ABSTRACT

Title of Thesis:	MENTAL ILLNESS DISCLOSURE IN ORGANIZATIONS: DYNAMICS BETWEEN DISCLOSER AND CONFIDANT
	Sara E. Barth, Master of Science, 2018
Thesis Directed By:	Assistant Professor, Jennifer L. Wessel, Department of Psychology

Employees with a mental illness regularly encounter situations where they must make decisions regarding the extent to which they discuss their stigma. Research shows that when the confidant reacts in a supportive manner it is beneficial to the individual disclosing. Research on stigma disclosure has not yet defined what differentiates a supportive response from an unsupportive one and there is evidence to suggest that people are unsure of how to best respond to a disclosure. In a series of three studies I seek to develop a better understanding of disclosure interactions by first examining what constitutes a supportive versus unsupportive confidant response by creating a typology of support. Second, I seek to examine whether those with a mental illness versus those without a mental illness perceive the supportiveness of responses differently. Third, I will examine what methods of disclosure are most effective in eliciting a supportive response.

MENTAL ILLNESS DISCLOSURE IN ORGANIZATIONS: DYNAMICS BETWEEN DISCLOSER AND CONFIDANT

by

Sara E. Barth

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Advisory Committee:
Dr. Jennifer L. Wessel, Chair
Dr. Paul Hanges
Dr. Edward P. Lemay, Jr.

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Introduction

In the workplace, employees with invisible or concealable stigmatized identities (e.g. non-heterosexual orientation, a mental illness, non-majority religion) regularly encounter situations where they must make decisions regarding the extent to which they discuss their stigma. When an individual decides to discuss their stigma with a coworker or supervisor they may encounter avoidant behavior (Devine, Evett, & Vasquez-Suson, 1996; Kleck, 1968a; Stephan & Stephan, 1985), hesitant behavior (Belgrave, 1985; Belgrave & Mills, 1981; Mills, Belgrave, & Boyer, 1984), those who express discomfort (Langer et al., 1976), or those who are accepting (Griffith & Hebl, 2002). Prior work has shown that when the confidant, or person to whom an individual discloses a stigma, reacts in a supportive or accepting manner, it is beneficial to the individual disclosing (Chaudoir & Quinn, 2010; Griffith & Hebl, 2002) thus demonstrating the important role of the response an individual receives when disclosing a stigmatized identity. However, research on stigma disclosure has not yet defined what differentiates a supportive response from an unsupportive one, and there is evidence to suggest that in practice, people are unsure of how to best respond to a disclosure (Martin, Woods, Dawkins, 2015). By understanding what behaviors are perceived by stigmatized individuals as constituting a supportive response to disclosure, it becomes possible to examine whether those without a stigma perceive the supportiveness of reactions differently, which further makes it possible to provide guidance to managers and other employees on appropriate response strategies. Additionally, it becomes possible to determine what methods of

disclosure elicit supportive responses, allowing for the counseling of employees from stigmatized groups, many of whom are uncertain of how to disclose (Ragins, 2008).

The present study focuses on this piece of the disclosure process that has received little attention in recent empirical research, that is - the dynamics of the interaction between the discloser and confidant (Chaudoir & Fisher, 2010; Wessel, 2017). Specifically, I focus on mental illness disclosure in the workplace and aim to identify what behaviors, on the part of the confidant, constitute a supportive or unsupportive response from the perspective of individuals with a mental illness, to what extent individuals with and without a mental illness perceive responses differently, and the methods of mental illness disclosure that elicit supportive responses.

Mental illness diagnoses are highly prevalent among the working adult population; it is estimated that one in four adults suffers from a diagnosable mental illness in the United States and that this number may rise to 55% by 2020 (Martin, Wood, & Dawkins, 2015). Individuals with invisible stigmas, such as those with a mental illness, often choose to keep this information private because they fear discrimination and exclusion (Clair, Beatty, & MacLean, 2005; Corrigan & Matthews, 2003; Ragins, Singh, & Cornwell, 2007) and as a result they experience increased internal anxiety, stress, and shame leading to negative psychological outcomes (Dinos et al., 2005; Lane & Wegner, 1995; Smart & Wegner, 2000). Although a direct link between mental illness concealment and physical health problems has not been previously tested, research has linked concealment of another stigmatized identity—sexual orientation—to poorer physical health outcomes (Cole,

Kemeny, Taylor, Visscher, 1996). Having to navigate these anxieties on the job likely leads to preoccupation from other work related duties which negatively impacts the organization via lost productivity and absenteeism. Depression alone is estimated to cause 200 million lost workdays each year, a financial cost to organizations of up to $24 billion (Stewart, Ricci, Chee, Hahn, Morganstein, 2003). Additionally, when individuals with depression are present at work their performance on the job is substantially reduced (Stewart et al., 2003). When individuals do decide to disclose their mental illness to coworkers and supervisors they receive more emotional support from their supervisors and coworkers than individuals who do not disclose and they no longer experience the cognitively taxing and distracting anxieties of concealing their stigma (Banks, Novak, Mank, Grossi, 2007; Rollins, Mueser, Bond, Becker, 2002). Due to the potential high cost, both at the organization and personal level, of concealing a stigmatized identity and the benefits associated with revealing an invisible stigma, it is imperative that we develop a better understanding of the disclosure process in order to help more employees with a mental illness disclose their stigma. An initial step in this goal is investigating the dynamics of the interaction between the discloser and confidant.

It is important to note that throughout much of this review I will cover prior work that has focused on lesbian, gay, and bisexual (LGB) individuals disclosing their sexual orientation. Much of the prior work on the disclosure of invisible stigmas in the workplace has focused on LGB individuals as compared to individuals with a mental illness (e.g.,Clair et al., 2005; Griffith & Hebl, 2002; Jones & King, 2013; King, Reilly, & Hebl, 2008; Ragins, Singh, & Cornwell, 2007). Both mental illness

diagnosis and LGB identification are considered to be invisible stigmas and as such, individuals identifying as part of either of these groups share some similar experiences. Additionally, mental illness disclosure has been compared to the "coming out" process of individuals who reveal their non-heterosexual orientation (Corrigan & Mathews, 2003). Due to these similarities, drawing on the research that has been done with LGB individuals serves as a starting place for the current work. At the same time however, there are important differences between these identities, which will be incorporated into the theory that drives this work.

Those with a mental illness are seen as having an illness that potentially impacts their ability to complete their job, an aspect that those who identify as LGB do not experience. Individuals diagnosed with a mental illness are often viewed as incompetent, unsuccessful, and unintelligent, biasing others' views of their ability to complete their jobs (Farina, Fischer, Boudreau, & Belt, 1996; Sibicky & Dovidio, 1986). In comparison, stereotypes associated with LGB men and women are much more related to their gender conformity such that gay males are seen as less masculine and more feminine while lesbian women are seen as more masculine and less feminine (Taylor, 1983). This stereotype impacts expectations for how LGB men and women will behave but does not bring into question their capabilities of being a productive coworker or employee. This unique difference in the stereotypes associated with these two stigmatized identities has important implications such that when an individual discloses a mental illness they may feel the need to compensate for this stereotype and convince the person to whom they are disclosing that their

mental capabilities are not compromised in any way, essentially downplay the impact of their illness on their daily functioning (Lyons et al., 2016).

In seeking to understand the nature of confidant responses to workplace disclosure of a mental illness I will first begin with a review of stigma and identity management as they broadly relate to stigmatized individuals and then more narrowly as they relate to those with a mental illness. This will be followed by a discussion of why individuals choose to disclose or not to disclose and a discussion of current disclosure models, highlighting foundational disclosure models and those that incorporate the confidant reaction into their theory. I will then discuss reactions to disclosure, the importance of these reactions, and possible explanations for why individuals with and without a stigma might perceive reactions differently. Finally, I will review different methods of disclosure or ways in which individuals choose to discuss their stigmas and potential strategies for eliciting a supportive response.

Stigma

"Stigmatized individuals possess (or are believed to possess) some attribute, or characteristic that is devalued in a particular social context" (Crocker, Major, & Steel, 1998, p. 505). As such, a stigma is defined as a devalued attribute specific to a particular context. Goffman (1963) includes the following in his list of stigmatized attributes: race, gender, values, beliefs, sexual orientation, religious affiliation, and personal experiences. In today's society, the list of stigmatized attributes is not limited to these identities however; mental illness is also considered to be a stigmatized identity in much the same way as race and sexual orientation (Link, 1987; Rabkin, 1974).

Stigmatized individuals experience stereotyping, status loss, and discrimination in their daily life (Link & Phelan, 2001). In social interactions stereotyping shapes what we notice, how we evaluate information, and how we remember specifics of the interaction or specifics pertaining to the individual (Crocker & Lutsky, 1986). These experiences and negative impacts extend to the workplace where stigmatized individuals experience stifled advancement, stifled personal development opportunities, and social isolation (Cox, 1993). Stigmas impact relationship development in general, but in the workplace the impact a stigma has on relationship development between coworkers has unique implications. Specifically, relationship development is a necessary and vital process for networking and career advancement (Day & Schoenrade, 1997). Hindered relationship development and networking, in turn, lead to poorer job performance, difficulties in being hired, and difficulties in maintaining a job (Stephan & Stephan, 1985).

An important distinction in Goffman's definition is that some stigmas are visible (e.g. race and gender) while others are unobservable or invisible, such as mental illness. This distinction in visibility of the stigma is important not only for the impact it has on the experiences of the stigmatized individual but also for the way in which stigmas are researched. Those with visible stigmas cope with the understanding and knowledge that others are aware of their identity and act in a certain way because of this, whereas those with invisible stigmas do not cope with this same situation (Jones & King, 2013). Some scholars have asserted that those with invisible stigmas are relatively "better off" (Jones et al., 1984). However, this is not a fair assessment because while those with invisible stigmas may be able to conceal the stigmatized

aspect of their identity, they have many other decisions they must engage in prior to and during any social interaction they have. Individuals with invisible stigmas must cope with the decision of whether, how, when, where, and to whom they should reveal or disclose their stigmatized identity and the possible outcomes of these decisions (Ragins, 2008). Due to the severity of mental illness stigmatization, the prevalence of mental illness diagnosis, and the disadvantages these employees face because of their stigmatization, it is imperative that we seek to understand their experiences in the workplace. An initial step in this goal is to examine the nature of mental illness disclosure and to identify aspects of the disclosure event which lead to positive experiences for both the discloser and confidant.

Identity Management

Identity management refers to the idea that individuals with an invisible stigma engage in behaviors aimed at managing their stigmatized identity—deciding if, when, where and how to reveal an invisible stigma (Ragins, 2008). The purpose of engaging in identity management behaviors is often for impression management reasons in which those with a stigmatized identity aim to influence the perceptions others' hold about them in relation to their social identity (Roberts, 2005). In addition to impression management goals, individuals with concealable stigmas are also internally motivated to disclose their stigma because it leads to a higher self-acceptance and alignment between one's internal and external view of the self (Cass, 1979; Jordan & Deluty, 1998; Rostosky & Riggle, 2002). Alleviating the psychological strain of concealing parts of oneself is consistent with self-verification theory (Swann & Read, 1981), which posits that people want to be understood by

others according to the beliefs they hold about themselves. Many different conceptualizations of identity management behaviors have been developed to articulate the multitude of behaviors involved in these presentation strategies.

Woods (1994) proposed three main strategies of identity management, which include: counterfeiting, avoiding, or integrating. *Counterfeiting* refers to behaviors such as fabricating an identity that is the opposite of the identity you are trying to hide. *Avoiding* refers to behaviors in which an individual ignores or does not address questions or information related to the stigmatized identity. *Integrating* refers to behaviors in which the individual's identity is acknowledged. Beyond this, other work has proposed identity management frameworks that are specific to certain stigmatized identities. Anderson and colleagues (2001) view identity management and disclosure as a continuum of behaviors that LGB individuals engage in. Specifically, they incorporated the following steps along the continuum: *explicitly out* or the complete reveal of one's sexual orientation, *implicitly out* or neither confirming nor denying one's sexual orientation, *avoiding* or the action of staying away from conversations in which one's sexual orientation could be revealed, and *hiding* or explicitly lying about one's sexual orientation.

Another conceptualization of identity management strategies can be found in Clair and colleagues (2005) work. Clair (2005) proposes that identity management behaviors fall into two categories, *revealing* or *concealing*. Clair (2005) also proposes the idea of signaling strategies. It is suggested that signaling serves as a way for someone to "test the waters" by gauging what a confidant's response will be to a disclosure without actually disclosing a stigma. In this way, if an individual

determines that the confidant will likely respond negatively they can "backtrack" before revealing anything.

More recently, frameworks have emerged specific to the way in which individuals manage and discuss physical disabilities. Lyons and colleagues (2016) proposed a framework whereby individuals with visible disabilities either claimed or downplayed their disabilities. *Claiming* is the act of highlighting positive aspects of one's disability and actively reframing the negative stereotypes. *Downplaying* is the act of shifting attention away from the disability and lessening the undesirable characteristics that are associated with it. In this work they find that claiming is a more beneficial strategy leading to higher perceptions of warmth and competence and ultimately better overall evaluations.

There are important consequences however for individuals engaging in identity management behaviors who are trying to carefully control who knows what in relation to their stigma. A model which addresses these consequences is the one developed by Pachankis (2007) that seeks to illustrate the unique impact stigma and identity management have on individuals with concealable stigmas. He proposes that individuals constantly engage in cognitive efforts to identify supportive others to whom they could disclose. This constant monitoring leads individuals to be preoccupied, and experience anxiety and shame. Being able to control when, where, and how one discloses his or her stigma, in this case mental illness, may be cognitively taxing but is more of an ideal situation than being forced into disclosing. This is not always the case for everyone however. Many individuals are often forced into disclosing their mental illness in order to obtain accommodations, explain gaps in

employment or hospitalizations, or explain specific behavioral symptoms (Ellison et al, 2003; Goldberg et al, 2005).

Research on these identity management behaviors have flourished in recent decades in seeking to examine the antecedents, behaviors, and consequences of identity management as individuals with a concealable stigma decide when, how, where, and to whom they will reveal their stigmatized identity (Griffith & Hebl, 2002; Johnson, Richeson, & Finkel, 2011; Jones & King, 2013; Ragins, Singh, & Cornwell, 2007). A primary limitation of the research on identity management behaviors is that little work has been conducted on the event of disclosure itself, the specific interactions between the discloser and the confidant, or on behaviors specific to those with a mental illness, instead focusing on the antecedents and outcomes of disclosure events (Pachankis, 2007; Ragins, 2008; Ragins & Cornwell, 2001). This past research has helped us to understand why individuals are motivated to disclose their stigma due to both internal and external factors and the consequences of disclosing one's stigma in the workplace, both positive and negative. In the current study, I aim to further our understanding of the disclosure process for those disclosing a mental illness by focusing on the dynamics between the discloser and confidant in the disclosure event itself.

Disclosure Decision Making

Disclosure of an invisible stigma to a coworker, supervisor, or subordinate has the potential to lead to both overt and subtle discrimination (Croteau, 1996; Hebl, Foster, Mannix, & Dovidio, 2002). Oftentimes individuals with a stigmatized identity will choose not to disclose their stigma due to the fear of exclusion or discrimination

(Clair, Beatty, & MacLean, 2005; Corrigan & Matthews, 2003; Ragins, Singh, & Cornwell, 2007). In the workplace many employees want to make and maintain positive impressions of who they are to supervisors, coworkers, and subordinates (Roberts, 2005). Due to this desire, individuals who conceal a stigmatized identity often do so because they are concerned about how they will be perceived. They often fear an increase in the amount of discrimination they will face by revealing a stigmatized identity (Griffith & Hebl, 2002; King & Botsford, 2009) or fear that their coworkers will isolate them (MacDonald-Wilson et al., 2011). Individuals choosing to conceal a mental illness cite the following motives in concealing this identity: "to protect my privacy," "do not want to be seen as asking for special treatment," "fear that disclosure would lead to biased work evaluations," "to avoid being thought of as less competent," "because it is the cultural norm not to complain," (MacDonald-Wilson, et al., 2011). Individuals who may be in denial about their mental illness may also conceal their identity because it is not an identity that is important to them (MacDonald-Wilson et al., 2011). Concealing an invisible identity is linked to lower affective commitment to the organization (Day & Schoenrade, 1997) and also to an increased likelihood of stress-related physical symptoms (Cole et al., 1997).

By concealing an identity, even a stigmatized identity, one effectively inhibits their ability to feel authentic with those around them. When an individual feels authentic to who they believe they are it aids in verifying and maintaining their sense of self in addition to building and fostering stronger and more meaningful relationships with others (Creed & Scully, 2000). As such, feeling authentic in relationships is a motivating reason for many individuals who decide to disclose their

stigmatized identity (Friskopp & Silversten, 1996). There are also more practical reasons someone may decide to disclose an invisible stigma at work, such as disclosing their sexual orientation in order to obtain same-sex partner benefits or disclosing a disability in order to receive accommodations (Clair & Beatty, 2005). Individuals disclosing for benefits to their psychological health and overall well-being decide to disclose in order to feel a sense of release from the burden of hiding a central part of one's identity thereby freeing oneself from the negative psychological strain and emotional stress associated with concealing (Major & Gramzow, 1999; Pachankis, 2007; Smart & Wegner, 1999, 2000).

Even though many individuals with an invisible stigma choose to keep this information private and experience increased internal anxiety, there is research to suggest that there are benefits an individual experiences upon disclosing. Individuals who choose to disclose their stigma receive more emotional support from both supervisors and coworkers and are more likely to remain in their job longer than individuals who do not disclose (MacDonald-Wilson et al., 2011). In addition, individuals who disclose an invisible stigma experience the added benefit of a psychological release from the cognitively taxing experience of self-monitoring (Cain, 1991). This psychological release frees up cognitive resources that the individual can now devote to other workplace responsibilities, a benefit to not only the individual's well-being in the workplace but also to the organization at large and thus another illustration of the importance of understanding workplace disclosure.

Models of Disclosure

In the current arena of disclosure research there are many existing models of disclosure (e.g. Greene & Faulkner, 2002; Omarzu, 2000; Ragins, 2008). Each of these models focuses on a different part of the process and many approach disclosure from a slightly different perspective. More recent models of disclosure incorporate time and feedback loops, an important addition for thinking about how interactions during the disclosure event impact the disclosure itself and future actions related to the disclosure (e.g. Chaudoir & Fisher, 2010; Clair, Beatty, MacLean, 2005).

Omarzu's (2000) Disclosure Decision Model begins with goals motivating the disclosure. If the goals are salient, the individual then decides to disclose their invisible stigma and further assess the situation by taking into consideration if the target and strategy of disclosure are appropriate. If deemed to be so, the discloser then assesses the potential utility and risk of the event. Within this conceptualization Omarzu (2000) posits that when a potential confidant responds in a positive manner to a disclosure event with another person and the individual who wishes to disclose their stigma witnesses this that individual becomes more likely to disclose his or her own stigma to that person. This suggests that the nature of the confidant's reaction is important to the discloser but at this time no empirical investigations have been made into the nature of these reactions.

Greene & Faulkner (2002) demonstrated that responses of the confidant are important in determining the utility of the social benefits of disclosure. Additionally, it is suggested that when a confidant responds in an understanding and accepting way this might promote feelings of self-worth in the discloser (Beals, 2003) and increase feelings of social inclusion (Reis, Sheldon, Gable, Roscoe, & Ryan, 2000). Greene's

(2006) model discusses the experience of negative confidant responses from the perspective that the discloser will anticipate a negative response and thus avoid the disclosure altogether. This is a limited perspective because individuals can mistake social cues and when they do so may encounter a situation in which they anticipated a positive response from the confidant but in the moment receive a negative response. Thus, it is important to consider what a negative response actually is and explore methods of disclosure that help those wishing to disclose an invisible stigma avoid receiving a negative response.

Another model of disclosure conceptualizes the disclosure process as occurring differently across life domains and incorporates individual and environmental factors in each of these domains (Ragins, 2008). An important aspect of this model is the disconnect individuals with invisible stigmas feel when they have disclosed their stigma in one life domain but not another. For instance, an individual could have a mental illness that their family and close friends are aware of but their supervisor, coworkers, and subordinates are not. Ragins' (2008) model acknowledges that positive responses to disclosure likely lead to a sense of trust and security for the individual with the invisible stigma. The model posits that the fear of a negative response alone is enough to inhibit an individual from disclosing. The model stops here however and does not extend to what the possible behaviors are that make up the positive response that leads to a sense of trust and security.

Chaudoir & Fisher (2010) describe a disclosure process model that is motivated by approach- and avoidance-focused goals. This model suggests that people either choose to pursue positive outcomes (e.g. acceptance, understanding) or

choose to avoid negative outcomes (e.g. anxiety, social distancing). Chaudoir and Fisher's (2010) model purports that during the disclosure event a positive confidant response may "prompt the discloser to talk more and discuss increasingly intimate information (pg. 11)." Researchers have shown that sharing intimate, emotional information increases intimacy and liking in relationships (Chaikin & Derlega, 1974; Ludwig, Franco, & Malloy, 1986). Increased liking and intimacy in a relationship is seen as positive for the future of the relationship and as such, a positive or supportive confidant response likely results in positive long-term outcomes for the individual disclosing. Conversely, when the discloser does not receive a supportive response they may suppress further intimate information, which has been shown to impede the quality of the interaction and decrease liking (Butler et al., 2003). Again, like in Ragins' (2008) model, this model does not explore what behaviors constitute supportive and unsupportive responses that supposedly lead to positive and negative outcomes.

An important theoretical limitation to almost all of these models (see Chaudoir & Fisher, 2010 and Greene & Faulkner, 2002 for exceptions) is that few incorporate the response of the confidant, yet theory points to this piece as having the potential for being impactful. Furthermore, none of the existing models discuss what it means to be supportive/unsupportive towards an individual disclosing an invisible stigma. Additionally, an important methodological limitation to many of these models of disclosure is that they pertain to social interactions not exclusive to work situations. In 2013, the U.S. Bureau of Labor Statistics published data from the American Time Use study showing that most employed individuals spend more time

at their jobs than with their families. The workplace also has unique attributes that other social situations do not such as performance assessments, supervisor support, coworker relationships, and the impact of organizational climate on behavior and possible confidant reactions. Due to these differences between contexts it is important that disclosure research be extended to the workplace with a focus on resolving some of the prior discrepant findings discussed previously. The present study seeks to overcome these limitations by investigating the confidant reaction and thereby elucidating the dynamics of the disclosure process for individuals disclosing a mental illness in the workplace.

