the rest of the data and resolved discrepancies based on consensus.

The next stage of the data analysis was carried out by the first and third author who independently reviewed all codes applied to the data collected as part of Study 1. Discrepancies in decisions were resolved based on consensus until 100% agreement was reached. As part of this iterative review process, these authors noticed that identified categories of prejudicial and discriminatory practices varied depending on the context of individuals' functioning at the workplace, namely, if these practices were related strictly to work tasks and duties or more broadly to social interactions with co-workers. As a result, using a consensus process, we sorted our identified categories into two broad domains – work performance and collegial interactions. In addition, these authors also ranked the categories pertinent to each of these two domains based on the saliency of identified prejudicial and discriminatory practices.

The third stage of the data analysis involved the coding of data collected as part of Study 2 and was conducted by the first three authors. The second and third authors independently coded all data using the already established list of categories, domain of workplace context and pathways of manifestation. Discrepancies were resolved based on consensus until 100% agreement was reached among the first three authors. These authors also reached consensus about a few new categories that emerged from this second set of data in regards to some of the more blatant expressions of workplace discrimination.

3. Results

3.1. Manifestations of psychiatric prejudice and discrimination at the workplace

The iterative analysis of collected data revealed discrete categories of prejudicial and discriminatory practices encountered by workers with serious mental health illnesses. These categories were conceptually organized into the two broad domains of work performance and broader collegial interactions at the workplace. This taxonomy of workplace prejudicial and discriminatory practices is presented in Table 2. Practices within each of the work performance and collegial interactions domains are listed in a progressive order from the most subtle to the most salient manifestations of psychiatric prejudice and discrimination at the workplace.

Table 2
Taxonomy of workplace prejudice and discrimination toward people with psychiatric conditions

Work performance domain	Definition	Examples
<i>Unreasonable expectations about work capacity</i>	Supervisors or co-workers question a worker's competence, capacity to sustain work, ability to achieve high standards of work, reliability, and ability to handle responsibility. Co-workers or supervisors make high demands on a worker with a mental illness, ignoring her limitations or disregarding her need for accommodation. Co-workers make a worker with a mental illness feel that she has to work harder to prove that she is capable of doing the same job as everyone else.	<p>"A female top manager noticed my file because I had turned in my Ticket To Work. She questioned my ability to do my work, even though there are very high satisfaction surveys of my work available to her at her agency. I fell apart, stared crying and became suicidal."</p> <p>"I felt alone and punished for my mental health problems. Management seemed to take the attitude that I was flawed and couldn't do work I had previously done."</p> <p>"My boss felt if I tried harder I could attend work, even when I obviously could not because of severe symptoms."</p> <p>"With mental illness one has to work extra (like when one is any minority in this society) sometimes to prove one is capable of doing the same job as someone who isn't a minority and mental illness is no exception."</p>
<i>Negative response to reasonable accommodations</i>	Management responds negatively to a worker's request for an accommodation, either by denying the request or by making it more difficult for it to be fulfilled. Co-workers feel an accommodation is something the worker has leveraged and which she does not deserve nor to which she should be entitled. Co-workers' emotional response to an accommodation could include envy, resentment, or a feeling that the person is somehow being privileged because of her disability.	<p>"When I brought the director a doctor's letter requesting I be given a leave of absence, she actually refused it and called police to have me escorted out of the building."</p> <p>"I was having a lot of emotional difficulties and requested time off or a modified work schedule for medical reasons. My employer demanded a diagnosis so my therapist/psychiatrist provided the diagnosis. My employer denied the request and noted that if I had serious psychiatric issues then I needed to quit."</p> <p>"It has been difficult to get special accommodations so that I can go to therapy."</p> <p>"Boss and peers frequently perceived my openness and disclosure as trying to get special privileges."</p> <p>"Some co-workers felt I was treated better than they were because of my disability."</p>
<i>Discrediting the person's professional competence</i>	Co-workers or supervisors demonstrate a lack of confidence in a worker's skills, efficiency, or ability to handle stress, and question her ability to do her job effectively due to her psychiatric background. There is a presumption of emotional vulnerability on the part of the worker that is expected to interfere with her job performance.	<p>"My boss questioned my competency to such an extent that she supervised every minute detail of my work."</p> <p>"Teaching personnel monitored my work assignment thinking I was unable to handle certain tasks."</p> <p>"Recently, some of my work has been very critical of a division of state government. In a meeting, several managers implied to a Commissioner that the real problem was my inability to control my negativity. There was a clear implication that it was psychiatric issues involved."</p>
<i>Prejudicial treatment</i>	A worker with a mental health background is treated differently by co-workers or supervisors. Such behaviors might include excluding or ostracizing this person within the context of work roles and responsibilities. Co-workers might not collaborate with that person or might delay doing work for her. Co-workers might manifest a reluctance to work with people who have disclosed a psychiatric condition, especially after they have been "outed" through hospitalization. A worker might be held to a different degree of work accountability as a result of her psychiatric condition. A worker might be discriminated against on an administrative level by receiving an unfair work evaluation.	<p>"I am only consulted when they need consumer sign-offs or apparent participation."</p> <p>"One girl made the comment she would not work for a crazy person."</p> <p>"The secretary . . . She does treat me differently than some of the other managers in the office. She is slow to do anything for me and often does sloppy work if she does it at all."</p> <p>"Supervisors refused to work [with] me or make me feel part of the organization."</p> <p>"Currently, I am being held to a higher standard than my colleagues. I'm being told that I must only follow the written curriculum. I can't use creative methods to supplement the curriculum because they think I'm using examples that are not appropriate . . ."</p> <p>"I received really vicious, negative, personally-attacking evaluations of my teaching performance and one student stated in her evaluation that someone receiving psychiatric treatment shouldn't be allowed to teach MSW students."</p>

