

STIGMA AND WORK



DISCUSSION PAPER

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ABSTRACT

This paper addresses what is known about workplace stigma and employment inequity for people with mental and emotional problems. For people with serious mental disorders, studies show profound consequences of stigma, including diminished employability, lack of career advancement and poor quality of working life. People with serious mental illnesses are more likely to be unemployed or to be underemployed in inferior positions that are incommensurate with their skills or training. If they return to work following an illness, they often face hostility and reduced responsibilities. The result may be self-stigma and increased disability. Little is yet known about how workplace stigma affects those with less disabling psychological or emotional problems, even though these are likely to be more prevalent in workplace settings. Despite the heavy burden posed by poor mental health in the workplace, there is no regular source of population data relating to workplace stigma, and no evidence base to support the development of best-practice solutions for workplace anti-stigma programs. Suggestions for research are made in light of these gaps.

Purpose

This paper was commissioned by the Working Group mandated by the Canadian Institute of Population and Public Health and the Institute of Neurosciences, Mental Health and Addictions of the Canadian Institutes of Health Research to suggest

priority areas for stigma research as part of a national research agenda on mental health and the workplace.

Stigma Defined

In ancient Greece, citizens pricked marks on their slaves using a pointed instrument,

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both to demonstrate ownership and to signify that such individuals were unfit for citizenship. The ancient Greek word for prick is *stig*, and the resulting mark, a stigma. In modern times, stigma is understood as an invisible mark that signifies social disapproval and rejection (Goffman 1963; Dovidio et al. 2000; Falk 2001). Stigma is deeply discrediting and isolating, and it causes feelings of guilt, shame, inferiority and a wish for concealment (Goffman 1963).

Caveat

Stigma literature relating to mental health focuses almost exclusively on mental disorders – illnesses that meet certain clinical thresholds for severity and duration, or mental health conditions that have been of sufficient severity to require psychiatric treatment. In this context, stigma has been variously understood as a consequence of the visible signs or symptoms of a disorder; a result of having received a psychiatric label, regardless of whether visible signs or symptoms are present; or as a consequence of having received psychiatric treatment, particularly if the locus of care was a psychiatric hospital or if treatment was legally mandated. While Canadians express stigmatized views of people with serious mental illnesses such as schizophrenia (Stip et al. 2001; Stuart and Arboleda-Flórez 2001; Thompson et al. 2002; Stuart 2003a; Stuart 2003b), the literature does little to examine the extent to which stigma is a consequence of other dimensions of mental health, such as less serious psychological or emotional problems like substance misuse or depression. Consequently, the remaining discussion concentrates on the stigma of severe mental illness and refers to information on other mental disorders when it is available.