Reactions to Disclosure

As has been stated previously, when an individual discloses a stigmatized identity there are many potential responses they may receive from the confidant. Categorizing responses into a typology of reactions to disclosure has not yet been done in the literature on workplace disclosures of stigmatized identities. However, the social reactions and social support literatures provide evidence for a basic understanding of what a supportive response is to disclosure of personal information. Social support is defined by Shumaker (1984) as "an exchange of resources between at least two individuals perceived by the provider or the recipient to be intended to enhance the well-being of the recipient." House and colleagues (1981) established four classes of supportive behaviors; these classes include emotional support (i.e. concern), appraisal support, (i.e. affirmation or feedback) informational support (i.e. advice or suggestions), and instrumental support (i.e. physical assistance). These classes of supportive behaviors are consistent with those established by Cutrona &

Suhr (1992) who created the Social Support Behavior Codes framework which include the following categories; informational support, tangible assistance (i.e. physical or instrumental help), esteem support, network support (i.e. connecting an individual to helping others), and emotional support. Similar categories of supportive behaviors are found in Shumaker's (1984) classification scheme, which includes emotional sustenance, material/tangible assistance, and informational support. The overlap between these three perspectives on supportive behaviors provides a framework through which to think about the confidant responses employees may receive when disclosing a mental illness in the workplace.

Classification schemes of negative social response behaviors are also not readily available within the workplace disclosure literature. However research within the social reactions literature again points to consistent behaviors that are viewed as unsupportive or negative when an individual reveals personal information. An important caveat to these behaviors is that they primarily emerge from research done with sexual assault victims. As such, some of the negative responses that sexual assault victims receive may not be typical of responses that someone disclosing a mental illness in the workplace would receive. Nonetheless, they provide a basis for understanding what are considered to be unsupportive or negative behaviors when responding to a disclosure of a stigmatized identity or attribute. Five facets of negative social reactions include: taking control of the victim's decisions, victim blaming, treating the victim differently, distraction, and egocentric behavior (Ullman, 2000). One would not expect someone to behave in a victim blaming way after learning of their coworker's mental illness, but they might treat the individual

differently, make themselves the focus of the situation, or quickly change the topic of conversation which could be perceived by the discloser as an unsupportive reaction. This basic understanding of socially supportive and unsupportive behaviors provides a framework for thinking about the different reactions someone may encounter when disclosing a mental illness in the workplace but because no study has yet to be done examining this situation in particular, it is important to extend this work to this arena.

Research Question 1: Among individuals who have disclosed a mental illness in the workplace, what behaviors are considered to be positive/supportive in responding to a disclosure of mental illness?

Research Question 2: Among individuals who have disclosed a mental illness in the workplace, what behaviors are considered to be negative/unsupportive in responding to a disclosure of mental illness?

Impact of Confidant Reactions

When an individual does make the decision to disclose their stigma in the workplace there are many potential responses they may encounter, all of which have important implications for both the individual and the future of the relationship between the discloser and the confidant. A recent study found that when an individual's first disclosure experience of a non-heterosexual orientation includes a positive confidant reaction that individual is more likely to disclose to others in the future which over time increases their level of trust in others and due to this has long term psychological benefits (Chaudoir & Quinn, 2010). In another study, coworker reactions fully mediated the relationship between disclosure behaviors and job satisfaction such that when a coworker reacted positively to a disclosure of non-

heterosexual orientation the individual disclosing experienced greater job satisfaction (Griffith & Hebl, 2002). These studies highlight the impact the confidant's response has on an individual disclosing a stigmatized identity.

There is other work, done outside of the realm of workplace disclosure, that highlights the impact confidant reactions have on individual well-being. When teens disclosed their non-heterosexual orientation to their parents, those that experienced an unsupportive reaction demonstrated increased binge drinking, illicit drug use, and higher rates of depression (Rothman, Sullivan, Keyes, & Boehmer, 2012). Research examining imagined supportive versus unsupportive reactions to disclosure of an invisible stigma suggest that confidant reactions are a powerful determinant of individual well-being. Individuals who were told to write about a personal secret while imagining an accepting confidant demonstrated fewer illnesses and lower feelings of alienation eight weeks after imagining the disclosure event (Rodriguez & Kelly, 2006). There is also work suggesting that even the perceptions of support in a response to revealing a personal secret has important implications on whether or not the individual will benefit (Kelly & McKillop, 1996).

Beyond the level of the individual, confidant reactions to disclosure have an important impact on the relationship between the discloser and the confidant. When the discloser receives a negative response their level of trust in the confidant will decrease which has been shown to decrease overall liking (Butler et al., 2003). This situation has unique implications in the workplace such that there is little employees can do to avoid their coworkers. If a disclosure plays out in an unsupportive or negative way the future of the relationship between those two coworkers could impact

the way in which the two individuals work together, the quality of their work, and their overall functioning.

Disclosure Disconnects

Another way to think about confidant reactions to disclosures of invisible stigmas is to consider why negative reactions occur in the first place, beyond any prejudiced opinions of the confidant. One such explanation is that individuals with visible or invisible stigmas and non-stigmatized individuals report feeling anxious during interactions with the other and at times try to avoid them altogether (Devine, Evett, & Vasquez-Suson, 1996; Kleck, 1968a, 1968b). Feelings of anxiousness and wanting to avoid an uncomfortable interaction have been suggested to be responsible for creating awkward moments and conversations between those with a stigma and those without (Hebl, Tickle, Heatherton, 2000). Some of the reasons cited as to why individuals without a stigma feel anxious during these interactions are because of fear (Haidt, McCauley, & Rozin, 1994; Rozin, Markwith, & McCauley, 1994), lack of experience and knowledge (Latane & Darley, 1970), and trying to suppress thoughts about the stigma the individual has (Wegner, 1994). In comparison, some of the reasons cited as to why individuals with a stigma feel anxious during interactions with someone who does not have a stigma are fear of rejection (Wright, 1983), a feeling of "being on stage" (Wright, 1983), self-loathing (Bull & Rumsey, 1988; Crandall, 1994), and over interpretation (Kleck & Strenta, 1980). This work provides some explanation as to why individuals may receive negative or uncomfortable reactions after disclosing a stigmatized identity. In order to more fully understand the impact of these awkward interactions it is also important to understand how the two

parties involved, discloser and confidant, interpret and perceive what is said in instances of disclosure.

When people from different backgrounds interact there can often be a mismatch in expectations for how each individual thinks the interaction is going to play out and subsequent misinterpretations of each other's actions or things said during the interaction. In a study assessing the perceptions of supportive behaviors following a disclosure of a cancer diagnosis, the cancer patients reported that they often encountered responses where the confidant expressed too much worry or tried to minimize the impact of the cancer on the patient (Dakof & Taylor, 1990). In this instance, the cancer patients found these reactions to be unsupportive and negative. However, from the perspective of the responder or confidant, it is easy to imagine how one would think that expressing worry and concern would make the patient feel like you genuinely cared about their health. It is also easy to imagine how one could think minimizing the diagnosis might make the patient feel better by not dwelling on something so major. Most people want to do the right thing and as such if the confidant in these situations knew that their reaction was perceived as negative and unsupportive they likely would not have responded in such a manner. This work suggests that confidants may not always be aware of how negative their responses are perceived to be by those with a stigma. One reason for why individuals with a stigma, in this case a mental illness, may view negative confidant responses to be more negative than the confidant views the response to be is because individuals with a mental illness are more vigilant to threats to their identity (Quinn, Kahng, Crocker,

2004). On the other hand, supportive behaviors are more easily detected by all individuals and as such may not be seen as differently as negative support behaviors.

Hypothesis 1: Reactions that involve emotional, appraisal, information, or instrumental support will be seen as supportive and perceived similarly by individuals with and without a mental illness diagnosis.

Hypothesis 2: Reactions that involve taking control of the individual's decisions, blaming the individual, treating the individual differently, distracting the individual, or egocentric behavior will be seen more negatively by individuals with a mental illness compared to individuals without a mental illness diagnosis.

Methods of Disclosure

When an individual has decided to disclose their invisible stigma there are a number of other decisions they now must execute. They must decide where and when it is appropriate to disclose, how much information to disclose, and what information they specifically want to tell the confidant. The previous discussion of Lyons and colleagues (2016) work on *claiming* (highlighting positive aspects of an identity) and *downplaying* (shifting attention away from an identity) as an identity management framework provides a strategy for discussing ones stigmatized identity that leads to greater overall evaluations. They find that when an individual with a physical disability *claims* their disability while talking about the stigma they receive higher evaluations of warmth. While this work specifically pertains to those with a visible stigma, it illustrates a way of talking about one's stigma that leads to positive

outcomes, suggesting that *claiming* could be a useful technique in disclosing a mental illness.

In addition to the potential positives of claiming one's identity when disclosing a stigma, the amount of affective or emotional content one incorporates when discussing a stigma has also been shown to impact relationship development. The extent to which the discloser discusses their stigma in an emotional way varies between people but across all there are important implications in how much or how little one discusses their stigma in an emotional way (Reis & Shaver, 1988). Specifically, one individual may present the factual information of their identity whereas another individual disclosing may discuss the emotions associated with this identity. Both empirical and theoretical work suggests that disclosures which include a higher level of affective content lead to more intimacy in the relationship (Reis & Shaver, 1988). While this evidence is specific to relationship intimacy, it is plausible that methods of disclosure which lead to greater liking long-term also result in more positive confidant reactions during the disclosure event.

Hypothesis 3: Disclosures that use the identity management strategy of *claiming* will result in more positive/supportive confidant reactions than disclosures that use the identity management strategy of *downplaying*.

Hypothesis 4: Disclosures with high affective content will result in more positive/supportive confidant reactions than disclosures with low affective content.

Other Potential Factors

In addition to the predicted relationships, other factors may influence the relationship between disclosure strategy and confidant reaction. For example, Reis & Shaver's (1988) model of disclosure in intimacy identifies a key aspect of disclosure as "the expression of feelings and experiences that characterize the discloser's inner self" (p. 378). Claiming is defined as, "deliberately accentuating positive aspects of the disability and reframing negative stereotypes associated with the disability" and downplaying is defined as, "both attempting to lessen the undesirable characteristics associated with the disability and shifting attention away from the disability" (Lyons et al., 2016, p. 4). As such, downplaying does convey the message that this disability (i.e. depression) is not of personal significance to the individual, counter to Reis and Shaver's (1988) model. When an individual claims their identity when disclosing they are saying that this disability is a central part of who they are, consistent with Reis and Shaver's (1988) model. Because these are the core definitions of claiming and downplaying it is important to keep these manipulations consistent with what has been done in previous research. However, I will explore whether perceived identity centrality mediates the relationship between identity management strategy and confidant response.

It is also possible that characteristics of the individual will influence the choice of confidant response by moderating the relationship between disclosure strategy and confidant response. For example, it is possible that the extent to which someone spontaneously adopts others points of view (perspective take), the extent to which someone has "feelings of warmth, compassion, and concern for others" (empathy), or the extent to which someone has "feelings of anxiety and discomfort"

(personal distress) may mediate the choice of confidant response (Davis, 1983). These individual difference moderators will be included to better understand whether any individual characteristics predict confidant response choices.

Finally, the participant's perceptions of the motivations behind the disclosers decision to disclose their stigma may influence the choice of response. Based on Chaudoir and Fisher's (2010) model of disclosure it would be expected that if participants perceive the discloser to be willing to discuss their stigma more than just in that disclosure event they would provide a positive response. Thus, perceived motivations will be assessed as a potential mediating variable.

Overview of Present Work

In a series of three studies I seek to uncover the behaviors and actions that make up a supportive versus unsupportive confidant reaction to disclosure of a mental illness. This will be accomplished by collecting critical incidents from working individuals with a mental illness who have disclosed their illness in the workplace, Study 1. The qualitative information collected in this study will be used to generate materials for Study 2, which will test how working individuals with and without mental illness perceive reactions to the disclosure of a mental illness. In Study 3, a sample of undergraduate participants will be recruited for a laboratory study that will examine which method(s) of disclosure elicit the most supportive reactions to disclosure of a mental illness.

Study 1: Method

The purpose of Study 1 was to qualitatively assess the experiences of employed individuals disclosing a mental illness diagnosis. In doing so a typology of supportive and unsupportive confidant reactions to mental illness disclosure at work was created.

Participants

A total of 37 participants were recruited (27 females; mean age=38.86, *SD*=13.23; 70.3% White, 27% Black, 2.7% Hispanic/Latino) to participate via organizations associated with mental health advocacy (e.g., National Alliance on Mental Illness, Depression and Bipolar Support Association). These organizations were asked to distribute the study materials through their contact lists, message boards, etc. All participants were employed and diagnosed with a mental illness (24.3 % major depression, 40.5% bipolar disorder, 24.3% other depression diagnoses, 5.4% persistent depressive disorder, 2.7% 'situational' depression, 2.7% dysthymia). Participants were not included or excluded based on diagnosis; any individual with a mental illness diagnosis was eligible to participate. This allowed for the collection of a larger number of participants and a wider range of mental illness disclosure experiences. Participants were employed across a representative sample of industries (e.g., Health Care, Education, Retail, Business/Finance). Participants who completed the study were compensated $20.

Procedure

All critical incident questions and other materials were administered using the online survey software, Qualtrics, on the participants' personal computers. After providing consent, participants were asked to provide a critical incident report of two

disclosure events. Upon completion of the study, participants were provided with a debriefing statement informing them about the purpose of the study.

Materials

Critical incidents of actual mental illness disclosure events were gathered from participants, focusing on the reaction of the confidant. The critical incident technique is a set of procedures used in collecting observations for the purpose of solving practical problems (Flanagan, 1954). This technique is particularly useful for conducting inductive research where there is a dearth of information known about the topic area. For the present work, collecting rich qualitative data via the critical incident technique is particularly useful because it allows for the collection of data directly from the source and because this topic area is not well explored in the literature. Participants were asked to describe an instance where they disclosed their mental illness to a coworker or supervisor (see Appendix A for all study 1 materials). Participants were first asked to describe the overall event. Second, participants were asked to describe in detail the way in which the confidant reacted and whether they felt this reaction was *supportive* or *unsupportive*. Participants were asked to describe a total of two disclosure events, one in which they felt the confidant reacted in a *supportive* manner and a separate event in which they felt the confidant reacted in an *unsupportive* manner (see Table 1 for examples of responses). In order to reduce the risk of selection bias in the events participants decided to describe they were asked to describe the most recent experience of these two types of events. In the event that a participant had only experienced one of these scenarios they were asked to complete just that portion. Not all participants had examples of both a supportive and

unsupportive confidant reaction, resulting in a final typology created from 31 examples of supportive confidant reactions and 30 examples of unsupportive confidant reactions. Order of question presentation was counterbalanced across participants. Participants were also asked to answer a series of demographic questions about themselves, including their age, gender, race/ethnicity, mental illness diagnosis, industry. If a participant had not disclosed their mental illness at all in their workplace, they were excluded from all analyses.

Analysis

To analyze Research Questions 1 and 2, responses were coded to create a typology of categories of positive (supportive) and negative (unsupportive) response behaviors to mental illness disclosure at work. The categories into which responses were sorted were determined by prior research and from the data themselves. I decided to use both an inductive and deductive approach in this study because some typologies of social support existed in other literatures (e.g. general social support, support for sexual assault survivors) but nothing existed within the mental illness disclosure literature. Thus, it was important to incorporate the existing work but to also allow for new types of behaviors that may be specific to mental illness disclosure to emerge. Based on prior disclosure research it was expected that some responses would fit into the following categories of positive support behaviors: emotional support, appraisal support, informational support, instrumental support (House, 1981). This list of categories was used as a starting point but it was not exhaustive and other categories were created from themes that emerged in the data by following the cut and sort coding technique (Lincoln & Guba, 1985). In this technique, quotes

and segments of the text that seemed important were separated. These quotes/segments were then sorted according to similarity. Once all quotes/segments were sorted these then represented the themes or the remainder of the support behaviors, both positive and negative.

Study 1: Results

Two researchers generated categories from themes that emerged in the data. It was determined that House's (1981) categories of social support fit the responses well and no other categories of positive support were created. This typology includes four behaviors depicting positive or supportive behaviors; emotional support (i.e. concern), appraisal support, (i.e. affirmation or feedback) informational support (i.e. advice or suggestions), and instrumental support (i.e. physical assistance). Emotional support is defined as showing esteem or trust for the individual, concern, listening, empathy, caring, love, and affect. Emotional support can be seen in this confidant response recounted by one participant, *"stayed quiet and listened and then tried to be understanding"* and in this confidant response, "*the lack of judgement and relatability were key in making this a very positive and supportive response to my sharing of my condition."* Appraisal support is defined as showing affirmation, providing feedback or social comparison, or providing information that is relevant to self-evaluation as seen in this response, *"She shared about her own struggles in the past"* and in this response, "*one of my coworkers told me that a member in their family also suffered from depression and that I could come talk to them anytime."* Informational support is defined as advice, suggestions, and directives and can be seen in this confidant

response, *"Told me that I will get better and told me to seek professional help and not to worry about what others think"* and in this response, *"encouraging me to 'speak up."* Finally, instrumental support is defined as aid in kind, money, labor, time, modifying the environment, physical assistance, providing a person with information that the person can use in coping with personal and environmental problems, and helping people to help themselves. Instrumental support can be seen in this response, *"shortly after the conversation they gave me contact information of a family member of theirs who was a mental health professional"* and in this response, "*what was supportive was their belief in me that I needed a breather and allowing me to get one, than being forced to continue working under stress, anger, and suicidal thoughts."* Often, multiple types of support were found in a single response, such as this one in which both emotional and appraisal support are present, "*While experiencing my most recent depressive episode I shared my diagnosis with my supervisor…I was met with empathy and understanding. She then shared that she has struggled with mental illness as well and was able to help me through that time."*

It was determined that five categories of negative or unsupportive behaviors were representative of the critical incident responses. These categories were more distinct from Ullman's (2000) framework of negative social reactions and included: insulting behavior (i.e. judgment or condescension), denial of symptoms (i.e. denying symptomatic behaviors or thinking the individual is using their illness as an excuse), avoidance (i.e. silence or glossing over information shared), denial of assistance (i.e. denying symptomatic behaviors or dismissing request for support), and future negative behavior (i.e. termination or exclusion; see Table 2 for all categories,

definitions, examples of each category, and frequencies observed). Insulting behavior is defined as being judgmental, showing condescension, and not showing empathy. Insulting behavior can be seen in the following confidant response, *"the person overlooked what I said and said that he only wanted the old me back"* and in this confidant response, "*he wouldn't listen and basically called me crazy."* Avoidance is defined as, changing the subject or glossing over the disclosure, silence, treating the individual differently and can be seen in this response, *"ignored or glossed over my disclosure of struggling with mental illness"* and in this response, "*They seemed to be unsure how to handle such information and chose to try and ignore it."* Denial of symptoms is defined as denying or dismissing the presence of an illness or symptomatic behaviors through indicating that the person is using their mental illness as an excuse and/or relating personal stories when they are not related. Denial of symptoms can be seen in the following response, *"told me that everyone, even he, feels depressed which made my depressed thoughts and feelings feel downplayed"* and in this response, "*she continually tried to relate her situation to mine, where there was no comparison."* Denial of assistance is defined as denying presence of an illness or symptomatic behaviors through dismissing request for accommodations or support which can be seen in this response, *"Get over it, let it go, put your big girl panties on"* and in this response, "*I kept asking the person for help, but instead, I was told to leave them alone as I was asking for too much."* Finally, future negative behavior is defined as termination or exclusion which are seen here, *"speaking to me differently behind my back, not inviting me to lunch anymore"* and in this response, "*I lost my job as a result of disclosing."* As with positive support behaviors, many negative

support behaviors were seen together in single responses. For example, this response combines insulting behavior, avoidance, and denial of symptoms, *"When I disclosed my personal struggle with depression and anxiety I was met with stunned silence. The colleague I spoke with did not know how to continue our conversation…The colleague made a quick reason to end the discussion and left my office. She assumed I should have been home in bed with the shades drawn and be a recluse. I felt slighted in that moment that I didn't receive any empathy or support from her."*

A single coder identified specific sentences and phrases from responses and attached a single behavior to each sentence or phrase. A second coder then attached a single behavior to these same sentences. Agreement was 81% across the two coders. The most common positive support behavior was emotional support (60%), followed by appraisal support (34%). Instrumental support (14%) and informational support (14%) were observed less frequently. Comparatively, the most common negative support behavior observed was insulting behavior (42%), followed by denial of assistance (34%), and denial of symptoms (31%). Displays of future negative behavior (22%) and avoidance (20%) were not observed as frequently in responses.

Study 1: Discussion

Critical incidents collected from 37 working individuals identify nine behaviors as being either supportive or unsupportive. Behaviors viewed as supportive included emotional support, appraisal support, informational, and instrumental support. These behaviors were generalizable and mapped on to House's (1981) framework of supportive behaviors which was used as an initial guide in sorting and

coding responses from this study. While emotional support was the most common behavior seen in participant responses, all identified positive support behaviors provide a blueprint for how to respond positively to someone disclosing a mental illness. This is a particularly important aspect of this work, as prior work has shown that, in practice, people are unsure of how to best respond to disclosures of stigmatized identities (Martin, Woods, Dawkins, 2015). Behaviors identified as being unsupportive include insulting behavior, denial of symptoms, denial of assistance, avoiding, or behaving negatively in the future. While these behaviors did not map on to Ullman's (2000) typology of negative social reactions as well as the supportive behaviors mapped onto House's (1981) categories of social support there was still overlap in behaviors indicative of unsupportive responses. Avoidance and denial of symptoms align with Ullman's (2000) behaviors of treating the victim differently and egocentric behavior, respectively. Insulting behavior, denial of assistance, and behaving negatively in the future were distinct from Ullman's typology and may be more unique to mental illness disclosure. Insulting behavior about another's diagnosis and denial of symptoms or denial of assistance were the most frequent negative support behaviors observed. While unfortunate that so many negative responses were encountered by participants, these behaviors highlight how not to respond to a disclosure of a mental illness at work.

Study 2: Method

Study 2 sought to assess the perceptions of confidant response behaviors to mental illness disclosure at work. Specifically, this study tested whether individuals

with and without a mental illness diagnosis perceive the supportiveness of responses similarly or differently.