Table 2
Continued

Work performance domain	Definition	Examples
<i>Hiring</i>	A potential employer discriminates during the hiring process when a person discloses a history of mental illness, either during the interview or on her résumé. This may manifest in any stage of the application process, from being denied an initial interview, to the person not being seriously considered for the job, to being flatly denied employment based on disability status.	<p>“When I came back from being hospitalized, I was subtly discouraged from applying for a job that had been virtually promised to me prior to the hospitalization.”</p> <p>“He then found out where I was applying for jobs and called the businesses. He told each one that I was crazy and probably dangerous, and told them I should not be hired.”</p> <p>“... [I] discovered that a colleague voted against my being hired because of my diagnosis.”</p> <p>“A person (not me) was not hired as a supervisor because she was labeled as a ‘psycho’.”</p>
<i>Advancement</i>	A worker with a mental health background is denied raises, promotions, and training opportunities within her field, to which she would otherwise be entitled. This denial of advancement or promotion may be within her organization or she may be denied a reference for another job. A worker experiences a consistent lack of recognition at work, and is forced to accept a salary that may reflect neither the quality of her job performance nor the length of her employment history.	<p>“Not giving me raises.”</p> <p>“When I was first diagnosed . . . , they withheld a promotion.”</p> <p>“I was denied a promotion [in the U.S. Army] that I had already earned and also denied schooling (Flight Training) that I had been guaranteed.”</p> <p>“Everyone knows of the few employees that have a psychiatric condition. Those individuals are ‘tolerated’ but promotions skip over those employees.”</p> <p>“I was told my salary would never go up no matter how well I did my job, or how long I worked there. If I thought I could compete on the open market, I would leave. I’m liked and accepted in most cases, but no step or merit increases.”</p>
<i>Forced out/harassment</i>	A worker who has disclosed a mental illness feels so singled out and pressured at work, that her work environment becomes intolerable, to the point where she feels she has no choice but to resign her position. A worker is threatened with being fired and chooses, voluntarily or under duress, to quit instead.	<p>“When I had a nervous breakdown in 2003, I almost lost my job. My boss wasn’t sympathetic at all and tried to force me out from my current job.”</p> <p>“The director of the hospital spoke to me privately in her office . . . She was not able to fire me on the spot, but she eventually made it so uncomfortable that I decided to quit.”</p> <p>“I attempted to continue working for a couple of weeks, but quit because they constantly questioned my judgment and made me feel incompetent.”</p>
<i>Firing</i>	A worker with a mental illness is terminated from her employment as a result of disclosure, or as a result of having had psychiatric difficulties on the job. Disclosure can be either voluntary or involuntary, such as in cases of being hospitalized for psychiatric reasons, prior to which she had not disclosed her condition.	<p>“I disclosed to my boss and was told maybe I should find a new job as I wasn’t able to catch on quickly enough to the work standards.”</p> <p>“I was going to be ‘laid off’ based solely on my mental illness, even though my annual evaluations had always been excellent.”</p> <p>“When I was discharged [from my hospitalization], I was not permitted to return to work and was told ‘the census dropped’ and [was] let go.”</p> <p>“I was fired shortly after returning from in-patient treatment for substance abuse disorder. I was told that I was ‘not the same’ after treatment and was fired.”</p>
Collegial interactions domain <i>Using mental illness as an overriding explanation of a person’s behavior</i>	Definition co-workers use a worker’s mental health background to explain any deviation from that person’s “normal” behavior and any atypical emotional state is attributed to that worker’s mental illness. Other mitigating factors are typically ignored. A worker’s justifiable response to a stressful situation may be typecast as a manifestation of that worker’s mental illness.	Examples <p>“Mistakes or errors in decision making would be attributed to the psychiatric illness, not to process or using poor judgment.”</p> <p>“I was experiencing some grief over [the] loss of a family member, and it was suggested to me [that] I be hospitalized.”</p> <p>“Many psychiatrists, nurses feel that once a psych patient, always a psych patient. These negative attitudes come from pathologizing the individual.”</p> <p>“An angry co-worker saw me standing alone in the parking lot and asked me if I ‘were having an episode.’ She continued to make negative comments towards me until I told her supervisor to meet with us.”</p>