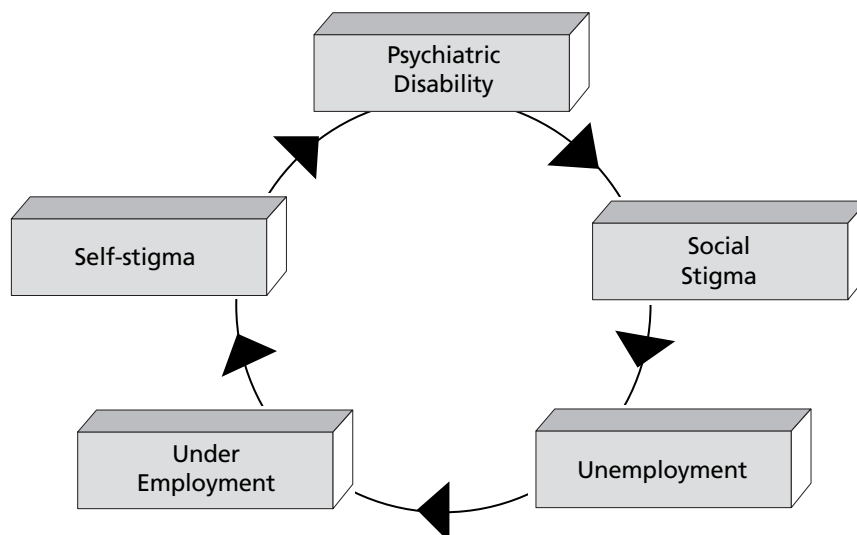
General Consequences of Stigma

“Stigma is an ugly word, with ugly consequences” (Leete 1992: 19), and mental illnesses confer the “ultimate stigma” (Falk 2001; Smith 2002). Goffman (1963) once said that people with mental disorders start out with rights and relationships, but end up with little of either. Stigma adds a dimension of suffering to the primary illness – a second condition that may be more devastating, life-limiting and long-lasting than the first (Schulze and Angermeyer 2003).

Most people with a mental illness are treated in the community, where stigmatizing attitudes can impede recovery and promote disability. Stigma hinders social integration, the performance of social roles, timely access to treatment and quality of life. Other consequences are unemployment, lack of housing, diminished self-esteem and weak social support (Link et al. 1991; Wolff 1997; Markowitz 1998; Wahl 1999a; Stip et al. 2001; Prince and Prince 2002). A key consequence of stigma is that we harbour lower expectations for people with a mental illness and easily accept a quality of life for them that we would not accept for ourselves (Jones 2001).

Stigma, and the expectation of stigma, can also produce serious disruptions in family relationships and reduce normal interactions (Wahl and Harman 1989). For families, stigma means fear, loss, lowered family esteem, shame, secrecy, distrust, anger, inability to cope, hopelessness and helplessness (Gullekson 1992). Families are often directly blamed for causing the illness or criticized for harbouring persons who are potentially harmful or offensive (Lefley 1992).

Stigma also surrounds mental health professionals and services. Sartorius (2004) notes that mental health professionals are

Figure 1. Stigma and Employment Inequity

themselves frequently portrayed as mentally abnormal, corrupt or evil. Psychiatric treatments, which are generally thought to be ineffective or iatrogenic, are approached with profound suspicion and often monitored with much more than the usual zeal. Mental hospitals disgust and horrify, and citizens actively fight to exclude treatment and residential facilities from their neighbourhoods. Stigma also contributes to the persistent under-funding of services and research. In times of economic restraint, the easiest budget to cut is the mental health budget because it rarely results in a public outcry. When there is new money, it goes to groups that are more publicly appealing: children with life-threatening diseases, cancer patients or those with heart disease. Consequently, disciplines related to mental health are less attractive as career options (Sartorius 2004; Kendell 2004).

The consequences of stigma are so pervasive and profound, the World Health Organization and the World Psychiatric Association have identified stigma related to mental illness as the most important challenge facing the mental health field

today (WHO 2001; Sartorius 2004).

Stigma and Work

No single activity conveys a sense of self more so than work. Work influences how and where one lives, it promotes social contact and social support, and it confers title and social identity. “What do you do?” is one of the first questions asked in any new social relationship. Mental health problems predict unemployment and reduced career goals, and the resulting economic hardship can disadvantage physical and emotional health, quality of life, community participation and recovery (Wahl 1999b). To be excluded from meaningful work not only creates material deprivation; it also erodes self-confidence and results in isolation, alienation and despair. Lack of adequate employment is a key risk factor for mental health problems ranging from mild psychosocial stress to serious depression and suicide (Kates et al. 1990). Figure 1 depicts this as a cycle of unfair and prejudicial attitudes leading to discriminatory employment practices, self-stigma and increased psychiatric disability.

Stigma and Unemployment

Employment discrimination occurs when someone is denied a job because of their psychiatric status without regard to their qualifications or capabilities; and it is illegal (Wahl 1999b). The Canadian Human Rights Act stipulates that employers must take appropriate steps to eliminate discrimination against employees and prospective employees. Short of undue hardship, employers must accommodate disabled people. In addition, Canada's Employment Equity Act is aimed at improving the representation of people with disabilities in the workforce (Canadian Human Rights Commission 2003).