Participants

Participants for this study were again a working adult sample and included individuals with a mental illness diagnosis and individuals without a mental illness diagnosis. A total of 77 (52 female; mean age = 40.6, SD= 12.1; 85.7% White, 6.5% Asian American, 3.9% Black, 3.9% Hispanic/Latino) participants *with* a mental illness (Bipolar Disorder = 37.7%, Major Depressive Disorder = 32.5%, More than two diagnoses = 16.9%, Anxiety = 7.8%, Schizophrenia = 2.6%, Post-Traumatic Stress Disorder = 1.3%, Eating Disorder = 1.3%) were recruited as an online sample from mental health community groups (National Alliance on Mental Illness, Depression and Bipolar Support Association). Participants were not included or excluded based on diagnosis; any individual with a mental illness diagnosis was eligible to participate. This allowed for the collection of a larger number of participants. A total of 89 (35 female; mean age =33.5, SD=8.2; 71.9% White, 13.5% Asian American, 11.2% Black, 3.4% Hispanic/Latino) participants *without* a mental illness were recruited as an online sample from Mechanical Turk. Of the total number of participants, 68 had a family member who has a mental illness diagnosis. Participants were employed across a representative sample of industries (e.g. Health Care, Technology, Education, Business/Finance, Retail,) with an average organization tenure of 3-7 years. Participants who completed this study were compensated $5 (support groups) or 50 cents (mTurk).

Procedure

All study materials and questionnaires were presented using the online survey software Qualtrics on the participants' personal computers. After providing consent, participants were asked to read vignettes describing confidant response behaviors to a disclosure event. Upon completion, participants were provided with debriefing information informing them of the purpose of the study.

Materials

Participants were presented with a total of eight vignettes. The first part of each vignette contained the same description (an individual has come to them at work disclosing that they have depression), but the second part of the vignette contained the response of a hypothetical confidant to the disclosure scenario which varied across each vignette. Eight confidant responses were written from the typology of support behaviors generated from Study 1 for a total of eight vignettes. Depression was chosen as the diagnosis for these vignettes because of its prevalence; it is one of the most commonly diagnosed mental illnesses, with a lifetime prevalence rate of 20.8% (Kessler et al., 2005). Participants were randomly assigned to take one of two perspectives when reading the vignette: the role of the discloser or the role of the confidant. This eliminated any confounds introduced as a result of all participants only taking on one imagined role (exclusively discloser or exclusively confidant). After reading each vignette participants were asked to evaluate the confidant response portion of the vignette. Specifically, they were asked to answer on a Likert scale ranging from 1 (*Not at all*) to 7 (*Extremely*) how supportive they thought each response was. Support (or lack of support) was assessed via a 6-item scale. Items specifically assessed how supportive, negative, helpful, useful, or well-intentioned the

participant thought the response was. Participants were also asked to choose the best and worst confidant responses from all confidant response behaviors read (See Appendix B for all measures). Participants concluded the survey by answering a series of demographic items including age, gender, race & ethnicity, whether or not they have any family members who have a mental illness diagnosis, industry, organizational tenure.

Analysis

This set of data concerns individual evaluations of support behaviors (confidant responses) to disclosure of a mental illness as it relates to one's own mental illness status. Hypotheses 1 and 2 were tested using a linear mixed model for repeated measures, given that the study tests the relationship between a between-subjects variable (mental illness status) on a within-subjects outcome (response to specific vignette compared to other vignettes). Each model included mental illness status as the between-subjects predictor variable and evaluation of support behavior as the within-subjects outcome variable. In addition, valence (positive and negative) of vignette was included as a predictor variable along with the interaction between mental illness status and valence. Finally, gender and family member mental illness status were included as control variables. The best/worst ratings were analyzed by comparing frequencies with a chi-square test. Specifically, the number of times each response category was chosen as the best or the worst was compared according to the between-subjects predictor (mental illness versus no mental illness).

In addition to these planned analyses, exploratory analyses were conducted to examine possible interactions and to examine differences in evaluations of specific

support behaviors. There is no existing work suggesting that family member mental illness status should interact with disability status but this potential interaction was explored because one could reasonably predict that if an individual has no mental illness diagnosis themselves but has experience with a loved one who has a diagnosis they may be more in tune with the experiences and wishes of that individual. Finally, gender was explored as a potential moderator given that men and women differ in their social behavior to a certain extent (Eagly, 2009; Hoffman, 1977).

Study 2: Results

Treatment of the Data.

I first compared the responses of participants randomly assigned to the discloser perspective to participants randomly assigned to the confidant perspective in order to ensure that it was reasonable to collapse across the perspectives. This comparison, a paired samples t-test, revealed no differences. In addition, perspective was interacted with mental illness status in a model with evaluation of support as the outcome variable. Perspective was not found to be a significant predictor on its own (b=.045, p=.685) nor was it found to interact with mental illness status (b=-.111, p=.501) and thus all future analyses include participants assigned to both perspectives (See Table 3 for t-test comparison statistics). Next, I ensured that the 6-item measure to assess supportiveness could be collapsed into a single measure for each vignette/support behavior. In a principal component factor analysis using varimax rotation of the 6-items for each support behavior separately, all six items loaded highly onto one factor accounting for at least 61% of the variance across each

vignette. A Procrustes rotation analysis was also conducted in which factor loadings for each set of items across vignettes were compared to the average loadings across all vignettes. Each 6-item scale for all eight vignettes were found to fit the average loadings demonstrating measurement equivalence. Additionally, all items achieved a sufficient alpha reliability (Emotional Support α=.902; Appraisal Support α=.898; Informational Support α=.882; Instrumental Support α=.916; Insulting behavior α=.908; Avoidance α=.827; Denial of Symptoms α=.865; Denial of Assistance α=.898; see Table 4 for all factor loadings and alpha reliabilities)

Exclusions

Attention-check items (e.g., Please select "strongly agree") were included in the survey measures to ensure high quality data. Inclusion of participants who failed attention-check items in the analysis did not change the pattern or significance of results and thus all participants were included in subsequent analyses.

Effect of Mental Illness Diagnosis on Perceptions of Support Behavior

Hypothesis 1 predicted that individuals with and without a mental illness would view the supportiveness of responses similarly across different types of support and hypothesis 2 predicted that individuals with and without a mental illness would view the supportiveness of negative responses differently in that those with a mental illness would view negative responses more negatively than those without a mental illness. These hypotheses were tested with a model which included mental illness diagnosis and valence of behavior (positive or negative) as predictor variables and evaluation of support behavior as the outcome variable. Gender and family member mental illness status were included as control variables. Mental illness status

was found to significantly moderate the relationship between valence and evaluation of support behavior (b=.385, p<.001). Simple slopes analysis reveals that individuals with and without a mental illness do not have different perceptions of how supportive positive behaviors are (b=-.0069, p=.927), thus I fail to reject the null hypothesis. Simple slopes analysis also reveals that individuals *with* a mental illness view negative support behaviors to be more negative than those *without* a mental illness (b= -.392, p<.001), providing support for Hypothesis 2 (see Table 5 for model statistics).

Comparison of Positive Support Behaviors

I also tested whether certain positive support behaviors are viewed as more or less supportive than others as a function of mental illness diagnosis. This was tested with a model in which evaluation of positive support behavior was the outcome variable and mental illness diagnosis was a predictor variable along with dummy coded support behaviors and interaction terms representing the interaction between mental illness diagnosis and each specific positive support behavior. Emotional support was chosen as the comparison group because it was found to be judged the most supportive response strategy. Dummy coded support behaviors were modeled as both fixed and random. The intercept was also modeled as random. As all variables were dummy-coded, no variables were centered. The results of this model show that mental illness diagnosis moderates the evaluation of how supportive emotional support is perceived to be as compared to both informational support (b=-.859, p<.001) and instrumental support (b=-.461, p<.001) (see Table 6 for model comparison statistics). Figures 1 and 2 depict the nature of the interaction between

evaluation of emotional support and evaluations of informational and instrumental support, respectively. A simple slopes analysis of these interactions suggest that participants with a mental illness perceive the supportiveness of emotional support (*M*= 4.56, *SD*=.493) to be more supportive than either informational (*b*=-2.21, *p*<.001; M=2.34, *SD*=.732; Figure 1) or instrumental support (*b*=-.681, p<.001; M=3.87, *SD*=.913; Figure 2) as compared to participants without a mental illness whose mean differences between emotional support (*M*=4.27, *SD*=.825) and informational (*b*=-1.35, *p*<.001*; M*=2.91, *SD*=.871) and instrumental (*b*=-.22, *p*=.010; *M*=4.05, *SD*=.805) support are smaller, though still significantly different.

To analyze whether mental illness status impacted the choice of the "best" response to mental illness disclosure, frequencies for each of the four positive support behaviors presented as response options (*emotional support, appraisal support, informational support, instrumental support)* were compared for individuals with and without a mental illness by conducting a chi-square test of independence. For participants *with* a mental illness, 57% chose emotional support as the best confidant response, 27% chose appraisal support as the best confidant response, 15% chose instrumental support as the best confidant response and 0% chose informational support as the best confidant response. For participants *without* a mental illness, 47% chose emotional support as the best confidant response, 28% chose appraisal support as the best confidant response, 19% chose instrumental support as the best confidant response and 1% chose informational support as the best confidant response. This test did not reveal any significant differences between individuals with a mental illness and individuals without a mental illness ($\chi 2$=1.86; see Table 7 for frequencies).

Comparison of Negative Support Behaviors

As before, I was interested in whether certain negative support behaviors would be viewed as more or less negative than others as a function of mental illness diagnosis. This was tested with a model in which evaluation of negative support behavior was the outcome variable and mental illness diagnosis was a predictor variable along with dummy coded negative support behaviors and interaction terms representing the interaction between mental illness diagnosis and each specific negative support behavior. Denial of assistance was chosen as the comparison group because it was found to be judged the most unsupportive or negative response behavior. Dummy coded support behaviors were modeled as both fixed and random. The intercept was also modeled as random. Again, no variables were centered. The results of this model show that mental illness diagnosis does not moderate the evaluation of how supportive certain negative support behaviors are perceived to be (see Table 8 for model comparison).

To analyze whether mental illness status impacted the choice of the "worst" response to mental illness disclosure, frequencies for each of the four negative support behaviors presented as response options (*insulting behavior, avoidance, denial of assistance, denial of symptoms)* were compared by conducting a chi-square test of independence. For participants *with* a mental illness, 50% chose denial of assistance as the worst confidant response, 29% chose denial of symptoms as the worst confidant response, 19% chose insulting as the worst confidant response and 1% chose avoidance as the worst confidant response. For participants *without* a mental illness, 46% chose denial of assistance as the worst confidant response, 17%

chose denial of symptoms as the worst confidant response, 21% chose insulting as the worst confidant response and 9% chose avoidance as the worst confidant response. This test did not reveal any significant differences between individuals with a mental illness and individuals without a mental illness ($\chi 2=5.48$; see Table 9 for frequencies).

Exploratory Moderation Analysis

Family member mental illness status and gender were included as exploratory moderators of the relationship between support behavior and evaluation of supportiveness. The model used to test the impact of these variables on evaluation of behaviors included evaluation of support behavior as the outcome variable and family member mental illness (or gender) as a predictor variable along with dummy coded support behaviors and interaction terms representing the interaction between family member mental illness (or gender) and each specific support behavior. Mental illness diagnosis was also controlled for in the model. Dummy coded support behaviors were modeled as both fixed and random. The intercept was also modeled as random. No variables were centered. For positive support behaviors, family member mental illness status was found to significantly moderate the evaluation of how supportive emotional support is perceived to be as compared to both informational (b= -.584, p=.001) and instrumental support (b=-.608, p<.001). Figures 3 and 4 depict the nature of the interaction between evaluation of emotional support and evaluations of informational and instrumental support, respectively. Simple slopes analysis of this interaction suggests that participants with a family member who has a mental illness perceive the supportiveness of emotional support (M= 4.55, SD=.540) to be more

supportive than either informational (b=-2.10, p<.001; M=2.45, SD=.785) or instrumental support (b=-.79, p<.001; M=3.75, SD=.879) as compared to participants without a family member who has a mental illness, whose mean differences between emotional support (M=4.30, SD=.783) and informational (b=-1.52, p<.001; M=2.78, SD=.882) and instrumental (b=-.18, p=.020; M=4.12, SD=.817) support are smaller. Gender was not found to moderate the evaluation of any positive support behaviors.

For negative support behaviors, family member mental illness status did not moderate the evaluation of any behaviors. Gender however did moderate the evaluation of how supportive denial of assistance is perceived to be as compared to denial of symptoms (b=.220, p=.009). Figure 5 depicts the nature of this interaction. This interaction shows that male and female participants have the same pattern when it comes to their perceptions of denial of assistance and denial of symptoms but that the magnitude of difference between these behaviors is larger for male participants (b=.149, p=.019) than it is for female participants (b=-.006; p=.920) such that male (M=1.42, SD=.756) and female (M=1.35, SD=.721) participants view denial of assistance in a similar manner but female participants (M=1.38, SD=.692) view denial of symptoms to be more negative than male participants (M=1.58, SD=.702).

Study 2: Discussion

This study sought to understand whether there is a disconnect between mental illness status and perceptions of supportiveness or unsupportiveness of confidant responses to disclosures of mental illness. Through a repeated-measures linear mixed model design, it was found that individuals with and without a mental illness have

similar perceptions of supportive responses and dissimilar perceptions of unsupportive responses to mental illness disclosure. Consistent with Hypothesis 1 it was found that individuals without a mental illness perceive positive support behaviors similarly to those with a mental illness. When it comes to negative support behaviors results were also as expected; individuals with a mental illness judged negative support behaviors to be more negative than individuals without a mental illness.

When comparing specific positive and negative support behaviors to each other it is found that mental illness status significantly impacts how supportive certain behaviors are perceived to be. For instance, when it comes to positive support behaviors, individuals with a mental illness perceive emotionally supportive responses to be much more supportive than both instrumentally and informationally supportive responses. Although the pattern of responses is similar for individuals without a mental illness, the magnitude of the difference between emotional support and instrumental/informational support depends on mental illness status of the participant. Specifically, participants without a mental illness perceive emotionally supportive responses to be more similar to informational or instrumental support, rather than identifying emotional support as much more supportive. There were no differences found for perceived supportiveness of negative support behaviors as a function of mental illness diagnosis.

Additionally, the experience of having a family member with a mental illness did impact participant perceptions; the interaction between evaluations of support and family member mental illness status mirrors the interaction between evaluation of

emotional support and informational and instrumental support for participants with and without a mental illness suggesting that participants who have a family member with a mental illness are more in-tune with how individuals with a mental illness perceive confidant reactions. Gender influenced perceptions of denial of assistance and denial of symptoms such that male and female participants view denial of assistance in a similar manner but female participants view denial of symptoms to be more negative than male participants.

Overall, these data suggest that individuals without a mental illness are mostly able to take the perspective of those with a mental illness. Participants without a mental illness have similar perceptions of how supportive positive support behaviors are overall, though they do not perceive emotional support to be nearly as supportive as participants with a mental illness. While participants without a mental illness do not view negative support behaviors to be quite as negative as participants with a mental illness they do still view negative support behaviors as negative compared to positive support behaviors. As such, this study demonstrates that there are minor discrepancies in perceptions of support between those with and without a mental illness. Even though there are differences in how support behaviors are perceived depending on one's mental illness status, these findings further support the use of these behaviors as a blueprint for appropriate positive support behaviors and inappropriate negative behaviors.

Study 3: Method

The purpose of Study 3 was to examine which method(s) of mental illness disclosure elicit the most supportive confidant reactions. This was done by examining the impact of identity management strategy (*claiming* and *downplaying*) and affect (*high* and *low*) on confidant responses to disclosures of mental illness.

Participants

Participants were recruited through the University of Maryland SONA system. A total of 172 (111 female; mean age = 19.54, SD=1.49; 40.1% White, 23.3% Black or African American, 21.5% Asian American, 6.4% Hispanic/Latino) participants were recruited. Of the total number of participants, 50 had a family member who has a mental illness diagnosis. Participants in this study were excluded post-hoc if they personally had a diagnosis of a mental illness. Participants were provided with .5 credit hours or $5 for participating in the study.

Procedure

All questionnaires were administered using the online survey software, Qualtrics, on computers within a laboratory setting. After providing consent, participants were asked to read a vignette describing a situation in which a supposed coworker discloses a depression diagnosis to them. Participants were randomly assigned to one of five conditions. Number of participants across each condition were sufficiently similar (Control = 32, Claiming with high affect = 36, Claiming with low affect = 37, Downplaying with high affect = 35, Downplaying with low affect = 32). Upon completion, participants were provided with debriefing information informing them of the purpose of the study.

Materials

Vignettes presented to participants described a situation in which a supposed coworker discloses a depression diagnosis. The way in which this individual discloses their diagnosis was manipulated across participants. Participants were randomly assigned to one of five conditions for a between-subjects design. The four methods of disclosure are based on Lyons and colleagues (2016) work about the benefits of *claiming* an identity relative to *downplaying* an identity and the work of Reis & Shaver (1988) showing the benefits of affective content in disclosures. The four methods of disclosure were the following: a) claiming one's depression diagnosis with high affective content, b) claiming ones' depression diagnosis with low affective content, c) downplaying one's depression diagnosis with high affective content, and d) downplaying one's depression diagnosis with low affective content. Claiming one's depression diagnosis with high affective content was depicted as follows:

> *"Although it can be difficult at times to not feel depressed, I know that living with a mental illness has had a positive impact on my life by making me stronger than I would have been otherwise. I know that some people may think I am less able to do my job because I have depression. This view makes me sad and at times nervous to tell people about my depression. However, I really feel like there is nothing I can't do at this point and I hope that others see that in me as well."*

Claiming one's depression diagnosis with low affective content was depicted as follows:

> *"Although it can be difficult at times to not feel depressed, I know that living with a mental illness has had a positive impact on my life by making me stronger than I would have been otherwise. I know that some people may think I am less able to do my job because I have depression but I really feel like there is nothing I can't do at this point and I hope that others see that in me as well."*

Downplaying one's depression diagnosis with high affective content was depicted as follows:

> *"Although people with depression may have difficulty, I try not to let having depression define who I am as a person. Some people may view me differently because of my depression. This view makes me sad and at times nervous to tell people about my depression. However, everyone has their own things they have to deal with in some form or another. I try not to see it as a big deal and hope that others don't define me by my diagnosis."*

Downplaying one's depression diagnosis with low affective content was depicted as follows:

> *"Although people with depression may have difficulty, I try not to let having depression define who I am as a person. Some people may view me differently because of my depression. However, everyone has their own things they have to deal with in some form or another. I try not to see it as a big deal and hope that others don't define me by my diagnosis."*

Methods of disclosure were pilot tested prior to collecting data to ensure that the manipulations were coming across as intended. A total of 18 individuals completed the pilot survey. Participants read each vignette and then answered three questions assessing their evaluation of whether the person in the vignette was claiming, downplaying, or talking about their mental illness in an affective manner (see Table 10 for descriptive statistics). Pilot testing revealed that conditions came across as intended such that conditions in which the individual claimed or downplayed their diagnosis were seen as such and conditions in which the individual disclosed their diagnosis with high or low affect were seen as such. In addition to these four manipulated methods of disclosure, there was a control condition in which participants were only told that a coworker has disclosed a mental illness to them (see Appendix C for full vignettes). After reading the vignette participants were presented with possible ways to respond to the disclosure and asked to choose the response that best fit with how they would respond if they were the confidant in this situation. The possible response options were the same as the reactions presented in Study 2 and

representative of the eight categories of positive and negative support behaviors generated from Study 1. Participants were also asked to determine how likely they would be to respond with each of the eight behaviors on a 0-100 slider scale.

Participants natural inclination to take the perspective of others was included as an exploratory moderator. This was measured via the Interpersonal Reactivity Index (Davis, 1980). Three subscales from this measure were included, the perspective taking subscale, the empathic concern subscale, and the personal distress subscale. Each subscale was made up of 7 items and answered on a 1-5 response scale (1 = Does not describe me well and 5 = Describes me very well). Each subscale achieved a sufficient alpha reliability (Perspective taking α=.76; Empathic Concern α=.62; Personal Distress α=.73).

Single items were used as exploratory mediators to assess the participant's perceptions of the motivations behind the disclosers decision to disclose their stigma. These were assessed via Likert scale questions assessing the participant's perceptions of how likely they think it is that the discloser disclosed because they felt people were going to find out anyway or because the discloser wanted them to know (1=Not very likely and 5 = Very likely). Participants were also asked how willing they think the discloser is to talk more about their stigma and whether or not the discloser would be receptive to answering questions about their stigma (1 = Not very will/Not very receptive and 5= Very willing/Very receptive). Finally, participants were asked how central they felt the discloser's identity (mental illness diagnosis) was to the discloser (1= Not very central, 5 = Very central). Participants concluded the survey by

answering a series of demographic items including age, gender, race & ethnicity, whether or not they have any family members who have a mental illness diagnosis.

Analysis

Simple linear regressions were used to determine the method(s) of disclosure that maximally predict a supportive confidant response (Hypotheses 3 and 4). The dependent variables were composite scores calculated from the likelihood of responding variables. Specifically, participant's likelihood of responding with each positive support behavior were averaged together and participant's likelihood of responding with each negative support behavior were averaged together. The independent variable in each regression was the condition participants were randomized into (claiming with high affect, claiming with low affect, downplaying with high affect, downplaying with low affect, control). Gender and family mental illness status were included as control variables in the model. In order to examine how disclosure strategy impacted likelihood of responding with specific confidant response behaviors, a Multivariate Analysis of Covariance (MANCOVA) was used. The dependent variables were the likelihoods of responding with each support behavior (8 response behaviors). The independent variable was the condition participants were randomized into (claiming with high affect, claiming with low affect, downplaying with high affect, downplaying with low affect, control). Gender and family mental illness status were included as control variables in the model. Again, as in Study 2, gender & family mental illness status were explored as possible moderating variables and included as interaction terms with condition.

It is important to note that the initial analysis technique for this study was logistic regression because the dependent variable (8 response choices) was going to be collapsed across the multiple response options to create two categories: positive and negative support behaviors. Logistic regression was not able to be conducted on this data however because all participants chose one of the four positive response options and thus there was no variance in the dependent variable. Tables 11 and 12 display the means, standard deviations, and correlations of all tested variables.

Study 3: Results

Exclusions

Attention check items were included in the survey measures to ensure high quality data. Inclusion of participants who failed attention check items in the analysis did not change the pattern or significance of results and thus all participants were included in subsequent analyses.