Table 2
Continued

Work performance domain	Definition	Examples
<i>Patronizing</i>	Inquiries and insinuations are made regarding a worker's mental health background, so that an aura of over-protectiveness ensues, with the subtle inference or implication that the worker in question is not capable of being fully autonomous in managing their mental health.	<p>"Being tired or using an increased volume of voice would generally precipitate several minutes of questions about med compliance or change in baseline symptoms."</p> <p>"An assistant supervisor greeted me one morning with, 'How are you?' I said I felt fantastic. She replied loudly to the other workers, 'She's okay now and it's MY turn to be disabled so ya'll will treat me nice.' That crushed me."</p>
<i>Insensitive language</i>	The use of insensitive language directed towards mental illness or people with mental illnesses in general, which could take the form of jokes, ridicule, inappropriate attempts at humor, derogatory or demeaning remarks, or labelling. This might involve the use of diagnostic language in relation to non-clinical events or situations, or the use of onomatopoeia (i.e. cuckoo, ga-ga).	<p>"Sometimes people make jokes about people with mental illness (and that can hurt)."</p> <p>". . . Definitely no compassion with mental health issues, only discussion in the context of cruel jokes or negative stereotypes."</p> <p>"Well, I certainly hear troubled people referred to as 'nuts', 'crazy' . . ."</p> <p>"I was at a workshop with other teachers, we were learning about the brain. Since then, some teachers keep joking about the amygdala and emotional problems people have."</p>
<i>Condescending remarks concerning co-workers</i>	The use of derogatory or disrespectful language directed against specific workers with a psychiatric condition. Such types of speech could include condescending and judgmental remarks, references about a person's mental health status and/or background, general badmouthing, and office gossip. Condescending language could be directed toward clients or co-workers who are being talked about or being made fun of behind their backs.	<p>"They all expected me to be violent and my boss said, 'let me know if you're going to blow us all away.'"</p> <p>"Another orthopedic surgeon told a doctor I was sharing the clinic with that I was 'crazy' and the doctor should not share the office with me. Fortunately, the second doctor did not listen to the stigma."</p> <p>"The worst I saw was the disrespect mental health 'professionals' displayed regarding their patients-poking fun of them behind their backs, referring to their patients using derogatory terms."</p>
<i>Use of a person's mental health background as a power strategy</i>	A person's mental health background is used as leverage against her, as a form of intimidation, threat, or coercion, causing her to modify her behavior or speech. Comments made by a co-worker are designed to manipulate her emotions or behavior by exploiting her vulnerability as a psychiatric consumer, often with the veiled threat of consequence if she does not comply.	<p>"Faculty members, even in nursing, will make flippant remarks concerning this illness. They are not unlikely to use terms like 'crazy' or 'nut' and can dismiss a person with whom they disagree just by implying 'they or he or she has problems or issues.'"</p> <p>"If one argues with a 'normal' and that person starts losing the argument, they might say, 'I can't deal with you when you are this way, or are angry, etc.'"</p> <p>". . . My boss will say 'don't you need more medication?' when he disagrees with me."</p>
<i>Social exclusion at the workplace</i>	A worker is marginalized by her colleagues to the point where she is no longer welcome to participate in the daily discourse, give and take, and social flow of the work environment. She is excluded and ostracized from participating in social activities, gatherings, meals, parties, celebrations, or any other type of social events in which her colleagues customarily participate. This type of exclusionary behavior could take place at the workplace or off-site, both during and outside of typical work hours.	<p>"I have been socially and professionally marginalized, and expected to work without collegial support or interaction."</p> <p>"One day she mentioned that another person assigned to the library had tried to kill himself, and she couldn't understand that, how it was against God, etc. etc. I told her that sometimes people don't feel like they have a choice, that I had been in that position, too. After I told her my story, she kept her distance."</p> <p>"My boss at the job . . . asked all the other employees to write a statement about my abilities. All but one were negative, describing mistakes I had made just previous to my hospitalization. I had worked there as a productive employee (nurse practitioner) for 3 years prior to this experience. No one spoke to me when I came to pack up my office. I felt like they were afraid of me."</p>

3.2. *Pathways of prejudicial and discriminatory practices enactment at the workplace*

Data analysis revealed three main pathways through which psychiatric prejudice and discrimination are enacted at the workplace: direct, indirect and perceived. The first pathway involves direct expression of any subtle or blatant prejudicial and discriminatory treatment of workers with psychiatric backgrounds as illustrated by the examples below:

“When I came back from being hospitalized, I was subtly discouraged from applying for a job that had been virtually promised to me prior to hospitalization.”

“I had been hired as a staff psychiatrist at a State Hospital, in 1978. I had objected to some policies of the hospital. In discussions, I had said to others on the staff that I had been treated for mental illness, and I felt that my point of view was valid, and based on experience. The director of the hospital spoke to me privately in her office. She said that she was going to fire me for lying on my application. She said that I had not disclosed my mental illness. I said that I had. She looked up the original application, and found that I had answered ‘Yes’ to the question of being treated for mental illness. She was not able to fire me on the spot, but she eventually made it so uncomfortable, that I decided to quit.”

“I was doing in-service training for our county sheriff deputies. For most of the presentations, I recognized some, but minimal stigma. However, in one group, 8 of the 13 officers ‘fed’ on me like sharks. They told me that because I have bipolar disorder, I was a menace to society and should be locked up for the rest of my life. They also told me that the next time they get a suicide call, they will go 25 MPH so they get there too late and save everybody a lot of trouble. ‘Why should we risk our lives and those of others to save your sorry life?’ Those 8 officers, I later found out, transport persons with mental illness to the State hospitals.”

The second pathway involves the manifestation of prejudicial and discriminatory practices that are directed toward a co-worker, client, or customer who has a psychiatric disability. The worker who witnesses such expressions of psychiatric prejudice or discrimination may or may have not disclosed his or her own psychiatric condition. Although such practices are not directed toward the observer, they can have a strong negative impact on this person.

“I often hear incredibly stigmatizing remarks from people around me. Recent example: ‘All borderlines are anti-social drug addicts who you can see coming ½ a mile away.’ This type of thing is very painful to me and I am sometimes afraid to speak out even though

I know I should. Several of my close work neighbors have never realized I am a consumer even though it is no secret and I discuss it on the phone and with visitors. Why? I think I don’t fit the stereotype so it never enters their heads.”

“I am a librarian in a public library. Even co-workers who know of my psychiatric history make horrible degrading remarks about library patrons who are ‘perceived’ to be mentally ill. I have experienced everything from finding Christmas jokes made at the expense of “mental patients” in my printer (shared with another librarian who got them as E-mail) to terms like ‘nut-case,’ ‘wacko,’ ‘psycho,’ etc.”

The third pathway involves perceived or anticipated prejudicial and discriminatory treatment at the workplace. We coded this mechanism when a study participant anticipated such treatment without reporting observable evidence.

“I am working for a really good company and fear that my ability to qualify for promotion could be jeopardized if I disclose my condition. The airline that I work for is like a close-knit family and I am sure people would still accept me and not stigmatize me. However, I believe the leadership would characterize me as inferior and my career aspirations would be severely limited.”

“I am concerned that my co-workers would lose respect for my clinical judgment if they knew my true diagnosis- they are aware that I have had a “rough childhood” but do not know the half of it. My greatest fear is that my colleagues would think less of me and of my work; that my Clinical Director would think twice before referring challenging patients (or any patients) to me.”