Most people with a mental illness are both willing and able to work (Macias et al. 2001). Yet their unemployment rates remain scandalously high. Most studies report unemployment rates between 80% and 90% among severely mentally ill patients (Crowther et al. 2001; Dalgin and Gilbride 2003; Drake et al. 1998; Krupa et al. 2003; McQuilken et al. 2003). Those with an affective disorder have better employment rates than those with alcoholism or schizophrenia (Manning and White 1995).

Table 1: Association Between Unemployment and Psychiatric Disorder[†]

Disorder	Odds Ratios for Unemployment
Schizophrenia	4.98
Mania	4.98
Major depression	2.10
Dysthymia	1.69
Phobia	1.54
Panic disorder	2.35
Obsessive compulsive disorder	1.86
Antisocial personality disorder	5.89

[†] Adapted from Thompson and Bland (1995).

Data from Edmonton (Tables 1 and 2) show how employment rates vary by diagnostic group in a Canadian sample (Bland et al. 1988). This study also showed that those who were unemployed were twice as likely to report sub-clinical psychological symptoms in the two weeks before the interview, and four times more likely to have previously attempted suicide. This confirms that employment barriers exist across a wide range of mental health and emotional problems.

With figures such as these, it is not surprising that people with mental illnesses

Table 2: Lifetime Prevalence of Psychiatric Disorders in the Employed and Unemployed in Edmonton, Canada[†]

Prevalence	Employed	Unemployed	Odds Ratio
Substance use disorder	22.1%	45.9%	3.0
Schizophrenia	0.5	1.5	3.0
Affective disorders	8.8	15.5	1.9
Anxiety/somatoform disorders	12.1	14.3	1.2
Anorexia	--	0.7	15.6*
Antisocial personality disorder	2.8	15.1	6.2
Cognitive impairment	0.3	0.9	2.7
Any disorder	34.8	59.5	2.8

[†] Adapted from Bland et al. (1988).

* Unstable due to small numbers in sample. Results are weighted.

identify employment discrimination among their most frequent stigma experiences. For example, respondents to a consumer survey conducted by the Canadian Mental Health Association found that social and family life (84%), employment (78%) and housing (48%) were the three areas most affected by stigma (Canadian Mental Health Association, Ontario Division 1994).

In a survey of 74 people with schizophrenia receiving outpatient care in Maryland, all but one reported a recent stigma experience. The most commonly identified source of stigma were people in the community (61%), followed by employers and supervisors (36%) and then mental health caregivers (20%) (Dickerson et al. 2002). In a survey of 1,150 primary care patients in Minnesota, 67% of those with a history of depression and 58% of those with a prior psychiatric visit expected to experience employment-related stigma that would make it more difficult for them to find a job – twice the proportion of those with medical disabilities such as diabetes or hypertension. In addition, women were four times more likely to express employment concerns (Roeloffs et al. 2003). These findings suggest that women who are mentally ill may be doubly disadvantaged in the workplace and that other socio-demographic factors (such as age or ethnicity) may interact with the stigma of mental illness to cause a double disadvantage.

US studies show that employers are reluctant to hire someone with a psychiatric history. In a random sample of businesses, approximately half of the employers surveyed expressed discomfort at hiring someone with a previous mental hospitalization and 70% expressed discomfort at hiring someone who was on anti-psychotic medication. Forty-four percent would be

uncomfortable hiring someone who was in treatment for depression, and 69% would be uncomfortable hiring someone with a history of substance abuse (Scheid 1999). Similarly, a survey of 1,426 restaurant owners showed that while almost half had hired a physically handicapped person, only 29% had hired a mentally disabled person (Long and Runch 1983). Almost a quarter of US employers surveyed would dismiss someone for a previously undeclared mental illness, and half would rarely employ someone with a mental illness (Manning and White 1995). Approximately one in three mental health consumers in the United States has been turned down for a job for which they were qualified once their mental health problems were disclosed. For one in five, even attempts to contribute to volunteer jobs were thwarted. This was true for volunteering both inside the mental health system (20%) and outside it (26%). In some cases, job offers were withdrawn once a psychiatric history was revealed. Even when successful in obtaining a job, a quarter noted that co-workers and supervisors were unsupportive once their psychiatric status was known (Wahl 1999a; Wahl 1999b).