Effect of Identity Management Strategy and Affect on Supportiveness of Confidant Response

Hypotheses 3 and 4 predicted that the use of claiming or high affective content would result in more positive/supportive confidant responses during a disclosure than the use of downplaying or low affective content, respectively. It was found that the disclosure strategies of claiming with low affect (b=-10.42, p=.04), downplaying with high affect (b=-11.22, p=.026), downplaying with low affect (b=-12.54, p=.014) all significantly predicted a lower likelihood of participants responding with a positive confidant response behavior as compared to control. It was

also found that the disclosure strategies of downplaying with high affect (b=21.96, p=.025) and downplaying with low affect (b=*26.38*, p=.008) significantly predicted a higher likelihood of participants responding with a negative confidant response behavior as compared to control. Thus, there is partial support for hypothesis three, downplaying leads to more negative confidant responses, and no support for hypothesis four, affect largely does not influence confidant responses.

Post-hoc mean comparisons were evaluated to examine how specific conditions (claiming/downplaying, high/low affect, and control) predict confidant responses. These analyses revealed that participants were more likely to respond with emotional support when presented with control (M = 82.19, SD = 27.05) than they were when presented with downplaying with high affect (M = 61.35, SD = 39.21) or downplaying with low affect (M = 64.71, SD = 36.03). These findings are in the expected direction, downplaying one's mental illness, regardless of affect, decreases the likelihood of receiving a supportive confidant response.

Participants were more likely to respond with instrumental support when presented with control (M = 79.13, SD = 23.83) than they were when presented with claiming with low affect (M = 62.86, SD = 29.16), downplaying with high affect (M = 60.19, SD = 34.28) or downplaying with low affect (M = 55.71, SD = 33.27). No significant differences were found for likelihood of responding with appraisal support or informational support.

Participants were more likely to respond with insulting behavior when presented with downplaying with high affect (M = 38.68, SD = 45.27) and downplaying with low affect (M = 38.71, SD = 47.26) than they were when presented

with control (*M* = 14.90, *SD* = 27.19). In other words, downplaying one's mental illness, regardless of affect, results in a higher likelihood of a negative confidant response. Additionally, participants were more likely to respond with avoidance when presented with downplaying with low affect (*M* = 42.20, *SD* = 44.98) than when presented with control (*M* = 18.41, *SD* = 28.02).

Post-hoc tests revealed that participants were more likely to respond with denial of symptoms when presented with downplaying with low affect (*M* = 42.46, *SD* = 48.63) than they were when presented with claiming with high affect (*M* =37.70, *SD* =46.10). Participants were more likely to respond with denial of symptoms when presented with downplaying with low affect (*M* = 37.70, *SD* = 46.08) and downplaying with high affect (*M* = 42.46, *SD* =48.63) than they were when presented with control (*M* =14.25, *SD* =28.56). In other words, downplaying one's mental illness diagnosis, regardless of affect, results in a higher likelihood of receiving a negative confidant response.

Finally, participants were more likely to respond with denial of assistance when presented with downplaying with high affect (*M* = 35.59, *SD* = 46.52) and downplaying with low affect (*M* = 42.31, *SD* = 49.53) than when they were presented with control (*M* = 10.81, *SD* = 28.92). Post-hoc tests also revealed that participants were more likely to respond with denial of assistance when presented with downplaying with low affect (*M* = 42.31, *SD* = 49.52) than they were when presented with claiming with high affect (*M* = 20.06, *SD* = 38.86; see Table 15 for all post-hoc comparisons). Differences are in the predicted direction such that disclosures which

included downplaying resulted in a higher likelihood of receiving a negative/unsupportive confidant response.

The results of this study show that disclosures which include downplaying as an identity management strategy result in a higher likelihood of receiving a negative confidant response and a lower likelihood of receiving a positive confidant response when compared to both a disclosure including claiming as an identity management strategy and a disclosure which did not incorporate any identity management strategy (control). Additionally, disclosures which include claiming as an identity management strategy do not result in a higher likelihood of receiving a positive confidant response as compared to disclosures which include downplaying as an identity management strategy or are absent of an identity management strategy (control). High affect does not lead to a higher likelihood of receiving a positive confidant response as predicted, and in fact, both high and low affect in combination with downplaying lead to a higher likelihood of receiving a negative confidant response.

Exploratory Moderation Analysis

A series of individual characteristics were included as exploratory moderators. Given that there was no variance in reaction choice when supportive and unsupportive responses were collapsed in the previous analyses, I went directly to assessing the influence of the moderating variables on likelihood of responding with each of the eight possible response behaviors. Dummy coded condition was regressed on the likelihood of responding with each response option with the control condition as the comparison condition. Gender and family member mental illness status were

included as control variables for regressions in which they were not the focus. Each of the five exploratory moderator variables were included as interaction terms in separate regressions.

Family member mental illness status did not significantly moderate any relationships between condition and likelihood of responding in a certain way. Gender was found to significantly moderate the likelihood of responding with emotional support and instrumental support as a function of disclosure strategy. First, it was found that gender significantly moderates the likelihood of responding with emotional support when participants are presented with a downplaying with low affect disclosure as compared to control (b=-34.34, p=.046; Figure 6). Specifically, men are significantly less likely to respond with emotional support when presented with a downplaying with low affect disclosure as compared to control (b=-37.72, p=.005) while women are not significantly less likely to respond with emotional support when presented with a downplaying with low affect disclosure as compared to control (b=-3.38, p=.753). Second, it was found that gender significantly moderates the likelihood of responding with instrumental support when participants are presented with a downplaying with low affect disclosure as compared to control (b=-33.32, p=.026; Figure 7). Specifically, men are significantly less likely to respond with instrumental support when presented with a downplaying with low affect disclosure as compared to control (b=-43.23, p<.001) but again, women are not significantly less likely to respond with instrumental support when presented with a downplaying with low affect disclosure as compared to control (b=-9.91, p=.291; Figure 7). Gender did not significantly moderate any other relationships.

An individual's propensity to feel empathic concern for others was found to significantly moderate the likelihood of responding with appraisal support and informational support as a function of disclosure strategy. First, empathic concern significantly moderates the likelihood of responding with appraisal support when presented with a claiming with high affect disclosure (*b*=-45.63, *p*=.018; Figure 8), a claiming with low affect disclosure (*b*=-32.89, *p*=.05; Figure 9), and a downplaying with low affect disclosure (*b*=-40.82, *p*=.025; Figure 10) all as compared to control. Specifically, individuals who are high in empathic concern (1 SD above the mean) are significantly less likely to respond with appraisal support when presented with a claiming with high affect disclosure (b=-24.90, p=.048) and a downplaying with low affect disclosure (*b*=-21.93, *p*=.045) as compared to control. Individuals who are high in empathic concern are also less likely to respond with appraisal support when presented with a claiming with low affect disclosure (*b*=-19.68, *p*=.073) as compared to control, though not significantly. Individuals who are low in empathic concern (1 SD below the mean) are more likely to respond with appraisal support when presented with a claiming with high affect disclosure (*b*=17.99, *p*=.118), a claiming with low affect disclosure (*b*=11.24, *p*=.306), and a downplaying with low affect disclosure (*b*=16.45, p=.17) as compared to control, though not to a significant extent.

Second, empathic concern significantly moderates the likelihood of responding with informational support when participants are presented with a downplaying with high affect disclosure (*b*=-43.31, *p*=.012; Figure 11) and a downplaying with low affect disclosure (*b*=-36.01, *p*=.049; Figure 12) as compared to

control. Specifically, participants high in empathic concern are less likely to respond with informational support when presented with a downplaying with high affect disclosure (*b*=-26.01, *p*=.015) and a downplaying with low affect disclosure (*b*=-21.04, *p*=.056) as compared to control. Participants low in empathic concern are more likely to respond with informational support when presented with a downplaying with high affect disclosure (*b*=14.70, *p*=.203) and a downplaying with low affect disclosure (*b*=12.82, *p*=.294) as compared to control, though not significantly.

Finally, it was found that participants who are higher in empathic concern for others are more likely to show emotional support (*b*=12.95, *p*=.038) overall. Empathic concern does not impact the likelihood of responding with emotional support for any specific disclosure strategy however.

It was found that participants who are higher in perspective taking are more likely to show emotional support (*b*=11.22, *p*=.024) and are less likely to avoid (*b*=-11.64, *p*=.041) overall. An individual's perspective taking propensity did not moderate the relationship between support and disclosure strategy however.

An individual's propensity to feel anxiety and discomfort in the face of another persons emotions significantly moderated the likelihood of responding with appraisal support and informational support. It was found that participants who have a higher propensity for personal distress were significantly less likely to respond with appraisal support when presented with a claiming with high affect disclosure as compared to control (*b*=-28.76, *p*=.023; Figure 13), when presented with a claiming with low affect disclosure as compared to control (*b*=-35.97, *p*=.005; Figure 14), and when presented with a downplaying with high affect disclosure as compared to

control (*b*=-33.21, *p*=.009; Figure 15). Specifically, individuals high in personal distress (1 SD above the mean) are less likely to respond with appraisal support when presented with a claiming with high affect disclosure (b=-21.74, p=.055), a claiming with low affect disclosure (*b*=-25.75, *p*=.014), and a downplaying with high affect disclosure (*b*=-18.87, *p*=.081) as compared to control. Individuals who are low in personal distress (1 SD below the mean) are more likely to respond with appraisal support when presented with a claiming with high affect disclosure (*b*=12.53, *p*=.227), a claiming with low affect disclosure (*b*=17.11, *p*=.12), and a downplaying with high affect disclosure (*b*=20.7, p=.05) as compared to control.

Second, it was found that participants who have a higher propensity for showing personal distress were significantly less likely to respond with informational support when presented with a downplaying with high affect disclosure as compared to control (*b*=-26.62, *p*=.041; Figure 16). Specifically, participants high in personal distress are significantly less likely to respond with informational support when presented with a downplaying with high affect disclosure (*b*=-23.47, *p*=.034) as compared to control whereas participants low in personal distress are more likely to respond with informational support when presented with a downplaying with high affect disclosure (*b*=8.25, *p*=.443) as compared to control.

Exploratory Mediation Analysis

Identity centrality, motivation to disclose, and willingness to talk and answer questions were analyzed using the PROCESS macro for SPSS (Hayes, 2013). In this set of analyses, all conditions were compared to control. To begin, identity centrality was examined as a potential mediator of the impact of identity management strategy

on likelihood of responding with each support behavior. Gender and family mental illness status were included as control variables. The identity management strategy of claiming with high affect was found to significantly impact evaluations of identity centrality (*b*=.78, *p*=.002) such that when claiming with high affect was used as an identity management strategy, participants saw the identity of having a mental illness as more central to the person disclosing. There were no significant mediation effects however; identity centrality did not impact evaluations of likelihood of responding in a particular way. No other identity management strategies were found to be related to evaluations of identity centrality.

Two motivations to disclose were assessed, disclosing because people will find out anyway and disclosing because you want people to know. Participants were asked to infer the motivation as to why the discloser was disclosing their diagnosis. The identity management strategy of downplaying with high affect was found to be significantly related to the motivation of finding out anyway (*b*=-.467, *p*=.05) such that when someone downplays their mental illness with high affect while disclosing the confidant is less likely to think that the motivation behind the disclosure is because the confidant would find out anyway as compared to control. No significant effects were found between identity management strategy, the motivation to disclose because the discloser wants the confidant to know, and likelihood of responding with a particular support behavior.

Participants were also asked two questions about whether they thought the individual disclosing would be willing to talk further about their diagnosis and whether they thought the individual would be receptive to questions. Willingness to

talk more and being receptive to answering further questions were not found to be related to identity management strategy or affect nor were they found to be related to likelihood of responding with a particular support behavior, thus these exploratory mediators were not found to be significant.

Study 3: Discussion

The purpose of Study 3 was to examine which method(s) of mental illness disclosure elicit the most supportive confidant reactions. Results from this study partially supported the predicted hypotheses. Likelihood of responding to a disclosure with each of the eight presented support behaviors were assessed. These analyses revealed that it is really the combination of behaviors, identity management and affect, that have the strongest effect on predicting confidant response behaviors. In particular, claiming does not positively predict a supportive confidant response, affective content largely does not impact confidant responses, and downplaying results in a higher likelihood of encountering a negative confidant response, at both high and low affective content. The finding that claiming one's mental illness does not result in a positive or supportive confidant response is particularly interesting. One potential explanation for this is that stigma against mental illness is still too high and people are not yet at a point where they would be receptive to an individual proudly discussing having a mental illness.

Gender and a range of individual characteristics were found to significantly moderate the likelihood of responding with a particular confidant response behavior when presented with a particular disclosure strategy as compared to others. Men were

significantly less likely to respond with emotional or instrumental support when presented with a downplaying with low affect disclosure as compared to control. Women on the other hand did not exhibit a significant difference between likelihood of responding with emotional or instrumental support when presented with a downplaying with low affect disclosure as compared to control. This could be because women are more likely to provide support in general no matter the disclosure strategy.

Individuals higher in propensity to perspective take were overall more likely to provide emotional support and less likely to avoid, which is in the expected direction as those high in perspective taking are more likely to spontaneously adopt another's point of view.

An individual's propensity to feel empathic concern for others was found to significantly moderate the likelihood of responding with appraisal support and informational support as a function of disclosure strategy. Individuals high in empathic concern were more likely to provide support, appraisal and informational, when presented with the control disclosure as compared to both claiming and downplaying disclosures at high and low affective content levels. Individuals low in empathic concern did not exhibit any significant differences in likelihood of providing support. These findings are consistent with Davis' (1983) work showing that individuals higher in empathic concern show more concern for others as well as showing more selflessness. An individual's propensity to feel anxiety and discomfort as a result of another's emotions significantly moderated the likelihood of responding with appraisal support and informational support. Similar to empathic concern,

individuals high in personal distress were more likely to provide support, appraisal and informational, when presented with the control disclosure as compared to both claiming and downplaying disclosures at high and low affective content levels. Individuals low in personal distress did not exhibit any significant differences in likelihood of providing support, except when presented with a downplaying with high affect disclosure where they were more likely to provide appraisal support as compared to when presented with control.

One possible explanation for these findings is that the claiming and downplaying manipulations somehow inherently signal that the individual does not need help or support and as such participants who are higher in feeling empathy for others are more in tune with this signal and thus provide less support when a supposed coworker claims or downplays their mental illness diagnosis. This is in contrast to the control condition in which less information is provided where participants do not know what/if the individual disclosing needs support perhaps signaling to confidants high in empathic concern that they are in need of more support. Additionally, perhaps when an individual discloses in an emotional way this leads those high in personal distress to feel more anxiety and discomfort leading them to not know how to react. In the control condition where less information is provided perhaps these participants feel less anxiety and discomfort and are therefore freed to respond in a supportive way.

Identity management strategy was found to be significantly related to evaluations of identity centrality and evaluations of motivation behind the disclosure but these were not found to mediate the effect of identity management strategy on

likelihood of response behavior. The finding that downplaying was found to be related to lower perceptions of identity centrality aligns with the core message of downplaying as an identity management strategy as depicted in Lyons and colleagues' work (2016). However, the findings suggest that perceptions of identity centrality do not impact confidant responses. Identity management strategy was also not found to be related to perceptions of willingness to talk and answer questions. It is interesting that claiming and downplaying do not impact perceptions of willingness to talk or answer questions because claiming signals a level of comfortableness with their diagnosis which in turn signals a level of comfortableness in talking about it. One potential explanation is that when someone discloses something so personal others may not feel they can ask questions or talk further with the discloser unless the discloser explicitly opens the door to do so, which was not the case in the disclosures presented to participants.

Finally, affective content was not found to be related to evaluations of identity centrality, motivations to disclose, or willingness to talk and answer questions nor were these variables found to mediate the effect of affective content on likelihood of response behavior. Expression of feelings or affect is a key component of Reis and Shaver's (1988) model of intimacy in disclosure so these findings are counter to their model. One reason for this could be that the affective content manipulation was not strong enough or perhaps claiming and downplaying overshadowed any impact that affective content could have had on participant's perceptions of identity centrality.

While the findings from this study do not provide a blueprint for how to obtain a supportive response to disclosure of a mental illness at work, they do provide

some evidence for strategies that do not work well when disclosing a mental illness (i.e., downplaying) because they lead to a higher likelihood of receiving a negative or unsupportive confidant response.

General Discussion

Mental illness diagnoses are highly prevalent among the working adult population; it is estimated that one in four adults suffers from a diagnosable mental illness in the United States and that this number may rise to 55% by 2020 (Martin, Wood, & Dawkins, 2015). In the workplace, employees with a mental illness regularly encounter situations where they must make decisions regarding the extent to which they discuss their stigma. When an individual decides to disclose their illness the response that they receive has important implications. For example, when the confidant responds in a supportive manner it is beneficial to the individual disclosing (Chaudoir & Quinn, 2010; Griffith & Hebl, 2002). However, research has not yet extended our understanding of supportive confidant responses to the workplace nor has it defined what constitutes an unsupportive confidant response. Additionally, there is evidence to suggest that people are often unsure of how to best respond to a disclosure (Martin, Woods, Dawkins, 2005) and that those disclosing a stigma are often uncertain of how to do so (Ragins, 2008). This work takes an initial step in exploring the interaction between discloser and confidant during a mental illness disclosure and thereby further develops the literature pertaining to disclosures of mental illness at work.

In an initial study, a typology of support behaviors was created from qualitative accounts from employed individuals recounting incidents in which they

had disclosed a mental illness at work. Other frameworks of social support have been put forth (e.g. House, 1981; Ullman, 2000) and this typology provides support for those that have come before it while also generalizing social support frameworks to stigma disclosure. From these other frameworks of social support it seems that positive support behaviors may be more universal as compared to negative support behaviors where I saw more deviations in collected responses compared to past frameworks. Thus, another contribution of this work is that it elaborates and moves forward our understanding of negative social reactions.

Specifically, the following behaviors are seen as supportive: emotional support which is characterized by concern, listening, caring, and affect; appraisal support which is characterized by affirmation, feedback, and providing information that is relevant to self-evaluation; informational support which is characterized by providing advice, suggestions, and directions; and instrumental support which is characterized by providing the person with information that they can use in coping. This typology also details a set of behaviors that are not seen as positive, helpful, or supportive. These negative support behaviors include: insulting behavior which is characterized by being judgmental, not listing, and not showing empathy; denial of symptoms which is characterized by denying that the individual has any problems or thinking they are exaggerating; avoidance which is characterized by changing the subject or glossing over information shared; denial of assistance which is characterized by dismissing a request for accommodations or denying the presence of an illness; and future negative behavior which is characterized by termination or exclusion.

This typology contributes to both research and practice by providing a framework for how to respond to mental illness disclosures and perhaps more importantly how not to respond to mental illness disclosures. Providing this typology to employees, especially managers who are often the target of disclosures and who have reported being unsure of how to best respond (Martin, Woods, Dawkins, 2015), has the potential to inform managers and other employees of specific response strategies. If employees are more aware of positive response strategies to utilize and negative response strategies to avoid perhaps fewer individuals with a mental illness at work will encounter negative confidant reactions.

The next goal of this work was to understand if there is a disconnect in how individuals with and without a mental illness perceive the supportiveness of confidant response behaviors. It is known from prior work that non-stigmatized individuals often feel uncomfortable or awkward when interacting with a stigmatized individual (Hebl, Tickle, Heatherton, 2000) and that cancer patients found confidant responses to be more negative than they may have appeared to the confidants themselves (Dakof & Taylor, 1990). In the present work, it was found that individuals with and without a mental illness do have different perceptions of confidant responses to mental illness disclosure at work, but only for some response behaviors. In particular, it was found that all participants view supportive responses (collapsed across all possible supportive response behaviors) similarly, as hypothesized. An interesting aspect of participants perceptions of positive support behaviors, which was uncovered by examining the interaction between mental illness status and specific behaviors, is that those without a mental illness are not fully able to appreciate the supportiveness

of emotional support. The pattern of perceptions for positive support behaviors is consistent across mental illness status but individuals with a mental illness view emotional support to be significantly more supportive than other positive support behaviors, a distinction that is smaller for those without a mental illness.

In addition, as hypothesized, it was found that all individuals view negative support behaviors (collapsed across all possible negative response behaviors) as negative but that individuals with a mental illness view these confidant response behaviors as more negative than those without a mental illness. These results replicate the previously discussed work that has been done with cancer patients (Dakof & Taylor, 1990). This is interesting as it suggests again that those without a mental illness are not able to fully take the perspective of those with a mental illness, though they get close. These findings again highlight the utility of this information when thinking about application. They suggest that one must acknowledge that those without a mental illness perceive the information differently than those with a mental illness. So, when providing information about appropriate confidant responses one should introduce a level of perspective taking to lessen the gap between those with and without a mental illness.

This work also shows that emotionally supportive responses are perceived to be the most supportive, especially by those with a mental illness which again points to a potential target for organizational trainings. Ultimately, these results confirm that positive support behaviors are seen positively and should be used as response strategies as opposed to negative support behaviors which are seen negatively and thus should be avoided. This is especially true given that we know positive confidant

responses lead to long term psychological benefits and greater job satisfaction (Chaudoir & Quinn, 2010; Griffith & Hebl, 2002).

Another goal for this work was to evaluate the effectiveness of disclosure strategies in eliciting supportive confidant responses. In Study 3, I found that downplaying with high or low affect as a disclosure strategy led to a higher likelihood of the confidant responding with a negative response, specifically the negative support behaviors of insulting behavior, avoidance, denial of symptoms, and denial of assistance. Claiming however was not found to lead to a higher likelihood of an individual responding in a positive or supportive manner, as predicted, which could be for a few different reasons. Lyons and colleagues (2016) find in their work that claiming is a more effective strategy for positively influencing others' perceptions of an individual with a physical disability as compared to downplaying as a strategy. In this case, they find that claiming one's physical disability positively influences how competent others view the disabled individual to be. The current study differs from prior work in that I am not investigating physical disabilities but rather mental illness diagnosis. As such, the differences in these stigmas could be an explanation for why I find that claiming is not a positive disclosure strategy for employees with a mental illness. Further, this work also does not examine evaluations of competence. So perhaps even if competence evaluations are improved by claiming a mental illness this does not translate to the type of support given.

Another possible explanation of why claiming did not result in a higher likelihood of responding in a supportive manner is that mental illness diagnoses are still highly stigmatized (58% of Americans do not want someone with a mental

illness in their workplace; Pescosolido, 2013) and that claiming an identity with such negative stereotypes would never lead to a positive confidant response. For example, one study finds that the core facets predicting stigmatization of those with a mental illness are a perception that the individual with the disorder is personally responsible for their disorder and dangerous (Feldman & Crandall, 2007). Additionally, individuals diagnosed with a mental illness are often viewed as incompetent, unsuccessful, and unintelligent, biasing others' views of their ability to complete their jobs (Farina, Fischer, Boudreau, & Belt, 1996; Sibicky & Dovidio, 1986). Claiming one's stigma is proposed to operate as a positive identity management strategy by positively influencing competence perceptions. As competence perceptions are increased the negative stereotypes surrounding a stigma are proposed to diminish. Perhaps the stereotype of incompetence for those with a mental illness is so strong that it supersedes any of the positive aspects of claiming that work for other types of stigmas or like previously mentioned, perhaps increased perceptions of competence do not translate to confidant responses.

