



**Employee Disability Disclosure and Managerial Prejudices in
the Return-to-Work Context**

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RESPONSES TO EDITOR'S AND REVIEWERS' COMMENTS

We wish to thank the editor and reviewers for the positive feedback on the manuscript as well as for their helpful suggestions for improvement. Based on your guidance, we have made several changes to the manuscript. Below we outline the changes in a point-by-point fashion. The verbatim comments from the Editor/each of the two reviewers appears in italics, and our responses appear in plain text. As requested, changes to the manuscript appear in a different font colour (blue) for ease of location, and we specify below the particular page numbers of the revised manuscript on which changes appear.

Responses to Editor's Comments

Thank you for submitting your paper, "Employee Disability Disclosure and Managerial Prejudices in the Return to Work Context" to Personnel Review.

First, let me apologize for the delay in relaying a decision to you. I have now heard back from two reviewers for your paper. The reviewers recommend major revisions but also raise a number of concerns, some of which are significant. I also read the paper, as an EDI scholar, and felt that the topic of managerial reaction to disability type is important. I am happy to invite you to revise and resubmit your paper for further consideration.

Thank you for the opportunity to contribute to the *Personnel Review*. The research team found the comments and suggestions constructive and helpful. We have substantially revised the paper and believe that the new version is theoretically stronger.

As you will see, both reviewers felt that the present paper is undertheorized; in particular, the reviewers feel you need a stronger theoretical grounding or rationale to support the development of your hypotheses. Relatedly, the reviewers also raise question on the stigmatization ordering of mental, and physical disabilities as well as pending diagnosis of a disability. Reviewer 2 suggests exploring the works of Nev Jones to support your hypothesis. One reviewer points to the need to elaborate on the potential contribution of the present study, again you may wish to review the work of Michel Campolieti on accommodating workers with onset disability vs. congenital disability to address this point.

We have revised the theoretical background. We now use a social cognitive framework (Stone & Colella, 1996) and stereotype dimensions (Jones et al., 1984) to argue for differential treatment of persons with different types of disabilities. We have also provided a clear order of physical disability, pending diagnosis, and psychiatric disability. We have also elaborated on potential contributions of the study. Further, given that ADA precludes managers from accessing medical information of employees with disabilities, we elaborated how findings from the current study are applicable to a broader return-to-work context.

The reviewers also ask for clarification questions on the research design – e.g., why two

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3 *samples, and the influence of US vs. non US sample, along other queries on your measure and*
4 *analytical procedure. Reviewer 2 points out that managers in the US may not accessed medical*
5 *information at hiring, which is a practical concern. I would suggest addressing this as a*
6 *limitation or suggesting how hiring managers may come into such information.*
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9 We have provided clarifications on the research design questions. We have also included
10 information about U.S. vs. non-U.S. sample and ADA legislation in the discussion section.
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12 *The revisions requested by the reviewers are doable. I will be returning your paper to the*
13 *reviewers for a second opinion. The success will depend on how well you address the reviewer's*
14 *feedback. In your revision, please explain (item-by-item) how you have responded to each of the*
15 *points raised by the reviewers. Central to your revision, you need to build a strong and*
16 *compelling case for the importance and unique contribution of this study. I look forward to*
17 *receiving your revised paper.*
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21 Thank you for the opportunity. We found the comments helpful and constructive. We respond
22 below to how we have addressed each comment.
23

24 **Responses to Reviewer 1's Comments**

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27 *Thank you for submitting this paper on an interesting and important topic. I appreciate the use*
28 *of an experimental design and the mostly clear presentation. Despite these positive aspects of*
29 *your study, I see a number of issues that limit the potential contribution of the paper to the*
30 *literature. My main issues relate to an insufficient theoretical development of your manuscript,*
31 *some concerns regarding the contributions of your research, and a few methodological*
32 *concerns. Below, I outline these main concerns, as well as a few smaller concerns, in more detail*
33 *and provide suggestions for how you might address them. I hope that my comments will be useful*
34 *in developing this manuscript.*
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37 Thank you for your ideas and suggestions. We outline below a summary of changes, and the
38 changes appear in the revised manuscript in a different font colour (blue) for ease of location.
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41 *1. Insufficient theoretical development*