A psychiatric diagnosis can also undermine career advancement. In the United Kingdom, for example, 58% of employers would never hire someone with a diagnosis of depression for an executive position, compared to only 5% for a clerical position. Employers associated depression with impaired performance and sick time, more so than chronic physical conditions, suggesting that psychological causes for sick time are less credible than physical ones (Nicholas 1998).

A major dilemma for jobseekers then, is whether to divulge a mental illness to prospective employers. Honest

information may undermine employability, but failure to disclose may result in dismissal or other consequence (such as loss of benefits) when the truth finally comes to light. Mental health consumers often recommend keeping psychiatric treatment a secret, preferring to explain long absences from work with fictional or fake diagnoses, such as “exhaustion” (Schulze and Angermeyer 2003). In a study comparing patients who were hospitalized for medical and psychiatric reasons, over half with a past psychiatric hospitalization would hide this from their workmates, whereas none of those with a medical hospitalization would. The majority of workmates of psychiatric patients (64%) did not know the nature of their colleague’s hospitalization, whereas all of the workmates of medical patients did (McCarthy et al. 1995). Although the literature on disclosure is generally sparse, and there are no Canadian studies, there is some evidence from the United States that appropriate job matching may eliminate the need to disclose a psychiatric diagnosis to an employer (Dalgin and Gilbride 2003).

Stigma and Underemployment

Workers are underemployed when their jobs are inferior to their normal occupations or are economically inadequate. Underemployment may also include a psychological dimension if it entails lower job satisfaction with the non-economic aspects of the work, such as poor or disrupted relationships with co-workers or low decision latitude. Although thought to be pervasive among the mentally ill and other disadvantaged groups, underemployment has no official definition or statistics that are routinely collected or reported (Dooley 2003). Thus, the

epidemiology of under-employment among disabled groups is unknown. However, like unemployment, underemployment is thought to result in health and mental health effects (Dooley 2003; Grzywacz and Dooley 2003).

The jobs considered most suitable for people with a mental illness often involve menial labour, do not provide opportunities for skill development, do not promote a sense of mastery, negatively impact self-esteem and are a tangible source of psychological stress (Scheid 1999). In a survey of mental health consumers in the United States, one in three reported being counselled to take jobs below their educational level, intellect or training (Wahl 1999a). Most of those who will work in such jobs will last an average of only six months (Henry and Lucca 2002). Twenty-five percent of those with a psychiatric disability will have a job within 18 months, compared to half of those with a physical disability, but fewer than 15% of those with a previous psychiatric hospitalization will keep a job for five years (Botterbusch and Osgood 1997).

Mental health consumers who return to work often return to positions of reduced responsibility with little or no psychosocial support from former colleagues and workmates (Simmie and Nunes 2001; Nunes and Simmie 2002). As well, they may be the brunt of critical comments, such as “without you things were running more smoothly” (Schulze and Angermeyer 2003: 307). Using anecdotal experiences reported by Canadian mental health consumers, Figure 2 illustrates that it can be as difficult to keep a job as it is to get one once one’s mental illness is known. Indeed, as many as half of the competitive jobs acquired by people with a serious mental

illness end unsatisfactorily because of problems that occur once the job is in progress (Becker et al. 1998).

People with mental illnesses may face the highest degree of workplace discrimination of any disabled group. In the United States, mental disorders are the second-most common basis for charges of discrimination and workplace harassment (under the Americans with Disabilities Act), constituting 10% of all discrimination cases and 13% of all cases of workplace harassment (Scheid 1999).