The present work is consistent with Lyons and colleagues (2016) in that they find downplaying does not lead to improved evaluations of an individual with a physical disability, suggesting that downplaying is not an effective strategy when disclosing a mental illness at work. In this work we find that downplaying does not lead to support. One possible explanation for this is that downplaying as a disclosure strategy inherently signals that one does not need support. If downplaying does in fact signal this, it makes sense that if the individual disclosing a mental illness downplays

their diagnosis, the person they are disclosing to would not be likely to provide support but in fact more likely to provide a negative response.

From Study 1 though we see that employed individuals do receive supportive responses, thus there is more work to be done to understand the circumstances and aspects of how those supportive responses occur. For instance, acknowledging one's mental illness rather than claiming it may be more likely to lead to a positive confidant response. Acknowledging one's stigma has been shown to have positive effects on evaluations of the stigmatized by signaling that the individual is comfortable with their identity (Hebl, Tickle, & Heatherton, 2000). This has been shown to be true for individuals acknowledging their sexual orientation such that job applicants who acknowledge their gay and lesbian sexual orientation encountered less interpersonal discrimination (Singletary & Hebl, 2009). In another study, however, acknowledging one's gender as compared to verbalizing gendered traits did not have positive effects on job applicant evaluations (Wessel, Hagiwara, Ryan, Kermond, 2014). One potential explanation for why acknowledging one's stigma is positive for gay and lesbian individuals but not for women is that acknowledging is most effective when discussing stigmas that are not encountered as frequently (e.g. mental illness) because acknowledging a stigma diminishes any awkwardness or uncertainty on the confidant's part of what they should say or how they should act around the individual (Hebl et al., 2000). Acknowledging as an identity management strategy is very close to the control condition in this study in which the individual is depicted as simply stating that they have depression. The control condition consistently resulted in the highest likelihood of encountering a positive confidant response, suggesting that

acknowledging may be a beneficial disclosure strategy for individuals with a mental illness.

Affective content on the other hand may have had no effect on likelihood of response behavior for either supportive or unsupportive responses independent of identity management strategy because the potential positive benefits of affective content may not be effective in such a short time frame (a 20-minute lab session). Reis and Shaver's (1988) model of relationship intimacy posits that disclosures which include a higher level of affective content lead to more intimacy in the relationship. In the context of this study however participants read a vignette with an imagined coworker rather than experiencing a real-time disclosure with an actual coworker. In this case, the imagined paradigm may have diminished the true effect of intimacy building. Or perhaps because intimacy builds over time a single incident in which someone discloses something with high affect is not strong enough to induce an effect.

Limitations and Future Directions

Results from these studies contribute to the research on stigma disclosure and mental health status in the workplace, however there are a few limitations. First, this study only examined the experiences of individuals with the stigma of mental illness. Thus, more research should be conducted to better understand how these findings may or may not generalize to other stigmas. Second, Studies 2 and 3 portrayed individuals with only the diagnosis of depression and thus future research should incorporate other mental illness diagnoses. For instance, internalizing disorders are characterized by keeping ones struggles to oneself (e.g. anxiety disorders, depression

disorders) while externalizing disorders are characterized by maladaptive behaviors directed toward an individual's environment (e.g. schizophrenia, bipolar disorder). The differences in how these mental illness disorders manifest may engender different confidant responses regardless of the method of disclosure because of the stereotypes associated with each disorder. For example, the public perception of schizophrenia and mania are more negative than the public perception of depression (Norman, Sorrentino, Windell, & Manchanda, 2008; Roehrig & McLean, 2010) and it has been found that individuals with depression are perceived as less dangerous than those with schizophrenia (Crisp, Gelder, Goddard, Meltzer, 2005; Crisp, Gelder, Rix, Meltzer, Rowlands, 2000; Link, Phelan, Bresnahan, Stueve, Pescosolido, 1999; Phelan & Basow, 2007). Perhaps because of these stereotype differences individuals with different mental illness diagnosis would need to adopt different disclosure strategies.

As previously stated, this study only examined the experiences of individuals with a mental illness and therefore more research should be conducted to better understand how these findings may or may not generalize to other stigmas. For instance, Lyons and colleagues (2016) found that claiming as an identity management strategy was beneficial for those with a physical disability. That was not the case in the present work however, highlighting how different identity management strategies may or may not generalize to other stigmas. Individuals with a criminal past, a non-heterosexual orientation, or a substance abuse problem are also stigmatized and, like those with a mental illness, must weigh their options when it comes to disclosing this information about themselves. Individuals with a criminal past are stereotyped as

untrustworthy and dangerous (Falk, 2001) while gay males are seen as less masculine and more feminine and lesbian women are seen as more masculine and less feminine (Taylor, 1983). Similar to those with a criminal past, individuals with substance abuse problems are stigmatized as being dangerous and unpredictable (Schomerus, Lucht, Holzinger, Matschinger, Carta, Angermeyer, 2001) and as being personally responsible for their problem because of the choices they've made (Olsen, Richardson, Dolan, Menzel, 2011). Because the stereotypes associated with LGB individuals are not related to cognitive competency, similar to those with a physical disability, claiming may be a beneficial identity management or disclosure strategy. However, for stigmas more associated with an individuals mental capabilities, like those with a criminal past or those with substance abuse problems, the disclosure strategy of claiming may not be beneficial.

The examination of support behaviors from Study 1 should also be conducted with other stigmatized identities to understand if the typology of confidant responses, both supportive and unsupportive, is consistent across other identities. Given that House's (1981) framework for social support was generalizable to the mental illness disclosure sample collected here it is reasonable to expect that the positive support behaviors in the typology would generalize to other samples. Ullman's (2001) framework for negative social support was not as generalizable to the present sample however. Thus, conducting more qualitative work on identity management and disclosure strategies with other samples of individuals from different marginalized populations would further our understanding of the specific types of confidant reaction behaviors employees experience.

This work, apart from Study 1, does not have a high degree of ecological validity. For instance, vignette based studies are a useful place to start when understanding the concept space but they are not as realistic as an actual workplace and have come under criticism for being unrealistic (Hughes & Huby, 2002). Therefore, future work that gets closer at understanding the dynamics between discloser and confidant in a realistic work environment will enhance this work. A study which would investigate this could be a daily diary study surveying employees with mental illnesses as to their disclosure decisions and the confidant responses they receive as a result of their disclosures. Even though vignettes are not as realistic as an actual workplace, vignette studies maintain a high degree of internal validity and in this work the examples of real disclosure events taken from Study 1 to develop materials for Studies 2 & 3 increase the overall validity of the work.

Another limitation related to ecological validity for this study is that the vignettes state that the participant "has a relationship with this person that does not extend much beyond the bounds of work." This is fairly vague and in an actual work environment it is more likely that someone will disclose to a coworker once they have an established and trusting relationship (Chaudori & Fisher, 2010; Wessel, 2017). The ambiguity of this could have induced the participants to feel that the person disclosing was more or less an acquaintance and as such changed their response choices. However, because relationships can be complex, depicting a simple relationship serves as a worthwhile starting point which can be built off of in future studies by increasing details depicting the coworker relationship.

Next, this study does not address how motivations of the discloser impacts their choice for disclosure strategy but this is an important piece of the equation and should be included in future research. For instance, people disclose for different reasons (e.g. to obtain accommodations, explain gaps in employment, explain specific behaviors; Ellison et al, 2003; Goldberg et al, 2005) and it is unrealistic to think that a single disclosure strategy will be suitable for all people and situations. Thus, future work should investigate the motivations of the discloser, how these motivations impact their choice of disclosure strategy, and how these motivations impact the confidant response. One example of a future study to conduct in this vein is one that replicates the present work of claiming and downplaying and crosses it with seeking accommodations versus no accommodation seeking. If both downplaying and claiming inherently signal that no help is needed perhaps this explains the lack of support provided but when crossed with seeking accommodations it may signal something different. For instance, seeking accommodations signals a need for help and by signaling a need for help one may be more likely to encounter a supportive confidant response.

The results of the third study do not conclusively provide a guide for disclosure strategies that maximally elicit a supportive response. A grim outlook on the present findings is that disclosure of a mental illness leads to a higher likelihood of a negative confidant response. However, there are many more identity management strategies (e.g. counterfeiting, avoiding, integrating, Woods 1994; revealing, concealing, Clair, 2005; acknowledging, Hebl, Tickle, & Heatherton, 2000)

and thus future research should explore the impact that other identity management strategies have on eliciting supportive confidant responses.

Another limitation of this work is that the vignettes crossed identity management strategy with affect which did not allow for teasing apart the independent effects of claiming/downplaying and high/low affect. This could be improved by including a control condition that is not absent of both identity management and affective content but rather having two versions of a control condition, one which features identity management and the other which features affect. This would help tease apart the effect that was found in this work where the combination of behaviors seems to be driving the prediction of confidant response. However, the present design allowed for an important examination, how identity management and affect combined predict likelihood of confidant responses. This ultimately showed that claiming does not positively predict a supportive confidant response, affective content largely does not impact confidant responses, and downplaying results in a higher likelihood of encountering a negative confidant response, at both high and low affective content levels.

Conclusion

Overall, the present work is the first of its kind to establish a typology of support behaviors used in response to disclosures of mental illness in the workplace. This work also provides evidence for how response behaviors are perceived and when certain disclosure strategies lead to a particular response behavior. Specifically, individuals without a mental illness view supportive responses to be supportive and unsupportive responses to be unsupportive but they do not fully appreciate just how

supportive or unsupportive confidant response behaviors are as compared to the perceptions of those with a mental illness. Additionally, claiming and high affective content do not ensure a supportive confidant response but downplaying, no matter the affective content, predicts a negative confidant response. This line of research is far from complete, however. Future research should continue to investigate mental illness disclosure at work as it is an encounter that many employees will experience whether they are the discloser or the confidant

Tables

Table 1. Examples of Disclosure Incidents

	Response	Participant Characteristics
Supportive	She asked questions, showed caring, leaned in and put her hand on my arm. Clearly was concerned and wanted to help or at least provide some solace and comfort. She shared about her own struggles in the past.	39-year-old female working in Health Care
	I had to leave my desk and take a walk around the building. Likewise, I went outside for fresh air to cool off my brain. I then returned to work and still could not focus, so I asked for the day off. Immediately I was allowed to go home and was told to take time to get better, relax for the weekend. What was supportive was their belief in me that I needed a breather and allowing me to get one, than being forced to continue working under stress, anger and suicidal thoughts.	19-year-old male working in Business/Finance
	She asked me questions about how I deal with my depression, what hypomania is like and if I'm on medication. She seemed interested and non-judgmental.	25-year-old female working in Education
	I disclosed that I have bipolar disorder to my boss. She has been extremely supportive, and when I further disclosed about manic episodes occurring, she was patient, giving me space to go about my day at a pace I could at that moment. Her nonjudgmental attitude was the most significant for me.	35-year-old female working in Education
Unsupportive	Notice that they look at me more closely. When I've had a bad day or something has upset me they seem to get a bit nervous. As if I was going to totally lose it and do something outrageous. They have asked me "what do I have to be depressed about," which is depressing in itself.	58-year-old female working in Health Care
	The colleague I spoke with did not know how to continue our conversation. I shared my situation in a context of general discussion of mental health disorders in middle	33-year-old female working in Education

school students. The colleague made a quick reason to end the discussion and left my office.		
Person was clearly uncomfortable, lost eye contact, changed topic to something else and did not bring it up again, seemed like they wanted to end the conversation.	39-year-old female working in Health Care	
They were afraid of me and acted weird around me and wanted to get me fired. They would walk around me and say words like crazy. Then someone started talking about the mentally ill people who kill people.	33-year-old female working in Education	

Table 2. Typology of Supportive and Unsupportive Responses to Mental Illness Disclosure

	Category	Frequency (%)	Definition	Example
Supportive	Emotional	60.0	Esteem, trust, concern, listening, empathy, caring, love, affect.	"She stayed quiet and listened and then tried to be understanding"
	Appraisal	34.3	Affirmation, feedback, social comparison. Information is relevant to self-evaluation (social comparison).	"She shared about her own struggles in the past"
	Informational	14.3	Advice, suggestions, directives.	"Told me that I will get better and told me to seek professional help and not to worry what others think"
	Instrumental	14.3	Aid in kind, money, labor, time, modifying the environment, physical assistance. Providing a person with information that the person can use in coping with personal and environmental problems. Helping people to help themselves.	"Shortly after the conversation they gave me contact information for a family member of theirs who was a mental health professional"

	Insulting Behavior	42.9	Judgmental, condescension, not receiving empathy.	"The person overlooked what I said & said that he only wanted the old me back"
	Denial of Symptoms	31.4	Denying or downplaying presence of an illness or symptomatic behaviors through thinking person is using their mental illness as an excuse. Relating personal stories when they are not related.	"Told me that everyone, even he, feels depressed which made my depressed thoughts and feelings feel downplayed"
Unsupportive	Avoidance	20.0	Changing the subject or glossing over the disclosure, silence, standoffish, immediate change in non-verbal behavior towards the discloser. Glossing over information shared.	"Ignored or glossed over my disclosure of struggling with mental illness"
	Denial of Assistance	34.3	Denying presence of an illness or symptomatic behaviors through dismissing request for accommodations or support.	"Get over it, let it go, put your big girl panties on"
	Future negative behavior	22.9	Termination, exclusion.	"Speaking to me differently behind my back, not inviting me to lunch anymore"

Table 3. Descriptive Statistics and Paired Samples t-test Comparison of Outcome Variables for All Participants and By Perspective

	All Participants		**Discloser Perspective**		**Confidant Perspective**			
	M	***sd***	***M***	***sd***	***M***	***sd***	***t***	***p***
Emotional Support	4.40	.794	4.43	.777	4.37	.629	-.227	.821
Appraisal Support	4.25	.726	4.39	.737	4.15	.705	1.61	.112
Informational Support	2.65	.857	2.76	.829	2.54	.875	1.72	.090
Instrumental Support	3.97	.858	3.99	.878	3.95	.844	-.077	.929

Insulting Behavior	1.58	.823	1.49	.744	1.66	.888	-1.08	.282
Avoidance	1.53	.632	1.50	.568	1.55	.690	-.025	.980
Denial of Assistance	1.39	.734	1.37	.721	1.39	.750	.381	.704
Denial of Symptoms	1.49	.713	1.47	.728	1.51	.713	.298	.767

Table 4. Factor Loadings for 6-item Measure of Support for Each Confidant Response

Factor Loading	**Emotional Support**	**Appraisal Support**	**Informational Support**	**Instrumental Support**	**Insulting Behavior**	**Avoidance**	**Denial of Symptoms**	**Denial of Assistance**
Supportive	.888	.893	.892	.904	.900	.876	.892	.803
Negative	-.678	-.580	-.589	-.723	-.668	-.494	-.568	-.683
Helpful	.846	.883	.891	.897	.909	.875	.912	.883
Useful	.866	.833	.905	.891	.913	.859	.852	.886
Well-Intentioned	.858	.858	.699	.816	.819	.726	.739	.841
Reversed	-.783	-.810	-.808	-.803	-.906	-.799	-.823	-.853
α Reliability	.902	.898	.882	.916	.908	.827	.865	.898

Table 5. Hypothesis 1 & 2 Model Testing

Fixed Effect	**Model coefficient (standard error)**
Intercept	1.69**(.0577)
Controls	
L2Gender	.02(.048)
L2Family Member	-.075(.059)
Predictors	
L2Mental Illness	-.391**(.076)
L1Valence	2.14**(.066)

L2Mental Illness X L1Valence	.384**(.098)

Note. $p < .05$*, $p < .01$**; Gender (0=female, 1=male); Family Member = Family member mental illness status (0=no, 1=yes); Mental Illness Diagnosis (0=no, 1=yes); Valence (0=Negative, 1=Positive).

Table 6. Model Exploration – Comparison of Positive Support Behaviors

Fixed Effects	**Model 1** coefficient (standard error)	**Model 2** coefficient (standard error)	**Model 3** coefficient (standard error)
Intercept	4.41**(.092)	4.40**(.085)	4.23**(.091)
Controls			
L2 Gender	.041(.081)	.056(.078)	.056(.078)
L2 Family Member	-.048(.099)	.014(.096)	.016(.096)
Predictors			
L2 Mental Illness Diagnosis	-.014(.099)	-.068 (.095)	.294**(.119)
L1 Appraisal Support	-.149*(.074)	-.149*(.043)	-.136*(.059)
L1 Informational Support	-1.76**(.074)	-1.76**(.087)	-1.36**(.111)
L1 Instrumental Support	-.435**(.074)	-.435**(.064)	-.221**(.085)
L2MI Diagnosis * L1Appraisal			-.028 (.087)
L2MI Diagnosis * L1Informational			-.859**(.163)
L2MI Diagnosis * L1Instrumental			-.461**(.125)
Random Effects	**Model 1** variance	**Model 2** variance	**Model 3** variance
Intercept	.17	.423	.394
L1Appraisal Support		.137	.146
L1Informational Support		1.09	.923
L1Instrumental Support		.518	.475

Residual	.457	.088	.085

Note. $p < .05$*, $p < .01$**; Support behaviors dummy coded with emotional support as comparison condition; Mental Illness Diagnosis (0=no, 1=yes).

Table 7. Frequency Comparisons of *Best* Response Options Between Participants With and Without a Mental Illness

Response Choice	**With a mental illness (%)**	**Without a mental illness (%)**
Emotional Support	44 (57%)	42 (47%)
Appraisal Support	21(27%)	25 (28%)
Informational Support	0 (0%)	1 (1%)
Instrumental Support	12(15%)	17 (19%)
Total	77	85

Table 8. Model Exploration – Comparison of Negative Support Behaviors

Fixed Effects	**Model 1** coefficient (standard error)	**Model 2** coefficient (standard error)	**Model 3** coefficient (standard error)
Intercept	1.61**(.090)	1.57**(.088)	1.60**(.094)
Controls			
L2 Gender	-.001(.089)	.021(.084)	.021(.084)
L2 Family Member	-.102(.107)	-.068(.103)	-.068(.103)
Predictors			
L2 Mental Illness Diagnosis	-.384**(.104)	-.365**(.103)	-.432**(.122)
L1 Insulting Behavior	.189**(.051)	.189**(.057)	.195*(.078)
L1 Avoidance	.139*(.051)	.139*(.052)	.082 (.071)
L1 Denial of Symptoms	.101*(.051)	.101*(.045)	.082 (.062)
L2MI Diagnosis * L1Insulting Behavior			-.010 (.114)
L2MI Diagnosis * L1Avoidance			.121 (.105)
L2MI Diagnosis * L1Denial of Symptoms			.041 (.091)

Random Effects	**Model 1**	**Model 2**	**Model 3**
	variance	variance	variance
Intercept	.267	.424	.424
L1Insulting Behavior		.408	.411
L1Avoidance		.326	.325
L1Denial of Symptoms		.212	.213
Residual	.218	.065	.064

Note. $p < .05$*, $p < .01$**; Support behaviors dummy coded with denial of assistance as comparison condition; Family Member = Family member mental illness status (0=no, 1=yes); Mental Illness Diagnosis (0=no, 1=yes).

Table 9. Frequency Comparisons of *Worst* Response Options Between Participants With and Without a Mental Illness

Response Choice	**With a mental illness (%)**	**Without a mental illness (%)**
Insulting Behavior	15 (19%)	19 (21%)
Avoidance	1 (1%)	8 (9%)
Denial of Symptoms	22 (29%)	15 (17%)
Denial of Assistance	38 (50%)	41 (46%)
Total	76	83

Table 10. Means and Standard Deviations for Pilot Tested Vignettes

	Claiming (*sd*)	**Downplaying (*sd*)**	**Affect (*sd*)**
Claiming with High Affect	5.52 (.994)	3.86 (1.66)	5.22 (1.24)
Claiming with Low Affect	5.52 (1.41)	3.82 (1.72)	4.22 (1.44)
Downplaying with High Affect	4.09 (1.61)	4.30 (1.65)	4.90 (1.41)
Downplaying with Low Affect	3.85 (1.59)	4.85 (1.75)	3.45 (1.67)

Table 11. Descriptive Statistics of Key Variables of Interest

	M	***sd***
Emotional Support	69.30	34.46
Appraisal Support	60.05	31.16
Informational Support	49.69	32.30
Instrumental Support	65.11	30.38
Insulting Behavior	28.98	41.35
Avoidance	29.00	42.56
Denial of Assistance	32.27	39.41
Denial of Symptoms	27.91	43.09
Identity Centrality	3.09	1.03
Find out anyway	2.89	1.03
Want confidant	3.88	.818
Willingness to talk	3.78	.763
Receptive to Questions	3.65	.753
Perspective Taking	3.84	.548
Empathic Concern	3.75	.470
Personal Distress	2.59	.596

Family Member = Family member mental illness status (0=no, 1=yes); Gender (0=female, 1=male); Mental Illness Diagnosis (0=no, 1=yes); Support behaviors listed indicate likelihood of responding with this behavior after reading disclosure incident (0-100 scale).