42 *You have to do a much better job developing your hypotheses. Some of the sections outlining the*
43 *logic for your hypotheses are very short but include material that does not speak to the core of*
44 *your arguments. For example, in the section on Hypothesis 3 you fail to provide any rationale*
45 *for a directed prediction. You have to argue for more negative assessments of individuals with*
46 *psychiatric disabilities. I suggest that you carefully go through all hypotheses again and make*
47 *sure you focus on your central arguments and provide sufficient detail.*
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50 We appreciate your suggestions. We have substantially revised the paper's theoretical
51 foundation. Consistent with comments from you and Reviewer 2, we now build on Stone and
52 Colella's (1996) social cognitive framework and Jones' et al. (1984) work to substantiate our
53 hypotheses. Based on these theoretical frameworks and existing empirical findings, we argue that
54 the disability type has important implications for how persons with disabilities are evaluated.
55 Please see pages 5-9 for detailed revisions.
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Regarding all of the hypotheses, from your writing it sounds as if you assume that pending diagnosis is the best situation. However, maybe it is better to know that someone has a physical disability (the least stigmatized) than not knowing and speculating. This would imply that pending diagnosis would rank in the middle between physical and psychiatric disability. Generally, I would encourage you to think about how all of the conditions relate to each other (e.g., better or worse outcomes). This could make the manuscript much more interesting.

This is a very helpful suggestion. Based on the revised theoretical development, we have adjusted our predictions. More specifically, we argue that psychiatric disability is the most stigmatized, whereas physical disability is the least stigmatized. Given that a 'pending diagnosis' contains some elements of uncertainty, we position it between the physical and psychiatric disability types. Please see pages 9-10 for detailed revisions.

2. Unclear contributions

Your contributions are currently unclear. You write that you focus on the return-to-work context without outlining why this is important. Do you have any numbers to show how often this occurs? Do you have clear reasons to argue why this should be different from other evaluations or accommodation requests? The same applies to your second contribution. You write that you focus on other outcomes than managerial evaluations without explaining why the outcomes you chose are important. Ideally, you situate these explanations in the existing literature.

We have revised our introduction and discussion sections to clarify study contributions. We argue that attitudinal outcomes in the return-to-work context are likely to be different from the hiring context, as employees in the former already have secured employment. We further suggest that employees may acquire a disability condition during their employment and hence face a decision whether to disclose their disability type when returning to work. Unfortunately, we could not find meaningful statistics on how many people request a short- or long-term disability-related absence. Please see pages 2-4 for detailed revisions.

3. Some lack of clarity in writing

Your first paragraph is unclear. How do the detrimental consequences of discrimination go beyond finding and maintaining gainful employment? It seems to me as if discrimination on the job is one negative antecedent of maintaining gainful employment.

We have made substantial changes to the introduction section, including the first paragraph. We also provide examples of why evaluations of aggressiveness, professional trustworthiness, and organizational commitment have important implications for persons with disabilities. Please see pages 2-3 for detailed revisions.

On page 2, you state that "Nevertheless, managers do not understand the experience of work for employees with disabilities especially as these employees return to work from disability-related leave." Why is this the case? What do they not understand?

Thank you for pointing this out. We now provide clarifications for why it might be the case. Please see page 3 for detailed revisions.

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4. Methodological concerns

I am unsure why you collected two samples instead of collecting a larger sample and randomly assigning participants to four conditions (including the control group). Was there any particular reason for this? By doing this, you raised questions regarding the comparability of the samples. For example, 89% of the control group were from the U.S. versus just 57% in the three experimental conditions. Since work values and perceptions of people with disabilities differ between countries (Dwertmann, 2016), this could technically explain your effects. Please provide comparisons of all four conditions on other variables you have collected. You should also acknowledge this as a limitation.

We agree that randomly assigning participants to four conditions would represent a better methodological approach. Sample 1 was collected to test the hypotheses about the relative outcomes for Pat when Pat is labeled as having a physical, psychiatric, or pending diagnosis. However, as these groups did not allow us to answer the question of whether any explanation is better than no explanation, we collected a separate sample (i.e., Sample 2). We have now included comparisons on demographic variables for all four conditions. We did not find any differences in gender composition, organizational tenure, or age. There was a significant association between country and condition. We acknowledge this in the limitations section and suggest that future research should examine the differences in more culturally homogenous samples. Please see page 12 for detailed revisions.