Knowledge about how to make workplace accommodations for people with mental health problems is scant; however, there is growing agreement that organizational cultures must be modified to be more receptive to and tolerant of people with psychiatric disabilities (Scheid 1999). Workplace rehabilitation policies of the 1970s and 1980s inadvertently perpetuated underemployment by segregating those with serious mental illnesses in sheltered or transitional workplaces where wages were substandard and job mobility into the competitive labour market was rare (Drake et al. 1998). Since then, supported employment programs, although not widespread, provide competitive employment opportunities for people with psychiatric disabilities. Evaluations of supported employment and consumer-run businesses demonstrate that people with mental illnesses, even severe and persistent illnesses, can successfully obtain and maintain competitive employment (Latimer 2001; Krupa et al. 2003). At least one study has shown that regional variation in unemployment rates among those with a serious mental disorder can be linked to the availability (or unavailability) of supported employment programs (Drake et al. 1998). Virtually nothing is known about the effectiveness of other

workplace intervention strategies, such as educational programs or employee assistance programs, in diminishing employment inequity.

Self-stigma

Self-stigma occurs when negative social stereotypes are internalized and a mental illness comes to be viewed as a personal failure. Self-stigma results in a loss of self-esteem and self-efficacy and a reluctance to participate in social interactions (Holmes and River 1998). With respect to work, fear of stigma and rejection can undermine confidence with the result that people with a mental illness may make a poorer showing in job interviews. Over time, they will view themselves as ineffective and unemployable and will avoid job interviews altogether (Link 1982; Wahl 1999a). Indeed, 69% of mental health consumers responding to a recent US survey indicated they had not applied for jobs for fear of unfair treatment (Wilson 2004). However, research done in the UK civil service has shown that job performance reviews of people with psychiatric morbidity (presumably morbidity that was unknown to co-workers) were no worse than those of their symptom-free counterparts. Job performance was uncorrelated with symptom level (Nicholas 1998).

The anxiety and fear that workmates will find out may exact a significant psychological toll as well as increase workplace disability and cost. People with mental illnesses will go to great lengths to ensure that others do not find out, including staying in unsatisfactory situations for fear that moving will result in disclosure, avoiding friendships and avoiding treatment. In Ontario, for example, workers with mental health problems are less likely to take time off than are those with

Figure 2: Real People, Real Stories....

Work places can be like an army that shoots its wounded.

I have known people to "pretend" they have a physical problem and that's why they're away from work.

I have had to lie to get a job rather than admit to having a mental health problem.

They encourage you to use the Employee Assistant Program, but god help you if you actually use it...then you become 'labeled', and they use it against you.

I didn't know what my rights were as an employee, and I didn't have the strength to deal with them. I wanted to believe them when they said they cared.... I was vulnerable.... I was bullied.

I need a job that can help me build up my self-esteem and give me a feeling of being self-sufficient.

When I wasn't well, I didn't have the strength to stand up for myself.

They made it so hard for me at work; I think they were trying to force me to quit.

Mental health issues happen to anyone. It is beneath me to beg for a chance to work.

I was told not to talk to anyone at work about what I was going through.....

When I don't feel well, I need to feel secure that I can take the time I need, and not loose my job.

They treated me like a 'broken product' that you just discard if some small part isn't working the same as before.

Excerpts from *Real People, Real Stories....* (Mental Health Matters 2001)

physical conditions and are more likely to struggle through at sub-optimal work levels (Dewa and Lin 2000). In the United States, psychiatric disability has been associated with both work loss and work cutback days. The association of psychiatric disorder with work cutback days was greater for professional workers than for those in other occupations (Kessler and Frank 1997).

Lack of knowledge on the part of managers and supervisors hampers early recognition and speedy resolution of mental health problems in the workplace. "Managers can go a long way in lifting the veil of secrecy and ambivalence, which often surrounds mental health, by creating a climate in which open discussion of such concerns is not only tolerated but encouraged" (Schott 1999: 173). However, even when employee assistance programs are available, they may create and reinforce stigma and discrimination by calling into question the very competence and employment suitability of the individuals receiving services. Among military

personnel returning from Bosnia, for example, 61% agreed that admitting to a psychological problem would harm their careers. By comparison only 43% thought that admitting to a medical problem would be harmful (Britt 2000).

Strategic Directions for Future Research

The twentieth century stands out as a period of great awakening, not only with respect to the recognition of the frequency of mental disorders in populations, but their associated human, social and economic costs. It is now recognized that good mental health is an essential component of both social and economic capital. The influence of work on mental health has been of interest to Canadian researchers for over a decade (Baba et al. 1998) but not yet from the perspective of stigma. In light of the gaps outlined in the previous discussion, three priorities for stigma research are suggested for inclusion in a national research agenda on mental health and work.