The review of collected data revealed that all categories in our taxonomy of workplace prejudice and discrimination can be enacted through any of the three pathways separately or simultaneously. To capture the complexity of exposure to prejudicial and discriminatory practices by workers with mental health conditions, we developed a conceptual model that integrates the domains and pathways through which such practices can be manifest. This model (Fig. 1) depicts the overall framework of prejudicial and discriminatory challenges that individuals with mental illnesses may encounter at work.

4. Discussion

This study expands current knowledge about the complex multi-layered manifestations of mental illness-related prejudice and discrimination at the

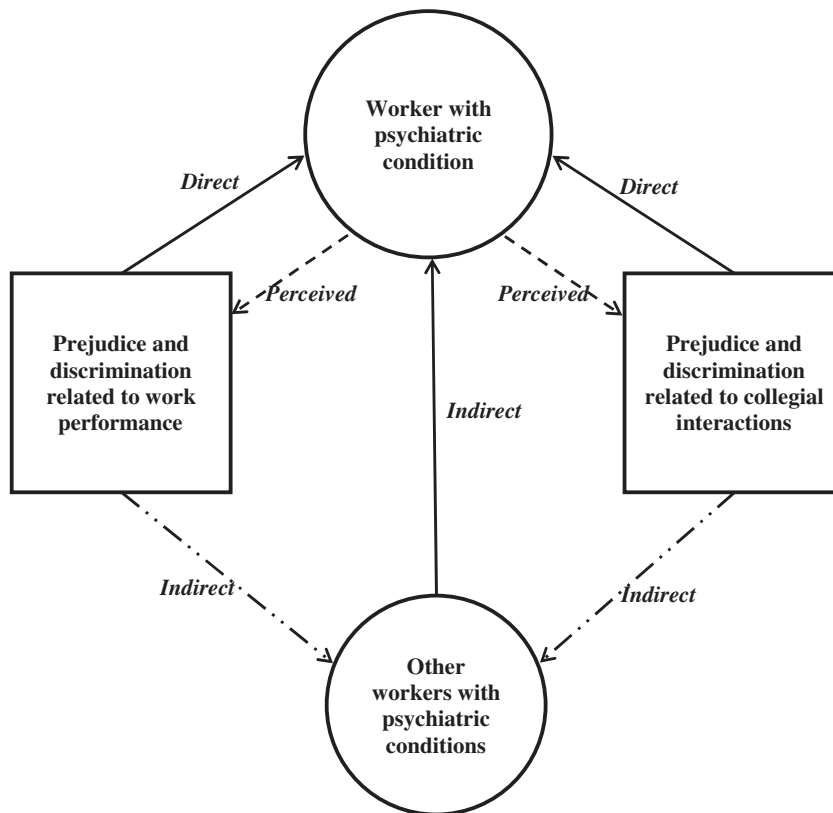


Fig. 1. Conceptual model presenting manifestations of prejudice and discrimination at the workplace.

contemporary workplace. First, it informed the development of a taxonomy that encompasses a wide range of prejudicial and discriminatory practices directed toward individuals with mental illnesses who aspire to work. Second, it contributed to the development of a conceptual framework that outlines different pathways through which specific prejudicial and discriminatory practices can impact workers with mental health conditions. Third, identified prejudicial and discriminatory practices offer a blueprint for guidelines on how to increase the social inclusion of individuals with mental illnesses in employment settings.

The presented taxonomy shows that there are two main domains of workers' involvement at the workplace that can be subjected to psychiatric prejudice and discrimination. The first domain is pertinent to workers' specific job duties, work performance and outcomes. The second domain encompasses a wide range of interactions with co-workers that are not directly related to the person's job description but constitute the fabric that integrates an individual into the specific workplace culture. These findings suggest that workers with psychiatric conditions can be subjected to prejudicial and

discriminatory practices that can affect not only their professional confidence but their sense of worthwhileness as a person as well.

Our findings within each of these two domains characterizing a person's functioning at work revealed that prejudicial and discriminatory practices occur along a continuum from very subtle to markedly blatant expressions of negative attitudes and behaviors toward mental illness in general and toward persons who have experienced psychiatric challenges. Our findings are consistent with well-established blatant patterns of work-related prejudice and discrimination directed toward individuals with psychiatric disabilities [7, 44, 49] as well as persons with other disabilities (i.e., [33]) such as reluctance to hire or promote, higher likelihood to fire/lay off, and social marginalization. However, this study's unique contribution is the operationalization of the more subtle prejudicial practices toward workers with mental health conditions. Awareness of such practices is particularly important because they constitute important, yet frequently unrecognized, expressions of negative attitudes that can become a source of discrimination against workers with

disabilities [6]. Although these subtle prejudicial practices may not represent employment discrimination from a legal standpoint, they clearly fit into the category of interpersonal mistreatment from an organizational psychology perspective [29]. The subtle prejudicial practices experienced by workers with mental health conditions can disrupt their sense of connectedness with the work environment [50], can cause significant distress, can compromise their work performance and can lead to eventual job loss [42].

Some of the most prominent and frequently reported subtle manifestations of psychiatric prejudice at the workplace involve verbal expressions of negative attitudes toward mental illness and toward individuals whose lives have been affected by mental illness. Allport [2] identified derogatory and defamatory speech (termed “antilocution”) as the first of five steps of prejudicial and discriminatory practices directed toward a minority group that, according to his model, culminate with attempts at extermination of its members. Consistent with our current understanding of verbal discrimination [24], mental illness-related insensitive and derogatory speech may refer to mental illness in general or may be directed toward a co-worker with a known psychiatric background. Untargeted verbal expressions can range from colloquial use of words like “crazy” and “loony” to humor, ridicule and derogatory comments about persons with mental illnesses. Although such verbal prejudicial practices appear more benign because they do not target a particular co-worker, they are of particular concern because, on the one hand, they are more frequent and typically are unaddressed by organizational policies, and, on the other hand, they may have a particular impact on workers’ decisions to disclose or not disclose their psychiatric background. Reluctance to disclose one’s disability prevents workers from requesting and obtaining accommodations and may lead to a job loss in cases of compromised work performance due to mental health distress and symptom exacerbation.