Please provide all items for perceived trustworthiness. From the one item, it seems as if this is more of a professional trust rating instead of an interpersonal trust rating. This could change the meaning of your results.

We now include all items for aggressiveness, professional trustworthiness, and organizational commitment scales. Please see page 13 for detailed revisions.

Why do you parcel five perceived trustworthiness items? I would understand doing so for longer scales but five items seem absolutely fine. Please report the results of the CFA without using parceling.

We used a parceling approach for trustworthiness items to minimize the redundancy of items as error terms for two trustworthiness items co-vary (“I feel that Pat will approach the job with professionalism and dedication” and “Given Pat’s track record, I see no reason to doubt Pat’s competence and preparation for the job”). We now report CFA results without parceling. Please see page 14 for detailed revisions.

We also ran additional analyses to ensure that the pattern and statistical significance of our findings do not change when we remove one or both items. We made a decision to retain the original 5-item scale as it has higher internal consistency. Please see the table below outlining each of the comparisons with different item composition of the trust scale.

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	ANOVA	<i>t</i> -test (comparing psychiatric and control group)
Trustworthiness, all items	$F(2,235) = 1.88, p = .156$	$t(128) = 2.01, p = .047$
Trustworthiness, item#1 excluded	$F(2,235) = 1.59, p = .206$	$t(128) = 2.02, p = .045$
Trustworthiness, item#2 excluded	$F(2,235) = 2.52, p = .084$	$t(128) = 2.01, p = .046$
Trustworthiness, items 1 & 2 excluded	$F(2,235) = 2.15, p = .119$	$t(128) = 2.03, p = .044$

Minor comments:

- You should define disability and maybe even physical and psychiatric disability. The importance of providing a definition has been highlighted by others to allow for a comparison of the results of different studies (Colella & Stone, 2005).

Thank you for this suggestion. We have included a definition of disability and specified different disability types. Please see page 5 for detailed revisions.

- You should use sub headers in the discussion to guide the reader (e.g., theoretical contributions, practical contributions, limitations, conclusion).

Good point. We have now included sub-headers in the discussion section.

In sum, although I think that you address an interesting issue, I believe that your paper could benefit from a more detailed theoretical development focus and clearer contributions. I hope that my comments prove helpful in this regard.

Good luck as you continue with this work!

Thank you again for your helpful comments and suggestions.

Responses to Reviewer 2's Comments

First, let me applaud the authors for examining the effects of the disclosure of disabilities on ratings of applicants. This topic is very important. Despite my enthusiasm for the topic, I do have several concerns about the manuscript.

We appreciate your feedback. We agree that this is an important topic and found your comments below to be helpful in revising the manuscript. We outline below a summary of changes, and the changes appear in the revised manuscript in a different font colour (blue) for ease of location.

1. The authors need to provide a more thorough review of the literature. Please see Stone and Colella (1996) for references on other studies that report that reactions to disclosure of a disability depends on the type of disability revealed (Tagalakis et al., Stone, 1986; Stone et al.). There are other studies in the literature on the effects of missing or disclosed information on ratings of applicants (Stone & Stone, 1989).