First Priority: Increase Targeted Research to Focus on Mental Health Stigma and Work

There are many gaps in our current knowledge of stigma and work. Although generally scant, the bulk of existing research comes from the United States or United Kingdom and focuses on stigma as a consequence of serious mental disorders. Virtually nothing is known about the extent and nature of workplace stigma in Canada, particularly as it applies to the full range of mental health problems likely to be found in workplaces. Attempting to understand the attitudes, behaviour and motivations of Canadian employers from data collected in social and economic systems with fundamentally different philosophical positions on work, economics, healthcare, social welfare, workplace disability, mental healthcare and a range of other socio-cultural and economic issues is fraught with difficulty, since all of these things can impact workplace environments. Only through a clear understanding of the nature and extent of workplace stigma in Canada can interventions be designed and appropriately targeted.

Therefore, a **first priority** for a Canadian research agenda must be to gain a better understanding of the extent and nature of mental health related stigma in Canadian workplaces, its determinants and its socio-economic consequences. Studies that should receive highest priority include research on the following:

- Knowledge, attitudes and practices of Canadian employers with respect to the range of mental health problems found in Canadian workplaces
- Employment and workplace experiences of people with mental health problems in order to depict the extent and nature of

stigma and its consequences, including the factors leading to job instability, underemployment and employment

- Social and organizational characteristics (such as policies, procedures, management structures or programs) that promote or impede stigma in the workplace
- How socio-demographic factors such as age, gender, ethnicity or socio-economic status may interact with mental health stigma to compound workplace disadvantage
- Analyses of legal and policy frameworks that reduce workplace stigma

Second Priority: Population Data on Stigma and Work

Despite the heavy burden of mental disorders, Canada does not have a mental health surveillance plan, although one has been under discussion for some time (Beauséjour 2001). Statistics Canada does collect selected mental health information through the Community Health Survey, but the schedule for future collection of mental health data have not yet been defined, and there is no current plan to include items that would broaden our understanding of stigma and work. For example, only two items on the current release of the Community Health Survey address stigma and neither bears any relevance to stigma experienced in the workplace. The creation of population-based data that can be used by researchers to better understand workplace stigma is, therefore, a **second priority** for a national research agenda. To this end, consideration should be given to including a workplace mental health module in an upcoming cycle of the Community Health Survey. Strategic funding initiatives developed through theme-based institutes could then be used to support secondary analyses of these data.

Third Priority: Creating Business-Research Alliances

In recognition of the economic implications of workplace mental health, the business community has now come together in several Canadian cities to examine ways of addressing this problem (Beauséjour 2001). The first Canadian business roundtable on mental health was held in 1998 in Ontario. The group recognized that Canadians have entered an economy of “mental performance” where the mental health of working populations and their families will be increasingly central to the successful workings of the twenty-first century economy. In recognition of the role played by stigma in relation to work, one of the goals identified in their Charter is to “defeat” the stigma attached to mental illness through workplace education (Global Business and Economic Roundtable of Addiction and Mental Health 2003).

Workplace anti-stigma programs and other such interventions require rigorous evaluation. Although increasing numbers of researchers are comfortable in conducting program evaluations, and Canada’s capacity for conducting mental health services research is growing, formal alliances between researchers and the business community in this area are noticeably absent. The Canadian Institutes of Health Research, through partnerships between theme-based Institutes, has an opportunity to take a more active role in creating the business-research alliances necessary to foster applied research and evaluation in workplace mental health. Not only would such collaborations give researchers opportunities to strengthen their knowledge of the mechanisms underlying workplace stigma, but they would also assist business leaders in their

pursuit of cost-effective best practices in stigma reduction. Therefore, creating research opportunities that partner applied researchers with business leaders, particularly employers who wish to undertake and evaluate workplace anti-stigma programs, is the **third priority** in support of a comprehensive national research agenda on mental health and work.

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