Condescending, judgmental comments and ridicule can also be directed toward co-workers with mental illnesses. Our participants’ reports revealed that such comments or attempts at humor may be directly expressed toward a co-worker with a known mental health background or may take the form of gossip or comments made behind the person’s back. While such verbal expressions of interpersonal mistreatment have been documented in previous studies [45], our study identified an additional prejudicial practice at the workplace that we defined as “use of the

person’s mental health background as a power strategy”. This practice involves the use of references to the person’s psychiatric condition as leverage to gain power or to win an argument in an unrelated professional or interpersonal context. This practice can be described metaphorically as “hitting below the belt” and has the purpose of intimidating and disempowering by using the implied suggestion that the co-worker’s competence and judgment capacity is compromised because of their psychiatric background. Our finding is consistent with a recent report that mental health professionals at times engage in biomedically oriented discourse as an invisible use of power and treatment coercion [15].

Our study revealed two other subtle prejudicial practices typically manifest within the context of broader interactions with co-workers and supervisors. The first practice, which we defined as “using mental illness as an overriding explanation of behavior,” describes a tendency to always attribute a co-worker’s behavior and mood at the workplace to their mental illness without accounting for the possibility that this person may appear distracted or upset due to other reasons, such as a particularly stressful event or medical condition. In this way, workers with mental health conditions are held to a different set of behavioral expectations and, unlike everybody else, are not allowed to “just have a bad day”. This approach generates a sense of unfairness which creates additional pressure to “act like everybody else” and often to overperform in order to prove oneself. Study participants described that such pressure made them not take a needed sick day, not take time off to go to a medical appointment, or not request an accommodation, and thus, caused them to endure additional stress and put their psychological wellbeing at risk.

The other subtle prejudicial practice, which we defined as “patronizing,” consists of inappropriate or untimely inquiries by supervisors or co-workers about the person’s mental status or mental health treatment, especially use of medications. While such inquiries at times may be benevolent and sincere, they can be experienced as condescending because they call into question the person’s capacity to manage their psychiatric condition. Our finding that such questioning in a work context can be experienced as negative and condescending suggests that supervisors and co-workers need to be sensitive in how they express sincere interest in a co-worker’s wellbeing, in general, as well as when voicing concerns regarding warning signs observed in that person’s behavior. The reports of study participants suggest that generic inquiries may not be necessary and that

concerns should be formulated in a way that preserves the person's dignity.

Our study also identified a set of more subtle prejudicial practices experienced by workers with mental health conditions specifically in the context of their work performance. One of these practices involves problematic expectations about the person's work capacity. Study participants identified as problematic both low and high expectations about their productivity and expertise. While lower expectations reflect traditional prejudicial stereotypes about the work-related impairments of workers with mental health backgrounds [25], higher expectations suggest a lack of understanding of the worker's psychiatric disability and a reluctance to consider work accommodations. Thus, supervisors' and co-workers' lack of understanding of the nature and course of mental illness and related functional limitations can be a source of reversed prejudice toward workers with mental health conditions that, in turn, can generate significant barriers to their employment success.

Problematic expectations about the work capacity and performance of workers with psychiatric disabilities contribute to the onset of two other prejudicial practices reported by study participants. On the one hand, prejudicial beliefs about compromised work capacity can lead to ongoing micromanagement by supervisors as well as differential assignment of work-related tasks and responsibilities that make the worker feel as though he or she is being treated differently. On the other hand, lack of understanding about the functional limitations associated with mental illness and about provisions for work accommodations addressed in the Americans with Disabilities Act (ADA) can lead to resentment among co-workers which, in turn, may socially marginalize workers with psychiatric conditions. Although such negative attitudes toward co-workers who receive accommodations were clearly identified as stigmatizing by study participants, the issue of an employee's response to accommodations for persons with disabilities is more complex because it also relates to workers' procedural justice inferences [10]. Often, such negative reactions are the result of limited or unavailable information about the person's functional limitations, thus leaving co-workers with a sense of unfairness regarding the implementation of procedures and the allocation of resources. This is true especially when an accommodation affects other workers in a negative way (e.g., having to work undesirable hours or shifts to accommodate someone who cannot be at work early in the morning) [10]. Colella and her

colleagues [10, 47] emphasized that the nature of the disability is an important factor influencing co-workers' response to accommodations; namely, those disabilities that are less visible, more socially undesirable and often believed to be self-caused are more likely to generate stronger negative attitudes among co-workers. Consequently, employees are more likely to react more negatively to the accommodations provided for workers with psychiatric disabilities than to those for persons with physical disabilities [10].

Another contribution of the study involves the mapping of different pathways through which identified prejudicial and discriminatory practices are enacted at the workplace. The most common, well-known and powerful mechanism of prejudice and discrimination involves the use of practices that target explicitly such workers either through open encounters or behind the scenes unfavorable decisions concerning them or through gossip and badmouthing. Another well-known mechanism involves the perception of prejudice and discrimination based on the belief that most supervisors and co-workers will devalue and discriminate against an individual with a psychiatric background [30]. Perceived prejudice is usually expressed as anticipation that supervisors and co-workers will discriminate against them sooner or later even if they have not yet done so. Study participants identified such fears as an ongoing source of concern and stress that could interfere with their work performance and could lead to modifications in their behavior at work, including a decision to work harder in order to prove oneself or not to take sick time or time off for medical appointments. Perceived prejudice can also result from self-stigma, i.e. the internalization of prejudicial stereotypes that lead to diminished self-esteem and self-efficacy [52]. When self-stigma becomes the source of perceived prejudice, the internalized lower expectations and beliefs about oneself tend to be projected onto supervisors and co-workers. However, it is important to emphasize that anticipated prejudice may or may not represent self-stigma. Both forms of perceived prejudice presuppose a higher level of prejudicial consciousness, a characteristic which has been associated with stronger personal impact of experienced prejudicial and discriminatory practices [38].