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3 We have substantially revised our theoretical background section. We now use a social cognitive
4 framework proposed by Stone and Colella (1996) to predicate our hypotheses. We also draw
5 from empirical research conducted by Brohan, Colella, Jones, Stone, Tagalakis, and other
6 researchers to support our predictions. Please see pages 5-9 for detailed revisions.
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9 *2. The authors need to provide a much stronger justification for their hypotheses. For example,*
10 *why do they predict that applicants with psychiatric disabilities will be perceived as more*
11 *aggressive or less trustworthy than those with a disclosed physical disability. Are people with*
12 *depression or chronic anxiety disorders perceived as more aggressive than others. Please*
13 *provide evidence for these perceptions about those with psychiatric or physical disabilities. See*
14 *the research by Jones et al. on stigmas and research in Social Psychology on inferences made*
15 *about people with disabilities. This is one of my major concerns about the paper.*
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18 We use two dimensions of disability – disruptiveness and danger (Jones et al., 1984; Stone &
19 Colella, 1996) – to provide justification for differences among different disability types. We also
20 provide empirical evidence from previous research to support our arguments. In the current
21 version, we clearly outline a ‘hierarchy’ of disability types. Please see page 7-9 for detailed
22 revisions.
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25 *3. I am also concerned that the study is not realistic because ADA and other disability laws*
26 *preclude hiring managers from accessing medical information about an applicant's disability.*
27 *You need to find other ways of manipulating types of disabilities. In view of this limitation, your*
28 *results have extremely limited implications for hiring those with disabilities.*
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31 *3. Given the arguments above, I am also concerned about the inferences you make from your*
32 *results. If hiring managers cannot access medical reports about applicants' disabilities, how do*
33 *your results have implications for hiring or placing individuals with disabilities. Please*
34 *explain.*
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37 We agree that many countries have regulations that prevent managers from accessing medical
38 files of their current employees. We acknowledge this in the discussion section. However, we
39 believe that our findings are applicable to a broader return-to-work context. There are many
40 ways managers can become aware of their employees’ disability status or type. For example,
41 employees may choose to disclose the nature of their disability via email when returning to work
42 from a short- or long-term absence. Please see pages 16-17 for detailed revisions. We have also
43 revised the introduction to clarify study contributions. Please see pages 2-4 for detailed revisions.
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46 Thank you for your comments and suggestions.
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Abstract

Purpose. This paper investigates the extent to which disability type contributes to differential evaluation of employees by managers. In particular, we examined managerial prejudice against psychiatric and physical disability as well as a pending diagnosis in a return-to-work scenario.

Design/methodology/approach. Working managers ($N = 238$) were randomly assigned to 1 of 3 scenarios containing medical documentation for a fictional employee that disclosed either the employee's psychiatric disability, physical disability, or pending diagnosis. We also collected a separate sample ($N = 42$) as a control group that received a version of the medical documentation but contained no information about a disability.

Findings. Compared with employees without stated disabilities, employees with a psychiatric disability were evaluated as more aggressive towards other employees, less trustworthy, and less committed to the organization. Compared to employees with either physical disabilities or pending diagnoses, employees with psychiatric disabilities were rated as less committed to the organization. We discuss implications for future research and the trade-offs inherent in disability labeling and disclosure.

Originality/value. The current study examines a broader range of outcomes (i.e., perceived aggressiveness, trustworthiness, and commitment) extending prior research and moving beyond performance evaluations of employees with disabilities. We also assess the relative status of a pending diagnosis, a type of disclosure often encountered by managers in accommodating employees returning to work from medical absence.

Keywords: disability; disclosure; return to work; stigma

Employee Disability Disclosure and Managerial Prejudices in the Return-to-Work Context

Employment rates for persons with disabilities are much lower than for individuals without disabilities (e.g., Kraus, 2017; Eurostat, 2017; Turcotte, 2014), and empirical evidence has long suggested that employees with disabilities face potential prejudice at all stages of a recruitment cycle (for a recent review, see Bonaccio *et al.*, 2019). While much research has focused on discrimination against employees with disabilities during a hiring process (Beatty *et al.*, 2019; Lyons *et al.*, 2017), prejudice against persons with disabilities goes beyond finding gainful employment (Snyder *et al.*, 2010; Stone and Colella, 1996). Even though employees with disabilities perform comparably to their co-workers without disabilities, studies continue reporting that employees with disabilities face numerous obstacles in the workplace (Kulkarni and Lengnick-Hall, 2014), including lower performance expectations from their supervisors (Dwertmann and Boehm, 2016) and perceived low levels of competence (Fiske *et al.*, 2002). As persons with disabilities might require a short- or long-term sickness absence from work (Post *et al.*, 2005) – indeed, in some cases, people acquire a disability during their employment (Reville and Schoeni, 2003) – understanding the factors that affect managerial perceptions of these employees when they return to work is extremely important. In the context of return-to-work, employees face a decision whether to disclose the nature of their disability. While such disclosure does not directly affect their employment status, it is likely to have implications for work-related outcomes.