Table 12. Bivariate Correlations Between Key Variables of Interest

	Variable	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
1	Condition																		
2	Family Member	-.053																	
3	Gender	.012	-.100																

4	Emotional Support	.062	.059	.066														
5	Appraisal Support	.038	-.005	.003	.494**													
6	Informational Support	-.018	-.182*	.090	-.086	.207**												
7	Instrumental Support	.051	-.021	.017	.656**	.271**	-.202**											
8	Insulting Behavior	-.001	-.097	-.008	-.781**	-.323**	.356**	-.758**										
9	Avoidance	.013	-.099	-.008	-.803**	-.338**	.301**	-.805**	.964**									
10	Denial of Assistance	-.041	-.116	-.005	-.824**	-.431**	.236**	-.705**	.906**	.922**								
11	Denial of Symptoms	-.010	-.091	-.010	-.819**	-.366**	.269**	-.802**	.961**	.980**	.938**							
12	Identity Centrality	-.263**	-.121	.158*	.096	.051	.017	.090	-.091	-.092	-.083	-.116						
13	Find out anyway	-.058	-.122	.052	-.026	-.037	.174*	-.067	.088	.090	.066	.066	.226**					
14	Want confidant to know	-.032	.017	-.172*	.116	.075	-.092	.116	-.111	-.096	-.131	-.117	.062	-.182*				
15	Willingness to talk	-.090	-.033	-.088	.082	.066	-.049	.017	-.042	-.049	-.049	-.050	.056	-.015	.322**			
16	Receptive to Questions	-.081	-.010	-.125	.101	.108	.078	.006	-.034	-.049	-.057	-.028	.103	-.100	.158*	.486**		
17	Perspective Taking	-.054	.135	-.040	.166*	.129	.067	.092	-.116	-.146	-.179*	-.144	-.087	.054	.074	.084	.030	1
18	Empathic Concern	.107	.015	-.430**	.105	.078	.030	.105	-.067	-.084	-.107	-.069	-.151*	.054	.173*	.109	.138	.233**
19	Personal Distress	.020	-.049	-.183*	-.071	-.094	-.098	-.005	.020	.013	.067	.017	-.054	.042	.029	.067	.010	-.224**	.194*

Note. $p < .05$*, $p < .01$**; Family Member = Family member mental illness status (0=no, 1=yes); Gender (0=female, 1=male); Mental Illness Diagnosis (0=no, 1=yes); Support behaviors listed indicate likelihood of responding with this behavior after reading disclosure incident (0-100 scale).

Table 13. MANCOVA for Effect of Condition on Supportiveness of Confidant Response.

Variable	**Wilks' Lambda**	***F***	***df***	***p***
Family member mental illness	.923	1.628	8	.121
Gender	.986	.274	8	.974
Condition	.732	1.598	32	.021

Table 14. Tests of Between-Subjects Effects for Effect of Condition on Supportiveness of Confidant Response.

	Variable	**Sum of Squares**	***df***	**Mean Square**	***F***	***p***
Condition	Emotional Support	8691.776	4	2172.944	1.858	.120
	Appraisal Support	1419.213	4	354.803	.357	.839
	Informational Support	3825.251	4	956.313	.941	.442
	Instrumental Support	11283.098	4	2820.774	3.180	.015
	Insulting behavior	15195.048	4	3798.762	2.278	.063
	Denial of Symptoms	17494.059	4	4373.515	2.489	.045
	Avoidance	10090.128	4	2522.532	1.650	.164
	Denial of Assistance	19754.578	4	4938.644	2.754	.030

Note. Support behaviors listed indicate likelihood of responding with this behavior after reading disclosure incident.

Table 15. Post-hoc Comparisons of Impact of Condition on Supportiveness of Confidant Response.

Dependent Variable	(I) Cond	(J) Cond	Mean Difference (I-J)	Std. Error	*p*	95% Confidence Interval for Difference	
						Lower Bound	Upper Bound
Emotional Support	Claiming with High Affect	C-LA	5.906	8.411	.484	-10.701	22.514
		D-HA	10.652	8.318	.202	-5.771	27.075
		D-LA	7.919	8.409	.348	-8.685	24.523
		Control	-9.689	8.565	.260	-26.602	7.223
	Claiming with Low Affect	C-HA	-5.906	8.411	.484	-22.514	10.701
		D-HA	4.746	8.064	.557	-11.178	20.669
		D-LA	2.013	8.233	.807	-14.244	18.269
		Control	-15.596	8.372	.064	-32.127	.936
	Downplaying with High Affect	C-HA	-10.652	8.318	.202	-27.075	5.771
		C-LA	-4.746	8.064	.557	-20.669	11.178
		D-LA	-2.733	8.131	.737	-18.787	13.322
		Control	**-20.341***	**8.270**	**.015**	**-36.671**	**-4.011**
	Downplaying with Low Affect	C-HA	-7.919	8.409	.348	-24.523	8.685
		C-LA	-2.013	8.233	.807	-18.269	14.244
		D-HA	2.733	8.131	.737	-13.322	18.787
		Control	**-17.609***	**8.398**	**.038**	**-34.191**	**-1.026**
	Control	C-HA	9.689	8.565	.260	-7.223	26.602
		C-LA	15.596	8.372	.064	-.936	32.127
		D-HA	**20.341***	**8.270**	**.015**	**4.011**	**36.671**
		D-LA	**17.609***	**8.398**	**.038**	**1.026**	**34.191**
Appraisal Support		C-HL	3.313	7.754	.670	-11.997	18.623

	Claiming with High Affect	D-HA	-4.730	7.668	.538	-19.871	10.410
		D-LA	.209	7.752	.978	-15.098	15.516
		Control	-3.323	7.896	.674	-18.914	12.268
	Claiming with Low Affect	C-HA	-3.313	7.754	.670	-18.623	11.997
		D-HA	-8.044	7.434	.281	-22.723	6.636
		D-LA	-3.104	7.590	.683	-18.090	11.882
		Control	-6.637	7.718	.391	-21.876	8.603
	Downplaying with High Affect	C-HA	4.730	7.668	.538	-10.410	19.871
		C-LA	8.044	7.434	.281	-6.636	22.723
		D-LA	4.940	7.496	.511	-9.861	19.740
		Control	1.407	7.624	.854	-13.647	16.461
	Downplaying with Low Affect	C-HA	-.209	7.752	.978	-15.516	15.098
		C-LA	3.104	7.590	.683	-11.882	18.090
		D-HA	-4.940	7.496	.511	-19.740	9.861
		Control	-3.533	7.742	.649	-18.820	11.755
	Control	C-HA	3.323	7.896	.674	-12.268	18.914
		C-LA	6.637	7.718	.391	-8.603	21.876
		D-HA	-1.407	7.624	.854	-16.461	13.647
		D-LA	3.533	7.742	.649	-11.755	18.820
Informational Support	Claiming with High Affect	C-HL	12.731	7.842	.106	-2.753	28.214
		D-HA	12.198	7.755	.118	-3.113	27.510
		D-LA	9.911	7.840	.208	-5.569	25.391
		Control	5.048	7.986	.528	-10.720	20.816
		C-HA	-12.731	7.842	.106	-28.214	2.753

	Claiming with Low Affect	D-HA	-.533	7.518	.944	-15.378	14.313
		D-LA	-2.820	7.676	.714	-17.976	12.336
		Control	-7.683	7.805	.326	-23.095	7.729
	Downplaying with High Affect	C-HA	-12.198	7.755	.118	-27.510	3.113
		C-LA	.533	7.518	.944	-14.313	15.378
		D-LA	-2.287	7.580	.763	-17.255	12.681
		Control	-7.150	7.710	.355	-22.375	8.074
	Downplaying with Low Affect	C-HA	-9.911	7.840	.208	-25.391	5.569
		C-LA	2.820	7.676	.714	-12.336	17.976
		D-HA	2.287	7.580	.763	-12.681	17.255
		Control	-4.863	7.830	.535	-20.323	10.597
	Control	C-HA	-5.048	7.986	.528	-20.816	10.720
		C-LA	7.683	7.805	.326	-7.729	23.095
		D-HA	7.150	7.710	.355	-8.074	22.375
		D-LA	4.863	7.830	.535	-10.597	20.323
Instrumental Support	Claiming with High Affect	C-HL	6.773	7.325	.356	-7.690	21.237
		D-HA	9.464	7.244	.193	-4.839	23.768
		D-LA	14.263	7.323	.053	-.197	28.724
		Control	-9.499	7.460	.205	-24.229	5.230
	Claiming with Low Affect	C-HA	-6.773	7.325	.356	-21.237	7.690
		D-HA	2.691	7.023	.702	-11.176	16.559
		D-LA	7.490	7.170	.298	-6.668	21.648
		Control	**-16.273***	**7.291**	**.027**	**-30.670**	**-1.876**
	Downplaying with	C-HA	-9.464	7.244	.193	-23.768	4.839
		C-LA	-2.691	7.023	.702	-16.559	11.176

	High	D-LA	4.799	7.081	.499	-9.183	18.781
	Affect	**Control**	**-18.964***	**7.203**	**.009**	**-33.186**	**-4.742**
	Downpla	C-HA	-14.263	7.323	.053	-28.724	.197
	ying with	C-LA	-7.490	7.170	.298	-21.648	6.668
	Low	D-HA	-4.799	7.081	.499	-18.781	9.183
	Affect	**Control**	**-23.763***	**7.314**	**.001**	**-38.205**	**-9.321**
	Control	C-HA	9.499	7.460	.205	-5.230	24.229
		C-LA	**16.273***	**7.291**	**.027**	**1.876**	**30.670**
		D-HA	**18.964***	**7.203**	**.009**	**4.742**	**33.186**
		D-LA	**23.763***	**7.314**	**.001**	**9.321**	**38.205**
Insulting Behavior	Claiming	C-HL	-11.265	10.043	.264	-31.096	8.565
	with	D-HA	-18.390	9.932	.066	-38.000	1.221
	High	D-LA	-18.230	10.041	.071	-38.056	1.596
	Affect	Control	5.027	10.228	.624	-15.168	25.222
	Claiming	C-HA	11.265	10.043	.264	-8.565	31.096
	with Low	D-HA	-7.125	9.629	.460	-26.138	11.889
	Affect	D-LA	-6.965	9.831	.480	-26.376	12.446
		Control	16.292	9.997	.105	-3.448	36.031
	Downpla	C-HA	18.390	9.932	.066	-1.221	38.000
	ying with	C-LA	7.125	9.629	.460	-11.889	26.138
	High	D-LA	.160	9.709	.987	-19.011	19.330
	Affect	**Control**	**23.416***	**9.875**	**.019**	**3.918**	**42.915**
	Downpla	C-HA	18.230	10.041	.071	-1.596	38.056
	ying with	C-LA	6.965	9.831	.480	-12.446	26.376
		D-HA	-.160	9.709	.987	-19.330	19.011

	Low Affect	**Control**	**23.257***	**10.028**	**.022**	**3.456**	**43.058**
	Control	C-HA	-5.027	10.228	.624	-25.222	15.168
		C-LA	-16.292	9.997	.105	-36.031	3.448
		D-HA	**-23.416***	**9.875**	**.019**	**-42.915**	**-3.918**
		D-LA	**-23.257***	**10.028**	**.022**	**-43.058**	**-3.456**
Denial of Symptoms	Claiming with High Affect	C-HL	-7.922	10.310	.443	-28.279	12.435
		D-HA	-16.657	10.195	.104	-36.788	3.475
		D-LA	**-21.326***	**10.308**	**.040**	**-41.679**	**-.974**
		Control	6.376	10.499	.545	-14.355	27.107
	Claiming with Low Affect	C-HA	7.922	10.310	.443	-12.435	28.279
		D-HA	-8.735	9.885	.378	-28.253	10.784
		D-LA	-13.405	10.092	.186	-33.332	6.522
		Control	14.297	10.262	.165	-5.966	34.561
	Downplaying with High Affect	C-HA	16.657	10.195	.104	-3.475	36.788
		C-LA	8.735	9.885	.378	-10.784	28.253
		D-LA	-4.670	9.967	.640	-24.349	15.009
		Control	**23.032***	**10.137**	**.024**	**3.016**	**43.049**
	Downplaying with Low Affect	**C-HA**	**21.326***	**10.308**	**.040**	**.974**	**41.679**
		C-LA	13.405	10.092	.186	-6.522	33.332
		D-HA	4.670	9.967	.640	-15.009	24.349
		Control	**27.702***	**10.295**	**.008**	**7.375**	**48.029**
	Control	C-HA	-6.376	10.499	.545	-27.107	14.355
		C-LA	-14.297	10.262	.165	-34.561	5.966
		D-HA	**-23.032***	**10.137**	**.024**	**-43.049**	**-3.016**

		D-LA	**-27.702***	**10.295**	**.008**	**-48.029**	**-7.375**
Avoidance	Claiming with High Affect	C-HL	-5.876	9.617	.542	-24.865	13.113
		D-HA	-6.342	9.510	.506	-25.121	12.436
		D-LA	-12.340	9.615	.201	-31.325	6.645
		Control	10.805	9.794	.272	-8.533	30.143
	Claiming with Low Affect	C-HA	5.876	9.617	.542	-13.113	24.865
		D-HA	-.467	9.221	.960	-18.674	17.740
		D-LA	-6.465	9.414	.493	-25.052	12.123
		Control	16.681	9.573	.083	-2.221	35.582
	Downplaying with High Affect	C-HA	6.342	9.510	.506	-12.436	25.121
		C-LA	.467	9.221	.960	-17.740	18.674
		D-LA	-5.998	9.297	.520	-24.355	12.359
		Control	17.147	9.456	.072	-1.524	35.819
	Downplaying with Low Affect	C-HA	12.340	9.615	.201	-6.645	31.325
		C-LA	6.465	9.414	.493	-12.123	25.052
		D-HA	5.998	9.297	.520	-12.359	24.355
		Control	**23.145***	**9.603**	**.017**	**4.184**	**42.106**
	Control	C-HA	-10.805	9.794	.272	-30.143	8.533
		C-LA	-16.681	9.573	.083	-35.582	2.221
		D-HA	-17.147	9.456	.072	-35.819	1.524
		D-LA	**-23.145***	**9.603**	**.017**	**-42.106**	**-4.184**
Denial of Assistance	Claiming with High Affect	C-HL	-8.119	10.416	.437	-28.686	12.448
		D-HA	-14.581	10.301	.159	-34.920	5.758
		D-LA	**-21.293***	**10.414**	**.042**	**-41.856**	**-.731**
		Control	9.789	10.607	.357	-11.156	30.734

Claiming with Low Affect	C-HA	8.119	10.416	.437	-12.448	28.686
	D-HA	-6.461	9.987	.519	-26.181	13.258
	D-LA	-13.174	10.196	.198	-33.306	6.958
	Control	17.908	10.368	.086	-2.564	38.381
Downplaying with High Affect	C-HA	14.581	10.301	.159	-5.758	34.920
	C-LA	6.461	9.987	.519	-13.258	26.181
	D-LA	-6.713	10.069	.506	-26.595	13.170
	Control	**24.370***	**10.242**	**.018**	**4.147**	**44.593**
Downplaying with Low Affect	**C-HA**	**21.293***	**10.414**	**.042**	**.731**	**41.856**
	C-LA	13.174	10.196	.198	-6.958	33.306
	D-HA	6.713	10.069	.506	-13.170	26.595
	Control	**31.082***	**10.401**	**.003**	**10.546**	**51.619**
Control	C-HA	-9.789	10.607	.357	-30.734	11.156
	C-LA	-17.908	10.368	.086	-38.381	2.564
	D-HA	**-24.370***	**10.242**	**.018**	**-44.593**	**-4.147**
	D-LA	**-31.082***	**10.401**	**.003**	**-51.619**	**-10.546**

Note. $p < .05$*, $p < .01$**; Claiming with High Affect (C-HA); Claiming with Low Affect (C-LA); Downplaying with High Affect (D-HA); Downplaying with Low Affect (D-LA). Bolded lines are statistically significant.

Figures

Figure 1. Interaction Between Emotional Support and Informational Support as a Function of Mental Illness Diagnosis

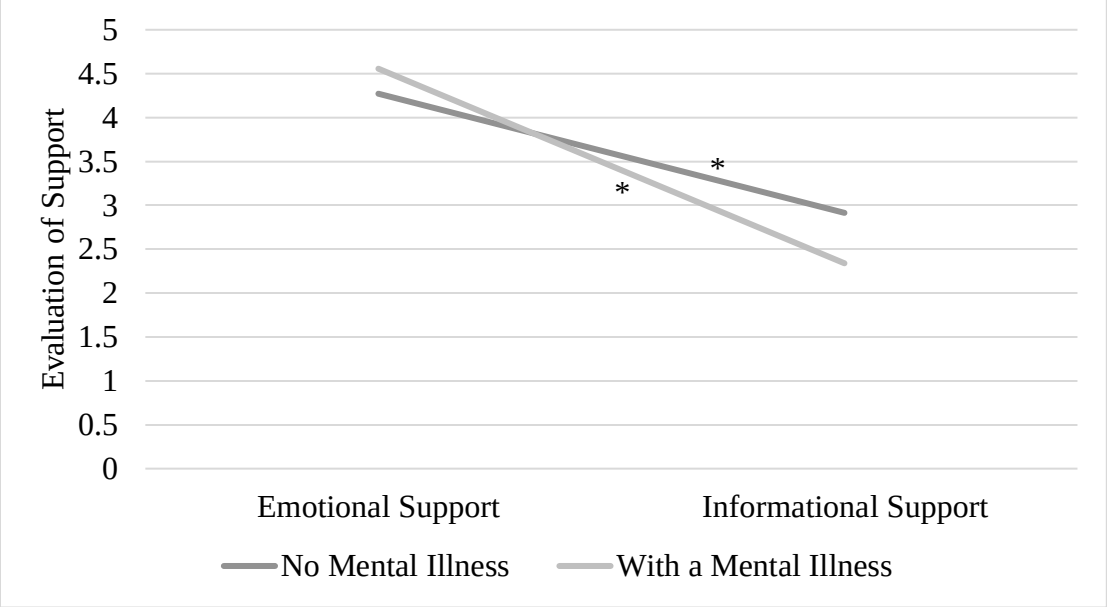


Figure 2. Interaction Between Emotional Support and Instrumental Support as a Function of Mental Illness Diagnosis

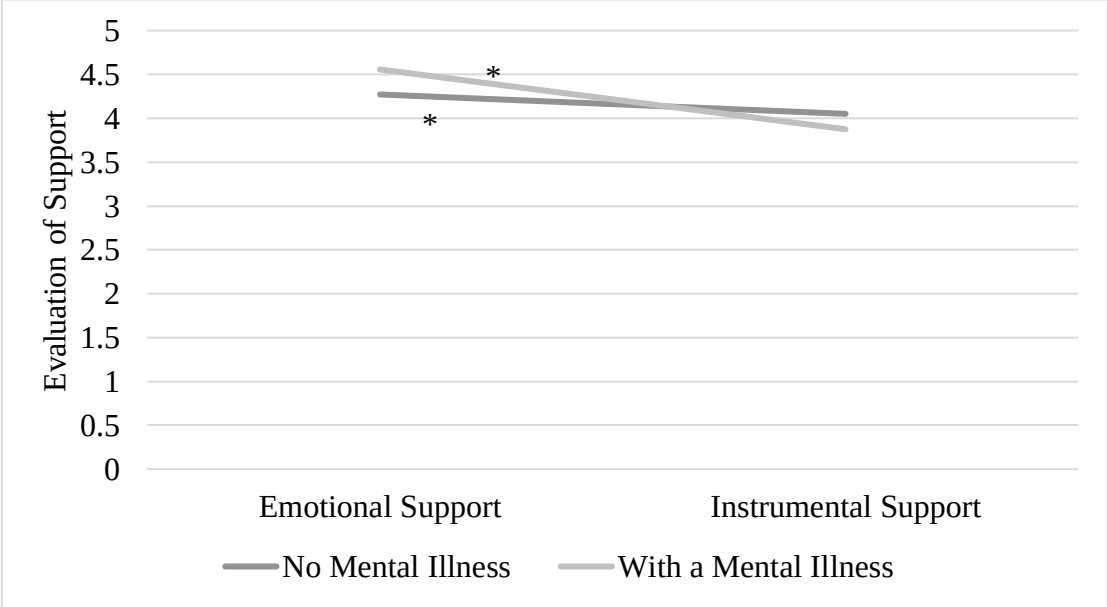


Figure 3. Interaction Between Emotional Support and Informational Support as a Function of Family Mental Illness Diagnosis

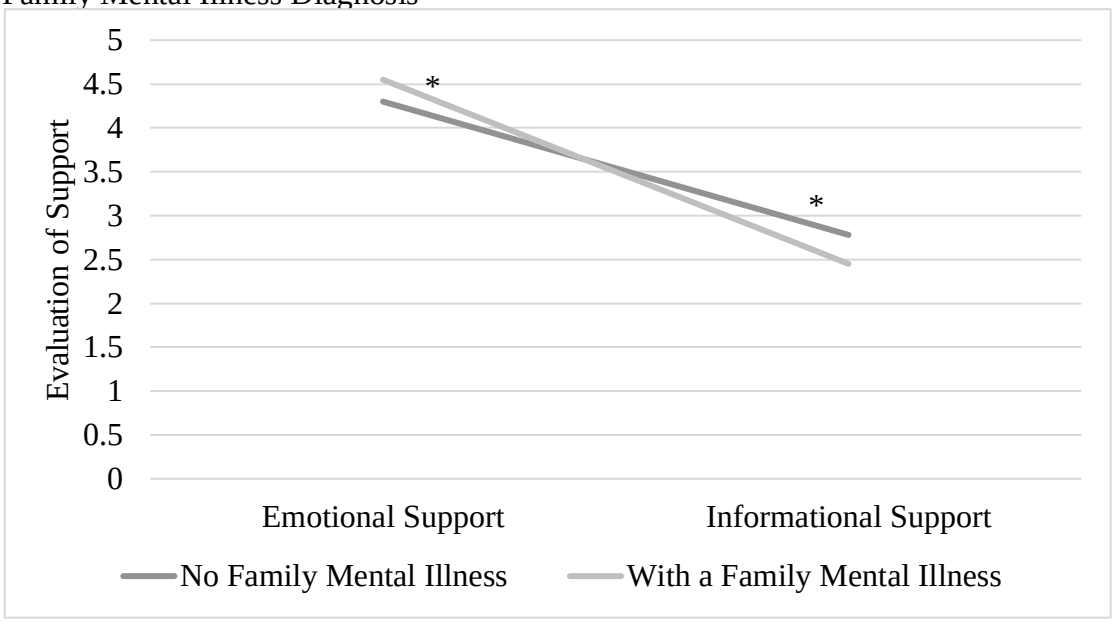


Figure 4. Interaction Between Emotional Support and Instrumental Support as a Function of Family Mental Illness Diagnosis

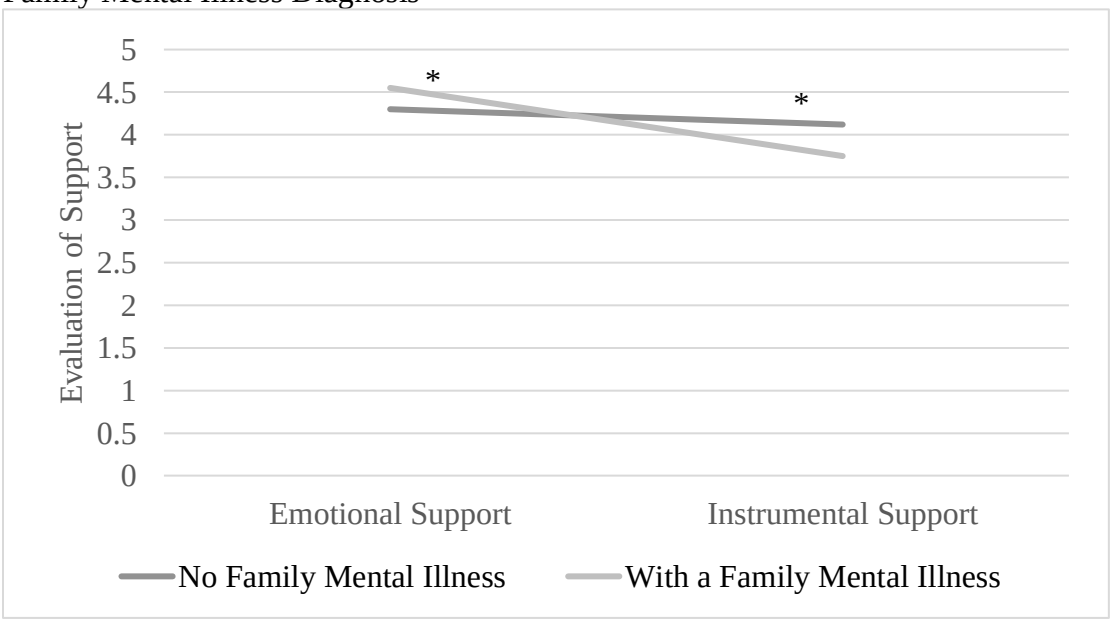


Figure 5. Interaction Between Denial of Assistance and Denial of Symptoms as a Function of Gender.