Our study also revealed a third indirect mechanism of workplace stigmatization that results from observing co-workers, clients, or customers with a known psychiatric background being treated in a prejudicial or discriminatory way. Observing such practices may increase the person's anticipation of being subjected to

similar practices if his/her own psychiatric condition is revealed and, thus, may result in avoidance and secrecy as means of coping with such fears. The perceived and indirect pathways of enactment of prejudice and discrimination toward persons with psychiatric conditions inform considerations in the decision-making about disclosing at the workplace when the person is in a position to make such a choice. Higher levels of indirectly observed and/or anticipated prejudice are more likely to result in a decision to not disclose at work. Such a choice precludes the possibility of receiving accommodations and supports that may be important for work success and, at times, vital for retaining one's job following an unanticipated psychiatric hospitalization and/or a period of compromised work performance when experiencing exacerbation of psychiatric symptoms [31].

Finally, an important contribution of our study is the finding that all categories of the taxonomy of prejudicial and discriminatory practices can be expressed through one or more of the identified pathways of their manifestation. This finding suggests that workers with psychiatric backgrounds can experience a very complex and fluid set of prejudicial practices that can strain their coping capacity. Such a potentially powerful and ongoing source of stress can interfere with both their work performance and their workplace integration.

Our findings have important implications for employers vis-à-vis the integration of workers with disabilities and the creation of an optimal work environment that promotes productivity through mutual respect and support. Our study highlights the tremendous need for agencies and businesses to implement policies that guarantee the civil rights, well-being and employment success of workers with psychiatric conditions. Guided by the taxonomy and conceptual model of prejudicial and discriminatory practices at the workplace, we developed a Technical Assistance Guide to help employers engage in a process to reduce or eliminate prejudice and discrimination in their agency or business [20]. This tool guides employers through the consecutive steps of identifying specific prejudicial and discriminatory practices that are of relevance to their organization, establishing policies to eliminate these practices, setting measurable benchmarks that indicate a successful implementation of these policies, and evaluating the outcomes of educational campaigns and/or policy changes. The Guide highlights employers' unrealistic expectations, problematic use of language and specific sets of problematic behaviors (i.e., micromanagement, patronizing, denial of training opportunities,

etc.) as prejudicial practices that are measurable and amenable to change and provides tips and examples to inform organizational changes. For example, one strategy to promote respectful language at the workplace is to develop and disseminate posters that educate workers about the differences between respectful and disrespectful language and why language matters. The Technical Assistance Guide provides an example for such an educational poster that can be easily reproduced and implemented across diverse organizations and businesses [20].

Our findings also suggest that employers may attempt to address psychiatric prejudice and discrimination under the umbrella of broader efforts that address bullying at the workplace since a wide range of bullying behaviors overlap with the prejudicial practices identified in our taxonomy. Bullying has recently been gaining growing interest from an organizational psychology perspective [1, 8]. Bullying consists of humiliations, insults or discourteous comments, disrepute of the person's work, unjustified sanctions or reproaches, attacks on the person's private life, isolation and overload of work that undermine the person's dignity and rights [8]. Workplace bullying refers to prolonged exposure to such hostile behaviors at work that can lead to severe stress reactions, including post-traumatic stress symptoms as well as symptoms of anxiety and depression [5, 9]. Exposure to workplace bullying has been identified as a severe social stressor with more crippling and devastating impact than the effects of all other work-related stressors put together [26]. Such negative impact on workers with psychiatric conditions may easily negate intended benefits from reasonable accommodations, may exacerbate original psychiatric symptoms and may lead to work interruptions and job loss. The relevance of a workplace bullying perspective in efforts to reduce and eliminate the prejudice and discrimination toward workers with psychiatric conditions is further highlighted by evidence that such workers, especially those with mood disorders, are more likely to be victims of workplace bullying [34].

Our study also has implications for mental health and rehabilitation practitioners because it points to the need to further educate and empower individuals with psychiatric disabilities to cope with and to combat prejudicial and discriminatory practices in general and specifically at the workplace. Guided by this need and more broadly by the taxonomy of workplace manifestations of psychiatric prejudice and discrimination, we developed an innovative peer-run group intervention

designed to help empower individuals with psychiatric disabilities in combating prejudice and discrimination [21, 22]. Although this curriculum does not specifically address prejudice and discrimination at the workplace, it can be used in diverse mental health and rehabilitation programs that support the recovery and employment of individuals with psychiatric disabilities. Currently, efforts are underway to address workplace prejudice and discrimination in the context of supported employment programs through a structured curriculum that intends to enhance the person's capacity to manage his or her mental illness in the context of work [19]. Ultimately, the employment integration and success of persons with psychiatric disabilities will depend on the transformation of the contemporary workplace through the implementation of policies of zero tolerance of prejudice and discrimination toward people with disabilities.

Presented findings need to be examined in light of study limitations. The non-representative nature of the sample is an important limitation because a larger sample might expand the range of prejudicial and discriminatory practices reported by workers with psychiatric disabilities. Since our sample consisted only of individuals who have worked successfully for prolonged periods of time after being diagnosed with a serious mental illness, we were able to identify a range of more subtle manifestations of psychiatric prejudice. However, it is possible that more nuanced categories of discriminatory practices might be identified if the data also included the reports of individuals whose attempts to enter the work force were rebuffed. Another limitation stems from the survey methodology in that we were unable to follow up with study participants to further elaborate on their reports about encountered prejudicial and discriminatory experiences. Finally, the study is based only on participants' self-report; however, existing research suggests that workers' self-report of prejudicial and discriminatory experiences is reliable since it tends to be consistent with economic measures of the effects of such practices on wages [7].