Given negative stereotypes associated with a disability condition (e.g., Colella *et al.*, 1998), it is not surprising that disclosing a disability, let alone the nature of the disability, to an employer is of particular concern to many employees (Brohan *et al.*, 2012). This is despite the presence of legislation in many jurisdictions (e.g., Americans with Disabilities Act; United

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3 Kingdom's Disability Discrimination Act; Ontario Human Rights Code) aimed at ensuring that
4 employees with disabilities are not discriminated against. Growing social pressure to prevent
5 discrimination against individuals with disabilities has led to disability-inclusive human
6 resources practices in some organizations (Moore *et al.*, 2017). Nevertheless, managers do not
7 necessarily understand the experience of work for employees with disabilities, [resulting in subtle](#)
8 [forms of discrimination and negative evaluations of persons with disabilities. For example,](#)
9 [incongruence in disability status between employees and their managers is associated with](#)
10 [worsened outcomes compared to situations when both employees and managers have similar](#)
11 [disability status \(Dwertmann and Boehm, 2016\), suggesting that managers without disabilities](#)
12 [may not fully relate to experiences of persons with disabilities and evaluate employees with](#)
13 [disabilities based on readily available stereotypes.](#) Stereotypes about the nature of disability
14 result in stigmatization and discounting of employees with disabilities (Barnes and Mercer, 2005;
15 Thornicroft, 2006). Furthermore, researchers have argued that due to an increased legal and
16 social pressure to appear egalitarian, subtle forms of workplace discrimination have become
17 more prevalent (e.g., Deal, 2007; Jones *et al.*, 2017), and these forms of discrimination can have
18 more detrimental consequences for the targets of discrimination compared to more formal forms
19 of discrimination (Dhanani *et al.*, 2018).

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22 In practice, in many jurisdictions, employees are required to supply medical
23 documentation outlining and thus disclosing the type of the disability when returning to work in
24 order to determine what sort of accommodation is required – for example, graduated return to
25 work, reduced working hours, or flexible working hours. Research on discrimination in
26 organizations (e.g., Colella and Varma 1999; Dhanani *et al.*, 2018; Miller and Werner 2005;
27 Santuzzi *et al.*, 2014) suggests that, in seeking and accepting accommodations, employees are
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3 stigmatized and possibly evaluated differently by their managers depending on type of disability
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5 disclosed. Both psychiatric and physical disability conditions are often invisible and may not be
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7 clearly connected to a certain disability type. Furthermore, different types of disability can be
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9 manifested in similar ways (Santuzzi *et al.*, 2014). From this perspective, the disability label (i.e.,
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11 physical, psychiatric) and the manifestations of the disability have considerable implications for
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13 how managers categorize and further evaluate employees (Taylor and Fiske, 1978).
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17 By investigating how disability type affects managerial evaluations, the current study
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19 makes three contributions. First, we aim to replicate prior research by comparing how the
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21 disclosure of psychiatric and physical disabilities affects managerial evaluations of these
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23 employees (Ren *et al.*, 2008) in the return-to-work context. To date, research on disability
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25 disclosure has largely focused on the hiring context (for a review, see Bonaccio *et al.*, 2019). The
26
27 return-to-work context is different from hiring as employees already have secured employment,
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29 thus affecting managers' attitudinal outcomes rather than their choices about whether to hire the
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31 person or not. Second, the current study extends prior research to a range of outcomes beyond
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33 task performance evaluations. We examine how the nature of disability affects managers'
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35 perceptions of the returning-to-work employees' likelihood that these employees will mistreat
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37 other employees, along with perceptions of employees' professional trustworthiness and
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39 commitment to the organization. While representing more subtle forms of discrimination, these
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41 evaluations might have far-reaching consequences for employees with disabilities. For example,
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43 perceptions of aggressiveness can result in ostracism and social isolation of employees with
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45 disabilities (e.g., Martin *et al.*, 2000), while managers' assessments of professional
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47 trustworthiness and organizational commitment are likely to have implications for income (e.g.,
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49 bonuses) and career advancement (e.g., Shore *et al.*, 1995).
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3 Finally, the current research tests experimentally a common problem faced by employees
4 with disabilities and managers who receive medical documentation substantiating the nature of
5 an employee's disability. Labeling a disability (e.g., psychiatric, physical) likely has a similar
6 effect to what existing meta-analyses (e.g., Ren *et al.*, 2008) of experimentally-based human
7 resource judgments of employee disabilities have found: performance expectations of employees
8 with psychiatric disabilities are lower than performance expectations for employees with
9 physical disabilities. What is not clear is whether another commonly encountered categorization
10 (i.e., 'pending diagnosis') may protect employees with disabilities from unfair managerial
11 evaluations. A 'pending diagnosis' label substantiates a disability for purposes of the employer,
12 but does so without providing information about its medical nature. This categorization does not
13 label or disclose the type of disability open to stigma. Therefore, the current study compares the
14 evaluations of multiple types of disability against the 'pending diagnosis' label.
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31 **Theoretical Background and Hypotheses**