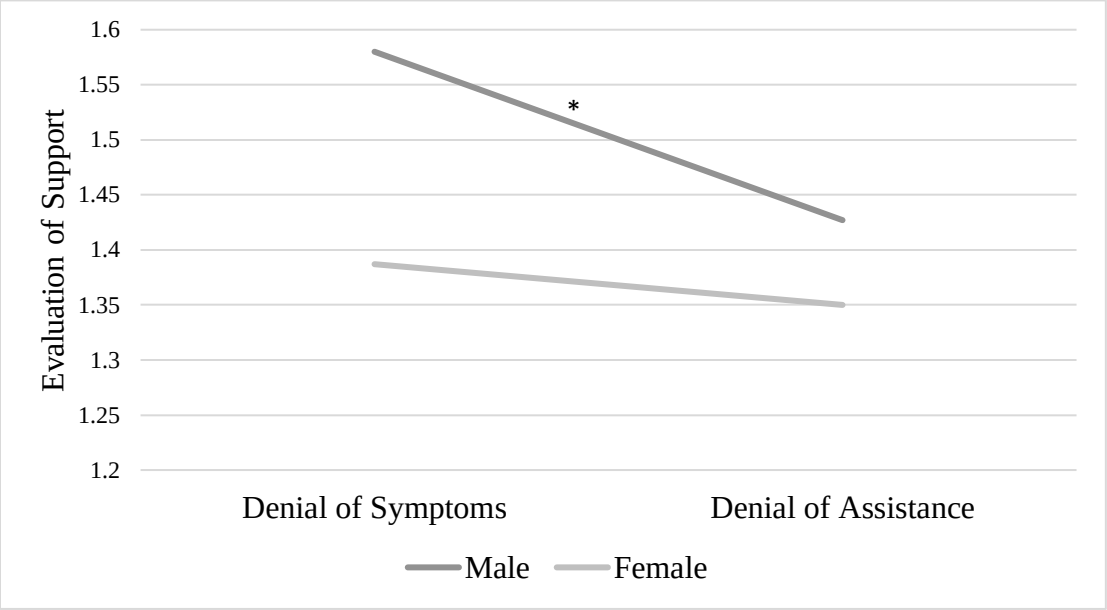


Figure 6. Interaction Between Disclosure Strategies and Gender on Likelihood of Responding with Emotional Support.

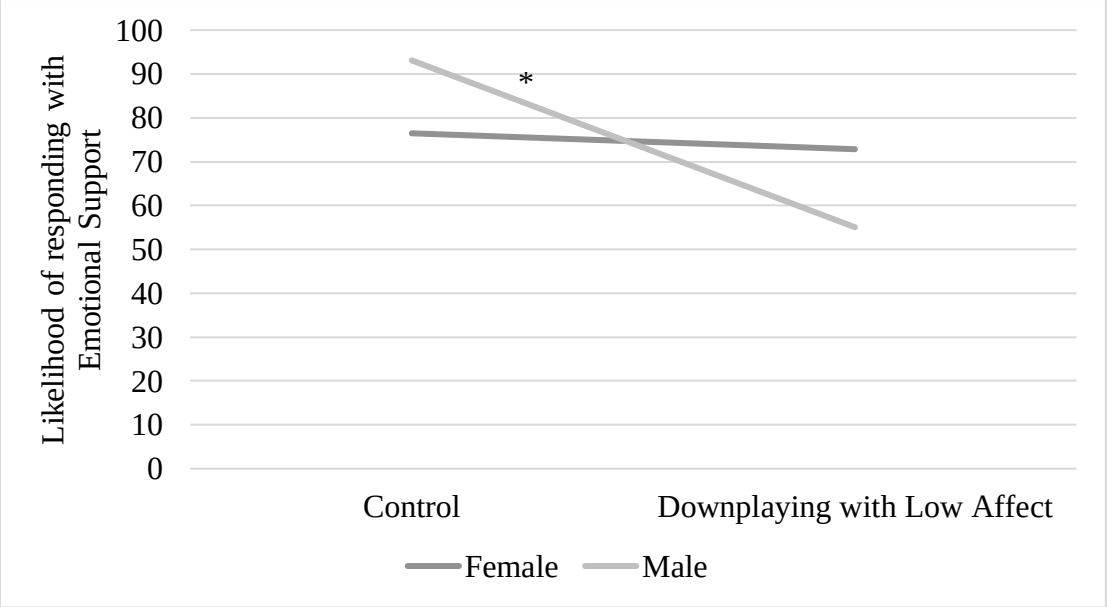


Figure 7. Interaction Between Disclosure Strategies and Gender on Likelihood of Responding with Instrumental Support.

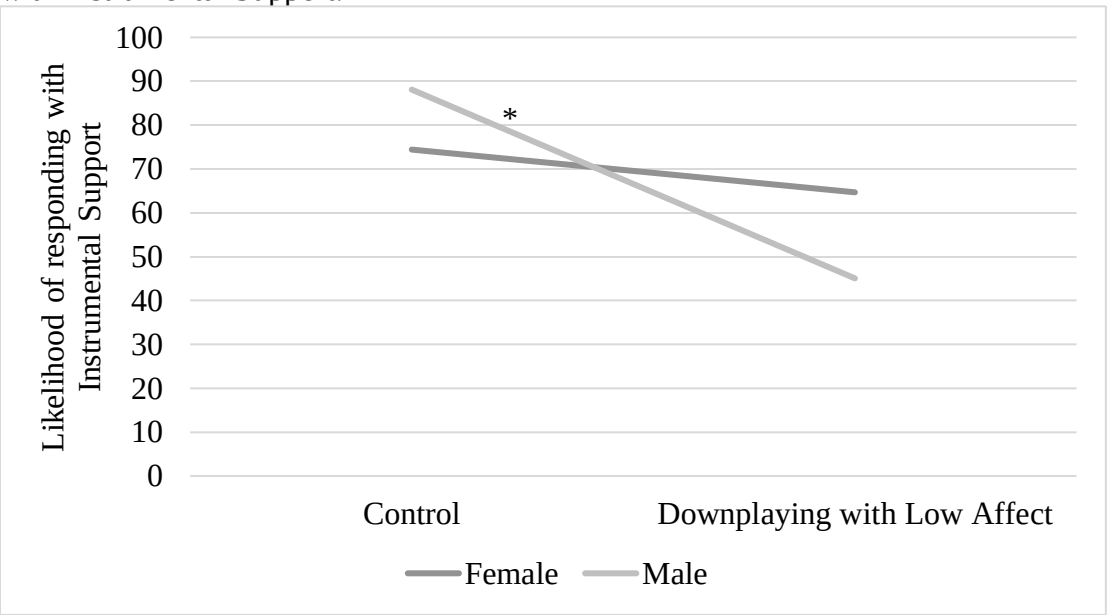
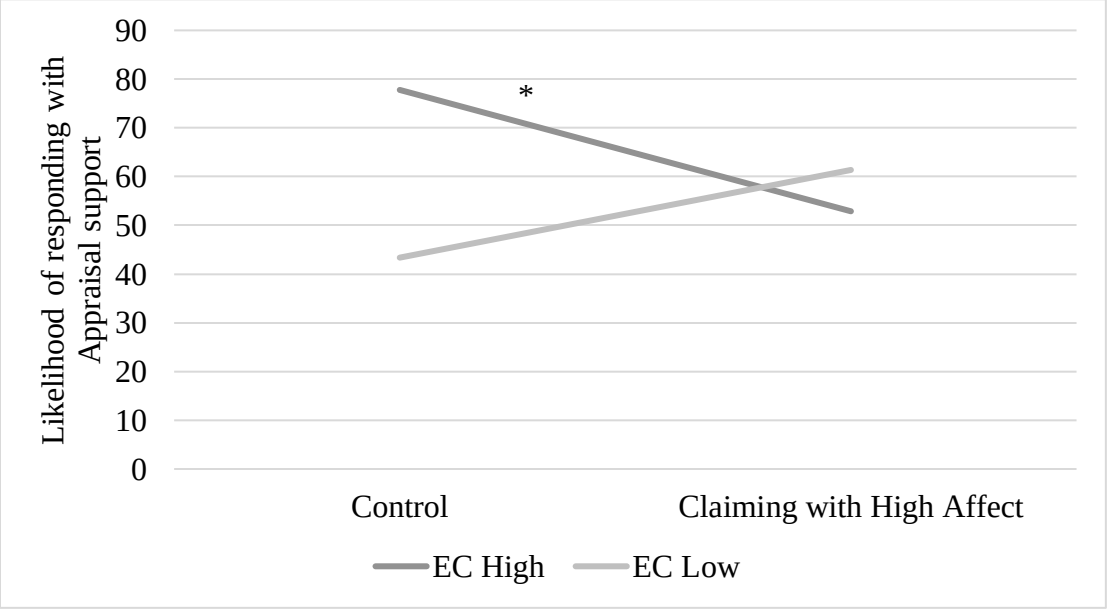
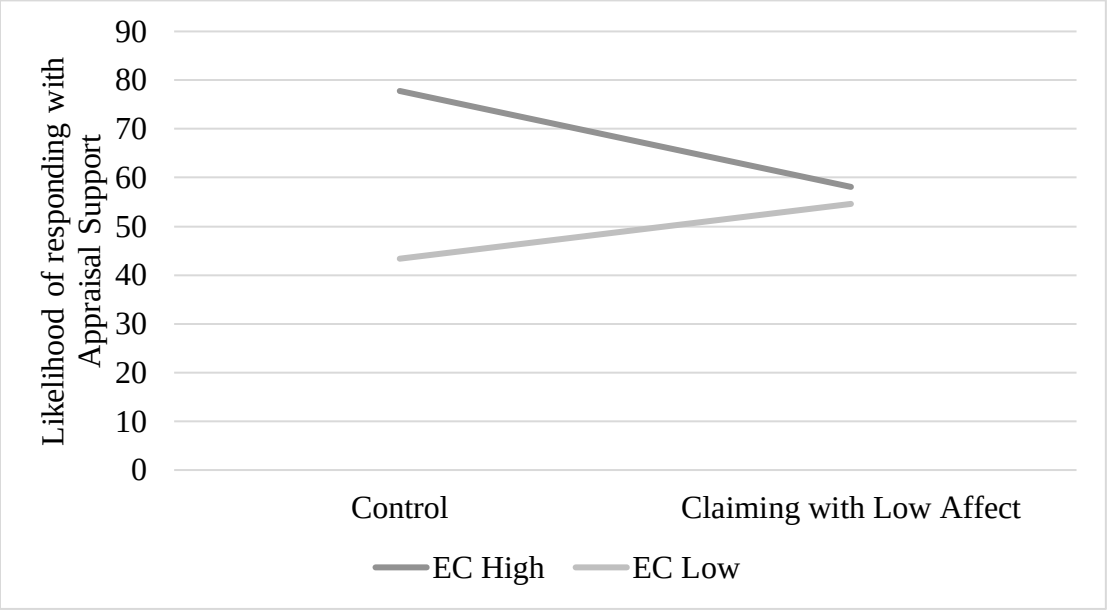


Figure 8. Interaction Between Disclosure Strategy (CHA and Control) and Empathic Concern on Likelihood of Responding with Appraisal Support.



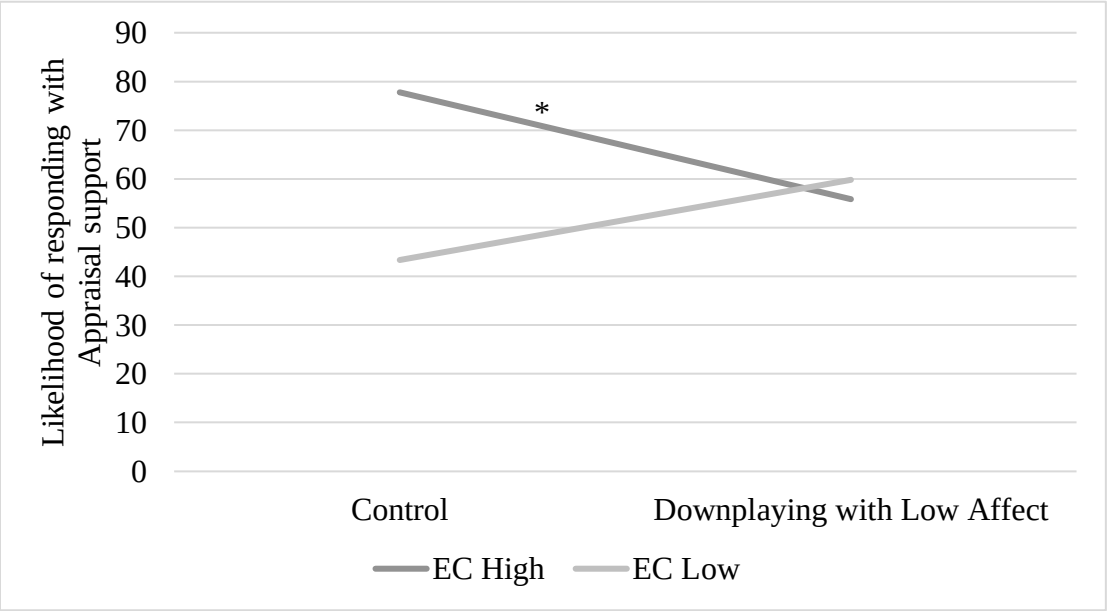
Note. EC High = Empathic Concern plus 1 standard deviation; EC Low = Empathic Concern minus 1 standard deviation.

Figure 9. Interaction Between Disclosure Strategy (CLA and Control) and Empathic Concern on Likelihood of Responding with Appraisal Support.



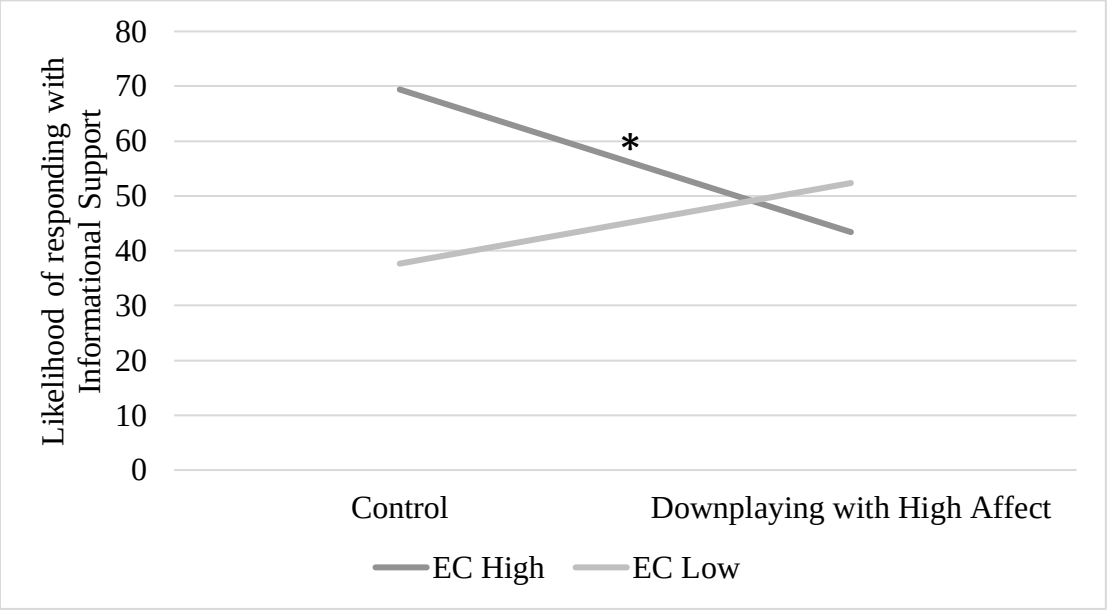
Note. EC High = Empathic Concern plus 1 standard deviation; EC Low = Empathic Concern minus 1 standard deviation.

Figure 10. Interaction Between Disclosure Strategy (DLA and Control) and Empathic Concern on Likelihood of Responding with Appraisal Support.



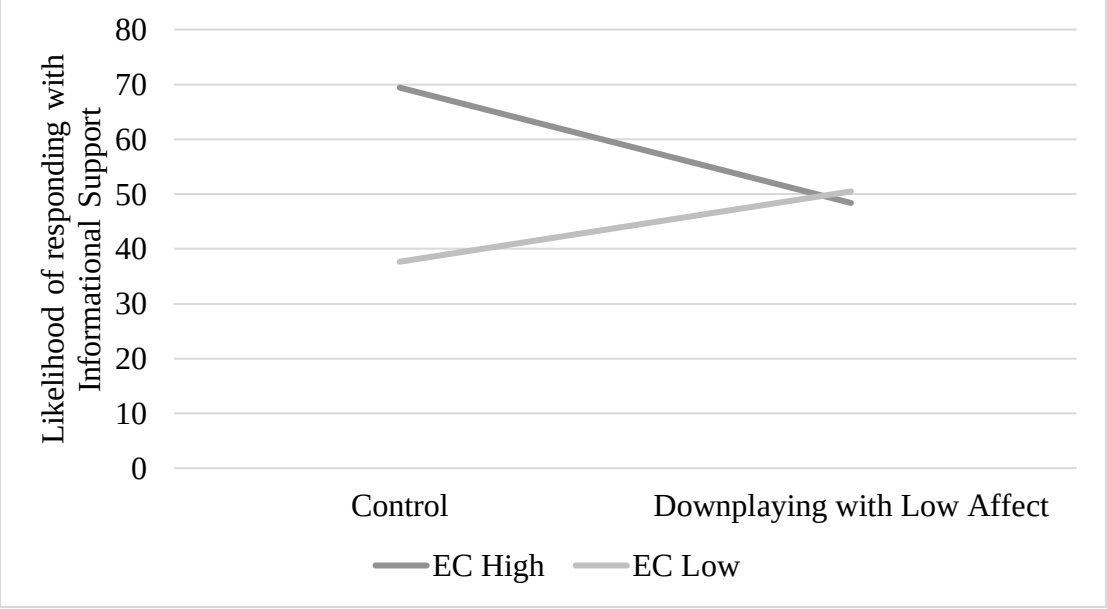
Note. EC High = Empathic Concern plus 1 standard deviation; EC Low = Empathic Concern minus 1 standard deviation.

Figure 11. Interaction Between Disclosure Strategy (DHA and control) and Empathic Concern on Likelihood of Responding with Informational Support.



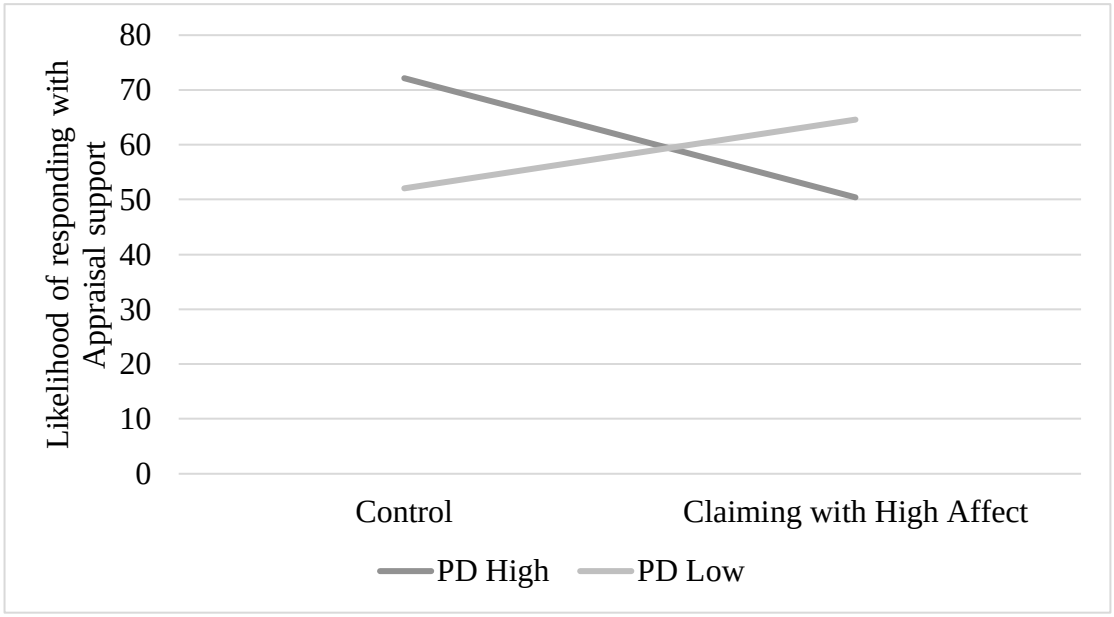
Note. EC High = Empathic Concern plus 1 standard deviation; EC Low = Empathic Concern minus 1 standard deviation.

Figure 12. Interaction Between Disclosure Strategy (DLA and control) and Empathic Concern on Likelihood of Responding with Informational Support.