5. Conclusions

Individuals with psychiatric disabilities encounter a wide range of prejudicial and discriminatory practices at work that may interfere with both their work performance and their integration into the social fabric of the work environment. Psychiatric prejudice and discrimination in the contemporary workplace span a

continuum ranging from subtle expressions to blatant acts of social injustice and workplace bullying. While the ADA attempts to target tangible acts of discrimination, more attention is needed to implement changes in the workplace culture that will address specific manifestations of psychiatric prejudice which are less overt but may have an insidious negative impact on individuals with mental health backgrounds who have entered the mainstream workforce. The creation of a work environment free of psychiatric prejudice and discrimination would inevitably enhance the employment outcomes of persons with psychiatric disabilities and facilitate their overall recovery and societal integration.

Acknowledgments

This study was supported by grants (#H133G80124 and #H133G030190) from the National Institute on Disability and Rehabilitation Research, U.S. Department of Education. The views expressed herein are those of the authors and do not necessarily reflect the policy or position of any funding agency.

Human Participant Protection: This study was approved by the Boston University Charles River Campus Institutional Review Board and written consent was obtained from all study participants.

References

- [1] M. Agervold, Bullying at work: A discussion of definitions and prevalence, based on an empirical study, *Scandinavian Journal of Psychology* **48**(2) (2007), 161–172.
- [2] G.W. Allport, *The nature of prejudice*, Addison-Wesley Publishing Company, Cambridge, MA, 1954.
- [3] M.C. Angermeyer, M. Beck, S. Dietrich and A. Holzinger, The stigma of mental illness: Patients' anticipations and experiences, *International Journal of Social Psychiatry* **50**(2) (2004), 153–162.
- [4] J. Arboleda-Florez, Considerations on the stigma of mental illness, *The Canadian Journal of Psychiatry/La Revue canadienne de psychiatrie* **48**(10) (2003), 645–650.
- [5] C. Balducci, F. Fraccaroli and W.B. Schaufeli, Workplace bullying and its relation with work characteristics, personality, and post-traumatic stress symptoms: An integrated model, *Anxiety Stress Coping* 2011; Feb. 23(Epub ahead of print), 1–15.
- [6] M.L. Baldwin, Can the ADA achieve its employment goals? *Annals of the American Academy of Political and Social Science* **549** (1997), 37–52.
- [7] M.L. Baldwin and S.C. Marcus, Perceived and measured stigma among workers with serious mental illness, *Psychiatric Services* **57**(3) (2006), 388–392.
- [8] C. Bonafons, L. Jehel, M.-F. Hirigoyen and A. Coroller-Béquet, Clarifying the definition of bullying, *L'Encéphale: Revue de psychiatrie clinique biologique et thérapeutique* **34**(4) (2008), 419–426.