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33 Disability represents an umbrella term for a physical or mental impairment that results in
34 participation restrictions or activity limitations (WHO, 2011). In addition to the legal definition,
35 Colella and Stone (2005) highlighted the importance of perceptual processes involved in defining
36 whether a person has a disability. Observers' judgments about persons' disability status are
37 considered a critical aspect in defining disability (Stone and Colella, 1996). Incorporating these
38 two views, we refer to disability as a physical or mental impairment that is recognized by others
39 (i.e., managers). Stone and Colella (1996) identified six types of disabilities: physical conditions,
40 mental conditions, sensory impairment, learning disabilities, neurological conditions, and
41 addictive disorders. In this paper, we focus only on physical and psychiatric (i.e., mental)
42 disabilities given their prevalence in the general population (Okoro *et al.*, 2018).
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DISCLOSURE AND PREJUDICE 6

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3 Managers do not make evaluations of employees, including persons with disabilities, in a
4 uniform way. Instead, a number of employee characteristics, including disability status and type,
5 drives managers' attitudes toward employees (Colella and Stone, 2005; Stone and Colella, 1996).
6
7 To understand how observers react to persons with disabilities, Stone and Colella (1996)
8 proposed a social cognitive framework that explains how non-disabled individuals react to
9 people who have disabilities. Individuals hold mental structures that help them organize and
10 process information (Rosch, 1975; Stone *et al.*, 1992), and these mental structures comprise of
11 mental schemas (also referred to as mental categories). Mental schemas greatly reduce cognitive
12 load by automatically categorizing the person to a certain cognitive category based on the
13 person's attributes (e.g., an employee is classified as 'disabled'). While this cognitive process
14 simplifies information processing, such categorization has significant adverse consequences for
15 individuals with stigmatized identities (Beatty and Kirby, 2006; Stone and Colella, 1996).
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31 As a result of this categorization, additional information about the target person is
32 generated based on prototypical attributes of the mental category. These attributes include
33 stereotypes, i.e., generalized beliefs about members of a particular category (Jones *et al.*, 1984).
34 While stereotypes can have positive or negative valence (Lambert *et al.*, 1997), disability status
35 is generally associated with negative stereotypical beliefs (Colella and Varma, 2001; Stone and
36 Colella, 1996). Extremely negative stereotypes are referred to as stigmas: "attributes that serve as
37 the basis for the person being perceived as atypical, aberrant or deviant and thus being
38 discredited by those who are not stigmatized" (Stone *et al.*, 1992, p. 388). Further, the
39 stereotypes that accompany a particular mental category are persistent even when individuals
40 encounter disconfirming information (Colella and Varma, 1999; Krueger and Rothbart, 1988).
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3 Hence, categorization of a person goes beyond first impressions and can taint subsequent
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5 judgments and evaluations of that person.
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8 Stereotypes associated with the assigned category generate managers' expectations about
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10 persons with disabilities (Stone and Colella, 1996). When a manager categorizes an employee as
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12 having a disability, they infer attitudinal and behavioral expectations based on the stereotypes
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14 pertinent to the disability category. The nature of disability (e.g., physical, psychiatric) is used to
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16 assign persons with disabilities to a mental category (Stone and Colella, 1996), and subsequent
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18 reactions of nondisabled individuals to people with disabilities depend on the disability type
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20 (Colella and Stone, 2005). The type of disability disclosed, and specifically the stereotypes
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22 connoted by the disability type, are considered the most critical factors that affect evaluations of
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24 persons with disabilities (Colella and Stone, 2005; Stone and Colella, 1996; Vornholt *et al.*,
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26 2013).
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31 Not all disabilities are evaluated equally. Disability type has important implications for
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33 the stereotypes it evokes in the observers. Building on Jones *et al.*'s (1984) work, Stone and
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35 Colella (1996) described how observers such as managers make distinctions among employees
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37 with disabilities on six dimensions – aesthetic qualities, origin, course of the condition,
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39 concealability, disruptiveness, and danger – and how different types of disabilities invoke
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41 stereotypes and expectations of how employees with these disabilities will behave. These
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43 stereotypes, for example, could bias personnel-related decisions (e.g., hiring, promotion) and
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45 prejudice perceived social performance and work competence of employees with disabilities
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47 (Cuddy *et al.*, 2007; Fichten and Amsel, 1986).
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52 Research has shown that stereotypes, specifically additional information that is generated
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54 based on attributes associated with different categories, differ significantly across disability types
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3 (McLaughlin *et al.*, 2004; Vornholt *et al.*, 2013). Depending on the disability type, disability
4 status can range from more to less preferential (Hernandez *et al.*, 2000). Disruptiveness and
5 danger dimensions (Stone and Colella, 1996) are particularly relevant to the stereotypical beliefs
6 of persons with physical or psychiatric disabilities. Disruptiveness refers to the extent to which a
7 disability condition has consequences for social interactions. A higher level of disruptiveness is
8 associated with more negative stereotypes, and disruptive individuals are viewed as emotionally
9 unstable, incapable of teamwork, and having poor social skills. Compared to persons with
10 physical disabilities, people who have cognitive-related disabilities (e.g., psychiatric illness) are
11 more likely to be perceived as more disruptive (Jones *et al.*, 1984). The danger dimension
12 represents perceptions of threat and the risk that the person poses to others. People who have
13 threatening disabilities (e.g., psychiatric disability) are more likely to evoke negative attitudes
14 compared to those who have less threatening conditions (e.g., physical disabilities). Overall,
15 people with psychiatric disabilities are viewed more negatively than individuals with physical
16 disabilities because of the ambiguity and perceived threat associated with the condition (Jones *et*
17 *al.*, 1984).