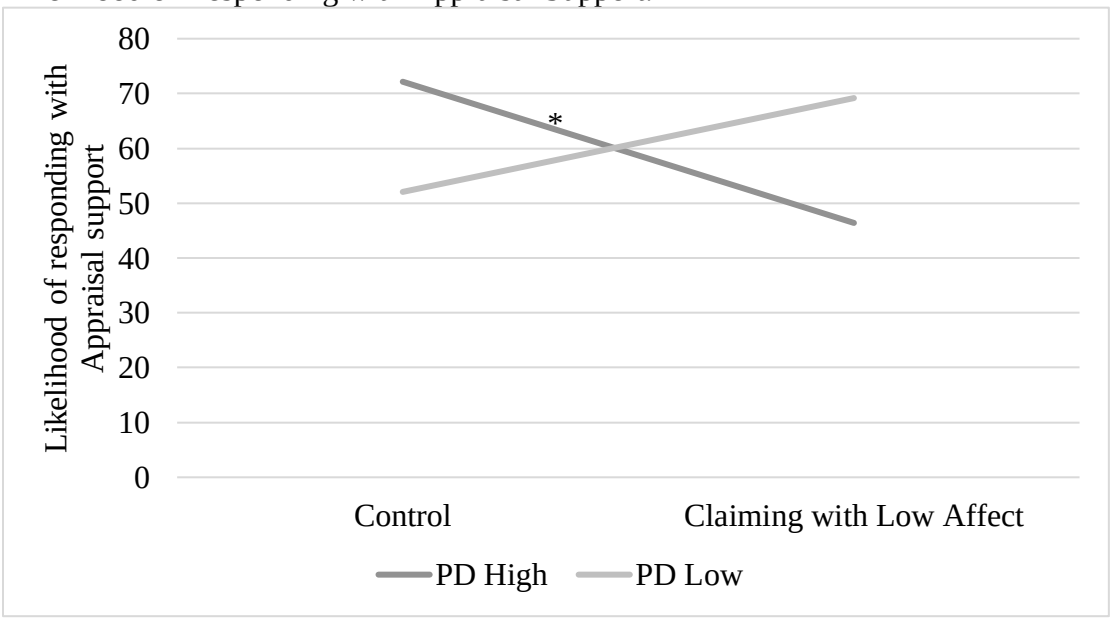
Note. EC High = Empathic Concern plus 1 standard deviation; EC Low = Empathic Concern minus 1 standard deviation.

Figure 13. Interaction Between Disclosure Strategy (CHA and control) and Personal Distress on Likelihood of Responding with Appraisal Support.



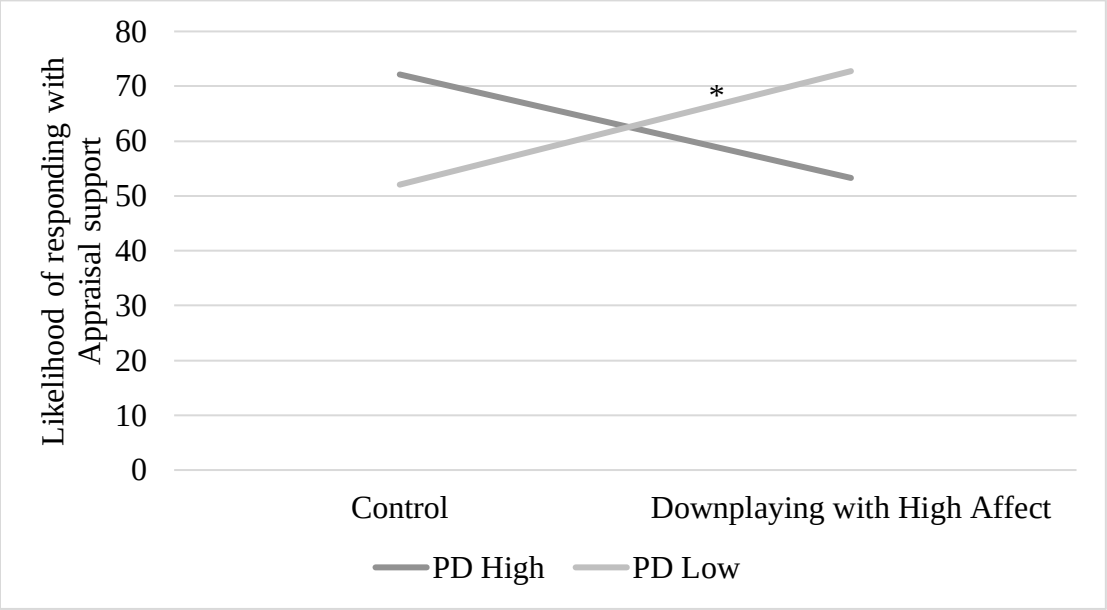
Note. PD High = Personal Distress plus 1 standard deviation; PD Low = Personal Distress minus 1 standard deviation.

Figure 14. Interaction Between Disclosure Strategy (CLA and control) and Personal Distress on Likelihood of Responding with Appraisal Support.



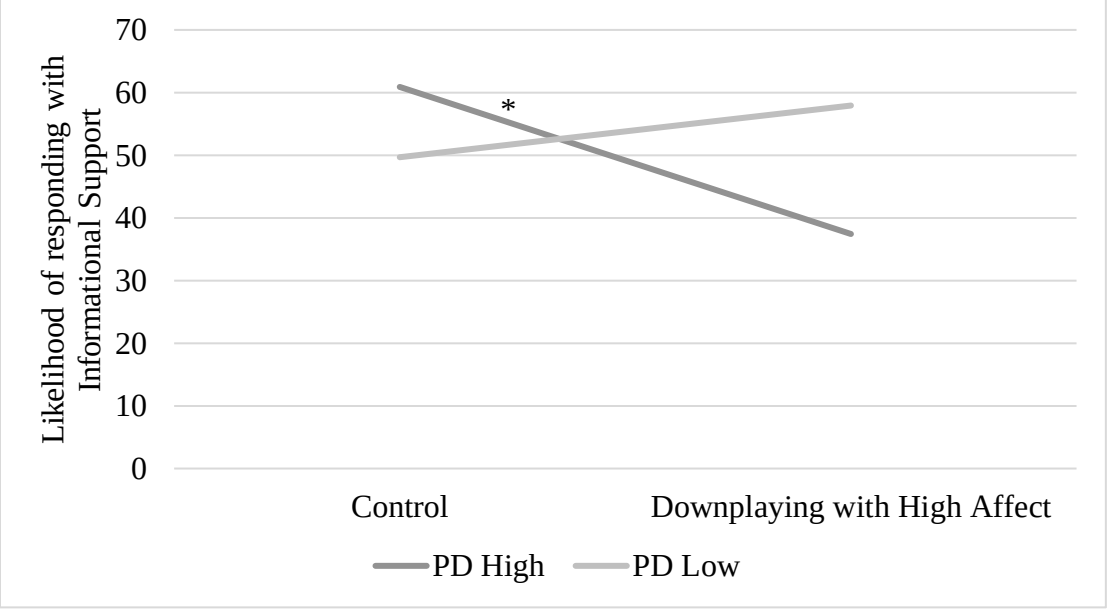
Note. PD High = Personal Distress plus 1 standard deviation; PD Low = Personal Distress minus 1 standard deviation.

Figure 15. Interaction Between Disclosure Strategy (DHA and control) and Personal Distress on Likelihood of Responding with Appraisal Support.



Note. PD High = Personal Distress plus 1 standard deviation; PD Low = Personal Distress minus 1 standard deviation.

Figure 16. Interaction Between Disclosure Strategy (DHA and control) and Personal Distress on Likelihood of Responding with Informational Support.



Note. PD High = Personal Distress plus 1 standard deviation; PD Low = Personal Distress minus 1 standard deviation.

Appendices

Appendix A: Measures for Study 1

Critical Incident Questions [Modeled after Dakof & Taylor (1990) interview questions]

In this survey, I'd like to ask you some questions about how people you work with have reacted towards you when you have disclosed your psychiatric diagnosis to them. After telling someone that you have a psychiatric diagnosis, people may behave toward you in a number of different ways. Some of these ways may be helpful and others may not. We are interested in understanding how individuals diagnosed with a psychiatric diagnosis feel in the moment when someone responds to a disclosure of this personal information. We would like to know about your experiences in two particular situations. One situation in which you felt someone reacted positively/supportively and a second situation in which you felt someone reacted negatively/unsupportively. When an individual discloses some piece of information about himself or herself to another there is the reaction by the confidant in that moment, during the disclosure, and then the way in which the confidant behaves in the days and weeks following the disclosure. For these questions, please focus on the manner in which the confidant responded in the moment of the disclosure.

1. Please describe the most recent workplace disclosure experience you have had where the person to whom you were revealing your psychiatric diagnosis, the confidant, responded in a positive/supportive manner. Please detail what you found to be positive/supportive about their response.
2. Please describe the most recent workplace disclosure experience you have had where the person to whom you were revealing your psychiatric diagnosis, the confidant, responded in a negative/unsupportive manner. Please detail what you found to be negative/unsupportive about their response.

Demographic Items

1. What is your gender?
   a. Male
   b. Female
   c. Other

2. What is your age (in years)?

3. Please indicate your race/ethnicity (choose one):
   a. Hispanic/Latino
   b. Asian American
   c. Native Hawaiian or Other Pacific Islander
   d. American Indian or Alaska Native
   e. Black or African American

f. White or Caucasian
g. Other

4. What psychiatric illness have you been diagnosed with?

5. How long have you been working at your organization?

6. What industry is your organization considered to be a part of?
   a. Business/Finance
   b. Education
   c. Food and Beverage/Restaurant
   d. Health Care/Medical
   e. Legal
   f. Manufacturing
   g. Military/Government
   h. Other Services
   i. Retail
   j. Technology
   k. Transportation/Utilities
   l. Other

7. Approximately how many people in your current organization have you disclosed your mental illness to?

Appendix B: Measures for Study 2

Task Introduction (Confidant Version)

In this study, I'd like you to read the following scenario. After reading this scenario you will be presented with a series of mini follow-up scenarios. You will read these and then answer questions about the entire scenario.

Imagine that you are at work and a coworker comes to you one day wanting to discuss something with you. You have worked with this coworker for a while and have a relationship with them at work but your relationship does not extend much beyond the boundary of work. In this discussion your coworker reveals that they have depression. Upon hearing this you react in the following way…[Shown Response #1]

Confidant Responses (Confidant Version)

Emotional Support: "You asked them questions about their diagnosis. You showed caring and compassion towards them and you wanted to provide a listening ear and comfort if they needed it."

Appraisal Support: "You shared with them that you have had a similar experience with depression and the two of you discuss the symptoms that you have both experienced."

Informational Support: "You encouraged them to 'speak up,' communicate assertively and 'act tough' when challenges arise."

Instrumental Support: "You told them that you have a family member who is a mental health professional who would be happy to speak with them. You then made sure that they had your family members contact information in case they wanted to contact them."

Insulting behavior: "You acted as if they were going to lose it or do something outrageous. You asked them, 'what do you have to be so depressed about?'"

Denial of Symptoms: "You expressed that you do not believe their symptoms are real and said that 'everyone gets depressed.' You thought their symptoms were just an excuse."

Avoidance: "You tried to avoid further discussion. You quickly looked away, brushed it off, and tried to change the subject."

Denial of Assistance: "You denied the existence of any problems they might be experiencing, told them to get over it, and did not express a willingness to help them in any way."

Task Introduction (Discloser Version)

In this study, I'd like you to read the following scenario. After reading this scenario you will be presented with a series of mini follow-up scenarios. You will read these and then answer questions about the entire scenario.

Imagine that you have a depression diagnosis and are currently working within an organization. How imagine that there is a coworker who you want to disclose this diagnosis to. You have worked with this coworker for a while and have a relationship with them at work but your relationship does not extend much beyond the boundary of work. Imagine that one day you go to them and disclose your depression diagnosis. Upon hearing this they react in the following way…[Shown Response #1]

Confidant Responses (Discloser Version)

Emotional Support: "They asked you questions about your diagnosis. They showed caring and compassion towards you and they wanted to provide a listening ear and comfort if you needed it"

Appraisal Support: "They shared with you that they have had a similar experience with depression and the two of you discuss the symptoms that you have both experienced."

Informational Support: "They encouraged you to 'speak up,' communicate assertively and 'act tough' when challenges arise."

Instrumental Support: "They told you that they have a family member of theirs who is a mental health professional who would be happy to speak with you. They then made sure that you had their family members contact information in case you wanted to contact them."

Insulting behavior: "They acted as if you were going to lose it or do something outrageous. They asked you, 'What do you have to be so depressed about?'"

Denial of Symptoms: "They expressed that they do not believe your symptoms are real and said that 'everyone gets depressed.' They thought your symptoms were just an excuse."

Avoidance: "They tried to avoid further discussion. They quickly looked away, brushed it off, and tried to change the subject."

Denial of Assistance: "They denied the existence of any problems you might be experiencing, told you to get over it, and did not express a willingness to help you in any way."

<u>Response Evaluations – To be answered after reading each confidant response</u>

Please answer the following questions in relation to this reaction:

1. To what extent was this reaction supportive?

1	2	3	4	5
Not at all supportive	Slightly supportive	Moderately supportive	Very supportive	Extremely supportive

2. To what extent was this reaction negative?

1	2	3	4	5
Not at all negative	Slightly negative	Moderately negative	Very negative	Extremely negative

3. To what extent was this reaction helpful?

1	2	3	4	5
Not at all helpful	Slightly helpful	Moderately helpful	Very helpful	Extremely helpful

4. To what extent was this reaction useful?

1	2	3	4	5
Not at all useful	Slightly useful	Moderately useful	Very useful	Extremely useful

5. To what extent was this reaction well-intentioned?

1	2	3	4	5

Not at all well-intentioned	Slightly well-intentioned	Moderately well-intentioned	Very well-intentioned	Extremely well-intentioned

6. If the scenario was reversed, I would want someone to react to me in this way?

1	2	3	4	5
Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree

Best/Worst Reactions

*From the options below please choose the reaction you think is the **best** reaction and the reaction you think is the **worst** reaction.*

[Response options same as above from either Discloser or Confidant version]

Demographic Items – For all participants

1. What is your gender?
   a. Male
   b. Female
   c. Other

2. What is your age (in years)?

3. Please indicate your race/ethnicity (choose one):
   a. Hispanic/Latino
   b. Asian American
   c. Native Hawaiian or Other Pacific Islander
   d. American Indian or Alaska Native
   e. Black or African American
   f. White or Caucasian
   g. Other

4. Have you ever been diagnosed with a psychiatric illness? If yes, what psychiatric illness have you been diagnosed with?

5. Has any family member that you know of ever been diagnosed with a psychiatric illness? If yes, what psychiatric illness has this individual been diagnosed with?

6. How long have you been working at your current organization?
   a. Less than 1 year
   b. 1-3 years
   c. 3-5 years
   d. 5-7 years

e. 7-10 years
f. 10-15 years
g. 15-20 years
h. 20 or more (if more than 20 years please specify):

7. What industry is your organization considered to be a part of?
   a. Business/Finance
   b. Education
   c. Food and Beverage/Restaurant
   d. Health Care/Medical
   e. Legal
   f. Manufacturing
   g. Military/Government
   h. Other Services
   i. Retail
   j. Technology
   k. Transportation/Utilities
   l. Other

Demographic Items - For participants diagnosed with a mental illness:

8. Have you disclosed your psychiatric illness to anyone at your current organization?

9. If yes, to approximately how many people have you disclosed?

Demographic Items - For participants *not* diagnosed with a mental illness:

8. Has anyone in your current organization ever disclosed a psychiatric illness to you?

9. If yes, approximately how many people at your current organization have disclosed a psychiatric illness to you?

Appendix C: Measures for Study 3

Task Introduction

In this study, I'd like you to read a scenario. After reading this scenario you will be presented with a series of questions about it. Please answer these questions carefully and honestly

Vignette

Imagine that you are at work and a coworker comes to you one day wanting to discuss something with you. You have worked with this coworker for a while and have a relationship with them at work but your relationship does not extend much beyond the boundary of work. In this

discussion your coworker reveals that they have depression. In revealing that they have depression your coworker explains that…[See Disclosure Manipulations below]

Disclosure Manipulations – [Modeled after vignettes from Lyons and colleagues 2016 Study 3]

Claiming with high affective content

"Although it can be difficult at times to not feel depressed, I know that living with a mental illness has made me stronger than I would have been otherwise. I know that some people may think I am less able to do my job because I have depression. This view makes me sad and at times nervous to tell people about my depression. However, I really feel like there is nothing I can't do at this point and I hope that others see that in me as well."

Claiming with low affective content

"Although it can be difficult at times to not feel depressed, I know that living with a mental illness has made me stronger than I would have been otherwise. I know that some people may think I am less able to do my job because I have depression but I really feel like there is nothing I can't do at this point and I hope that others see that in me as well."

Downplaying with high affective content

"Although people with depression may have difficulty, I try not to let having depression define who I am as a person. Some people may view me differently because of my depression. This view makes me sad and at times nervous to tell people about my depression. However, everyone has their own things they have to deal with in some form or another. I try not to see it as a big deal and hope that others don't define me by my diagnosis."

Downplaying with low affective content

"Although people with depression may have difficulty, I try not to let having depression define who I am as a person. Some people may view me differently because of my depression. However, everyone has their own things they have to deal with in some form or another. I try not to see it as a big deal and hope that others don't define me by my diagnosis."

Control

Imagine that you are at work and a coworker comes to you one day wanting to discuss something with you. You have worked with this coworker for a while and have a relationship with them at work but your relationship does not extend much beyond the boundary of work. In this discussion your coworker reveals that they have depression.

Dependent Variables:

1. Please decide which of the following reactions you would be most likely to give if you experienced this in the workplace.
    a. "You ask them questions about their diagnosis. You show caring and compassion towards them and you want to provide a listening ear and comfort if they need it."
    b. "You share with them some of your own previous struggles and help them to verify that what they are going through is real."
    c. "You encourage them to 'speak up,' communicate assertively and 'act tough' when challenges arise."
    d. "You are patient and give them space to go about their day at a pace that works for them. You provide them with any resources that you know of."
    e. "You act as if they were going to lose it or do something outrageous. You ask them, 'what do you have to be so depressed about?'"
    f. "You express that you do not believe their symptoms are real and say that 'everyone gets depressed.' You think their symptoms were just an excuse."
    g. "You try to avoid further discussion. You quickly look away, brush it off, and try to change the subject."
    h. "You deny the existence of any problems they might be experiencing, tell them to get over it, and do not express a willingness to help them in any way."

2. How central do you feel this person's depression diagnosis is to their identity and who they are as a person?

1	2	3	4	5
Not very central to their identity	Not central to their identity	Neutral	Central to their identity	Very central to their identity

3. How likely is it that this person disclosed their depression diagnosis because they felt people were going to find out anyway?

1	2	3	4	5
Not very likely	Not likely	Neutral	Likely	Very likely

4. How likely is it that this person disclosed their depression diagnosis because they wanted you, as their coworker, to know?

1	2	3	4	5
Not very likely	Not likely	Neutral	Likely	Very likely

5. How willing do you think this person is to talk more about their diagnosis?

1	2	3	4	5
Not very willing	Not willing	Neutral	Willing	Very willing

6. How receptive do you think this person is to answering questions about their diagnosis?

1	2	3	4	5

Not very receptive	Not receptive	Neutral	Receptive	Very receptive

7. Please rate each of the following reactions on how likely you would be to give this response if you were in this situation at work.

0	20	40	60	80	100
Unlikely to respond in this way					Very likely to respond in this way

   a. "You ask them questions about their diagnosis. You show caring and compassion towards them and you want to provide a listening ear and comfort if they need it."
   b. "You share with them some of your own previous struggles and help them to verify that what they are going through is real."
   c. "You encourage them to 'speak up,' communicate assertively and 'act tough' when challenges arise."
   d. "You are patient and give them space to go about their day at a pace that works for them. You provide them with any resources that you know of."
   e. "You act as if they were going to lose it or do something outrageous. You ask them, 'what do you have to be so depressed about?'"
   f. "You express that you do not believe their symptoms are real and say that 'everyone gets depressed.' You think their symptoms were just an excuse."
   g. "You try to avoid further discussion. You quickly look away, brush it off, and try to change the subject."
   h. "You deny the existence of any problems they might be experiencing, tell them to get over it, and do not express a willingness to help them in any way."

<u>Interpersonal Reactivity Index</u>

The following statement inquire about your thoughts and feelings in a variety of situations. For each item, indicate how well it describes you by choosing the appropriate response option on the scale at the top of the page. Answer as honestly as you can.

1	2	3	4	5
Does not describe me very well	Does not describe me well	Neutral	Describes me well	Describes me very well

   a. I often have tender, concerned feelings for people less fortunate than me
   b. I sometimes find it difficult to see things from the "other guy's" point of view
   c. Sometimes I don't feel very sorry for other people when they are having problems
   d. In emergency situations, I feel apprehensive and ill-at-ease
   e. I try to look at everybody's side of a disagreement before I make a decision
   f. When I seem someone being taken advantage of, I feel kind of protective towards them
   g. I sometimes feel helpless when I am in the middle of a very emotional situation

h. I sometimes try to understand my friends better by imagining how things look from their perspective
i. When I see someone get hurt, I tend to remain calm
j. Other people's misfortunes do not usually disturb me a great deal
k. If I'm sure I'm right about something, I don't waste much time listening to other people's arguments
l. Being in a tense emotional situation scares me
m. When I see someone being treated unfairly, I sometimes don't feel very much pity for them
n. I am usually pretty effective in dealing with emergencies
o. I am often quite touched by things that I see happen
p. I believe that there are two sides to every question and try to look at them both
q. I would describe myself as a pretty soft-hearted person
r. I tend to lose control during emergencies
s. When I'm upset at someone, I usually try to "put myself in his shoes" for a while
t. When I see someone who badly needs help in an emergency, I go to pieces
u. Before criticizing somebody, I try to imagine how I would feel if I were in their place

Demographic Items

1. What is your gender?
   a. Male
   b. Female
   c. Other

2. What is your age (in years)?

3. Please indicate your race/ethnicity (choose one):
   a. Hispanic/Latino
   b. Asian American
   c. Native Hawaiian or Other Pacific Islander
   d. American Indian or Alaska Native
   e. Black or African American
   f. White or Caucasian
   g. Other

4. Please indicate your year in school?
   a. First
   b. Second
   c. Third
   d. Fourth
   e. Fifth +

5. Have you ever been diagnosed with a psychiatric illness? If yes, what psychiatric illness have you been diagnosed with?

6. Has any family member that you know of ever been diagnosed with a psychiatric illness? If yes, what psychiatric illness has this individual been diagnosed with?

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