- [9] G. Brousse, L. Fontana, L. Ouchchane, C. Boisson, L. Gerbaud, D. Bourguet, et al., Psychopathological features of a patient population of targets of workplace bullying, *Occupational Medicine* **58**(2) (2008), 122–128.
- [10] A. Colella, R.L. Paetzold and M.A. Belliveau, Factors affecting coworkers' procedural justice inferences of the workplace accommodations of employees with disabilities, *Personnel Psychology* **57**(1) (2004), 1–23.
- [11] J.A. Cook, Employment barriers for persons with psychiatric disabilities: Update of a report for the President's Commission, *Psychiatric Services* **57**(10) (2006), 1391–1405.
- [12] M. Corbière, S. Zaniboni, T. Lecomte, G. Bond, P.Y. Gilles, A. Lesage, et al., Job acquisition for people with severe mental illness enrolled in Supported Employment programs: A theoretically grounded empirical study, *Journal of Occupational Rehabilitation* 2011, (Epub ahead of print).
- [13] P.W. Corrigan and A.C. Watson, Understanding the impact of stigma on people with mental illness, *World Psychiatry* **1**(1) (2002), 16–20.
- [14] A.H. Crisp, M.G. Gelder, S. Rix, H.I. Meltzer and O.J. Rowlands, Stigmatisation of people with mental illnesses, *British Journal of Psychiatry* **177** (2000), 4–7.
- [15] J. Cutcliffe and B. Happell, Psychiatry, mental health nurses, and invisible power: Exploring a perturbed relationship within contemporary mental health care, *International Journal of Mental Health Nursing* **18**(2) (2009), 116–125.
- [16] R.S. Dalgin and D. Gilbride, Perspectives of people with psychiatric disabilities on employment disclosure, *Psychiatric Rehabilitation Journal* **26**(3) (2003), 306–310.
- [17] E. Diksa and E.S. Rogers, Employer concerns about hiring persons with psychiatric disability: Results of the employer attitude questionnaire, *Rehabilitation Counseling Bulletin* **40**(1) (1996), 31–45.
- [18] A. Farina and R.D. Felner, Employment interviewer reactions to former mental patients, *Journal of Abnormal Psychology* **82**(2) (1973), 268–272.
- [19] M. Farkas and E.S. Rogers, Improved employment outcomes for individuals with psychiatric disabilities: NIDRR, (2011).
- [20] R. Forbess, M. Farkas, Z. Russinova and P. Bloch, Enhancing workplace inclusion for employees with psychiatric disabilities, Boston University Center for Psychiatric Rehabilitation, Boston, 2010.
- [21] C. Gagne, A. Bowers and Z. Russinova, Combating prejudice and discrimination through PhotoVoice empowerment: Workbook, University Center for Psychiatric Rehabilitation, Boston, 2010.
- [22] C. Gagne, A. Bowers, Z. Russinova, P. Bloch and S. McNamara, Combating prejudice and discrimination through Photo Voice empowerment: Leader's guide, University Center for Psychiatric Rehabilitation, Boston, 2010.
- [23] N. Glozier, Workplace effects of the stigmatization of depression, *Journal of Occupational and Environmental Medicine* **40**(9) (1998), 793–800.
- [24] C.F. Graumann, Verbal discrimination: A neglected chapter in the social psychology of aggression, *Journal for the Theory of Social Behaviour* **28**(1) (1998), 41–61.
- [25] C. Hand and J. Tryssenaar, Small business employers' views on hiring individuals with mental illness, *Psychiatric Rehabilitation Journal* **29**(3) (2006), 166–117.
- [26] L.J. Hauge, A. Skogstad and S. Einarsen, The relative impact of workplace bullying as a social stressor at work, *Scandinavian Journal of Psychology* **51**(5) (2010), 426–433.
- [27] S.P. Hinshaw and D. Cicchetti, Stigma and mental disorder: Conceptions of illness, public attitudes, personal disclosure, and social policy, *Development and Psychopathology* **12**(4) (2000), 555–598.
- [28] B. Kirsh, M. Stergiou-Kita, R. Gewurtz, D. Dawson, T. Krupa, R. Lysaght, et al., From margins to mainstream: What do we know about work integration for persons with brain injury, mental illness and intellectual disability? *Work* **32**(4) (2009), 391–405.
- [29] S. Lim and L.M. Cortina, Interpersonal mistreatment in the workplace: The interface and impact of general incivility and sexual harassment, *Journal of Applied Psychology* **90**(3) (2005), 483–496.
- [30] B.G. Link, F.T. Cullen, E.L. Struening, P.E. Shrout and B.P. Dohrenwend, A modified labeling theory approach to mental disorders: An empirical assessment, *American Sociological Review* **54**(3) (1989), 400–423.
- [31] K. MacDonald-Wilson, Z. Russinova, E.S. Rogers, C.H. Lin, T. Ferguson, S. Dong, et al., Disclosure of mental health disabilities in the workplace. In: I.Z. Schultz, E.S. Rogers, eds. *Handbook of Job Accommodation and Retention in Mental Health*, Springer, New York, 2010, 191–217.
- [32] D. Mechanic, S. Bilder and D.D. McAlpine, Employing persons with serious mental illness, *Health Affairs* **21**(5) (2002), 242–253.
- [33] J. Neath, R.T. Roessler, B.T. McMahon and P.D. Rumrill, Patterns in perceived employment discrimination for adults with multiple sclerosis, *Work* **29**(3) (2007), 255–274.
- [34] G. Nolfé, C. Petrella, G. Zontini, S. Uttieri and G. Nolfé, Association between bullying at work and mental disorders: Gender differences in the Italian people, *Social Psychiatry & Psychiatric Epidemiology* **45**(11) (2010), 1037–1041.
- [35] D.V. Perkins, J.A. Raines, M.K. Tschopp and T.C. Warner, Gainful employment reduces stigma toward people recovering from schizophrenia, *Community Mental Health Journal* **45**(3) (2009), 158–162.
- [36] D.A. Perlick, Special section on stigma as a barrier to recovery: Introduction, *Psychiatric Services* **52**(12) (2001), 1613–1614.
- [37] D.A. Perlick, R.A. Rosenheck, J.F. Clarkin, J.A. Sirey, J. Salahi, E.L. Struening, et al., Stigma as a barrier to recovery: Adverse effects of perceived stigma on social adaptation of persons diagnosed with bipolar affective disorder, *Psychiatric Services* **52**(12) (2001), 1627–1632.
- [38] E.C. Pinel and N. Paulin, Stigma consciousness at work, *Basic and Applied Social Psychology* **27**(4) (2005), 345–352.
- [39] N. Rusch, M.C. Angermeyer and P.W. Corrigan, Mental illness stigma: Concepts, consequences, and initiatives to reduce stigma, *European Psychiatry* **20**(8) (2005), 529–539.
- [40] Z. Russinova, Exploratory study of the relationship between stigma at the workplace and the vocational recovery of people with psychiatric disabilities, Final Report: NIDRR, 2007.
- [41] Z. Russinova, P. Bloch and A. Lyass, Patterns of employment among individuals with mental illness in vocational recovery, *Journal of Psychosocial Nursing & Mental Health Services* **45**(12) (2007), 48–54.
- [42] Z. Russinova, Y. Wan, E. Dan and P. Bloch, Impact of psychiatric stigma on work performance, *International Work, Stress, and Health Conference*, Miami, Florida, 2006.
- [43] SAMHSA. Resource Center to Promote Acceptance, Dignity and Social Inclusion Associated with Mental Health, Language matters - The ADS Center announces its name change & May is mental health month, 2008.
- [44] T.L. Scheid, Stigma as a barrier to employment: Mental disability and the Americans with Disabilities Act, *International Journal of Law and Psychiatry* **28**(6) (2005), 670–690.

- [45] B. Schulze and M.C. Angermeyer, Subjective experiences of stigma, A focus group study of schizophrenic patients, their relatives and mental health professionals. *Social Science & Medicine*, **56**(2) (2003), 299–312.
- [46] S. Stefan, Hollow promises: Employment discrimination against people with mental disabilities, American Psychological Association, Washington, DC, 2002.
- [47] D.L. Stone and A. Colella, A model of factors affecting the treatment of disabled individuals in organizations, *Academy of Management Review* **21**(2) (1996), 352–401.
- [48] H. Stuart, Stigma and work, *Healthcare Papers* **5**(2) (2004), 100–111.
- [49] H. Stuart, Mental illness and employment discrimination, *Current Opinion in Psychiatry* **19**(5) (2006), 522–526.
- [50] K.C. Townsend and B.T. McWhirter, Connectedness: A review of the literature with implications for counseling, assessment, and research, *Journal of Counseling and development* **83**(2) (2005), 191–201.
- [51] O.F. Wahl, Mental health consumers' experience of stigma, *Schizophrenia Bulletin* **25**(3) (1999), 467–478.
- [52] A.C. Watson, P.W. Corrigan, J.E. Larson and M. Sells, Self-stigma in people with mental illness, *Schizophrenia Bulletin* **33**(6) (2007), 1312–1318.