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38 Empirical findings provide support for this argument. In the hiring context, candidates
39 with psychiatric disabilities are rated as less employable and less capable compared to candidates
40 with physical disabilities or no disabilities (for a review, see Brohan *et al.*, 2012). Bell and Klein
41 (2001) demonstrated that a job candidate in a wheelchair is seven times more likely to be hired
42 compared to a person with a psychiatric disability. Even a history of a psychiatric disability (e.g.,
43 depression) can negatively influence hiring recommendations (Reilly *et al.*, 2006). Overall,
44 persons with psychiatric disabilities encounter more negative evaluations than those who have
45 physical disabilities (e.g., Pearson *et al.*, 2003; Stone and Sawatzki, 1980).
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3 When comparing attitudes toward people with physical disabilities and no disability,
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5 research demonstrates that physical disability does not necessarily elicit negative stereotypes. In
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7 fact, some studies show that people with physical disabilities are evaluated more positively than
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9 people without disabilities (Belgrave and Mills, 1981; Colella and Stone, 2005; Spirito-Dalgin
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11 and Bellini, 2008; Tagalakis *et al.*, 1988). One explanation for these findings is that physical
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13 disabilities are perceived to be predictable and hence are not viewed as disruptive or dangerous
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15 and may even evoke feelings of sympathy toward the person with physical disability (Tagalakis
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17 *et al.*, 1988). Interestingly, empirical findings suggest that the extent of disclosure does not
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19 significantly affect evaluations of persons with disabilities, but rather those evaluations and
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21 attitudes depend on the type of disability disclosed (Spirito-Dalgin and Bellini, 2008).
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26 When a manager becomes aware of a particular disability ‘label’, stereotypes attached to
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28 that category become activated in the manager’s mind and subsequently guide their perceptions
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30 toward the employee (Biernat and Dovidio, 2000). Stereotyping is largely an unconscious
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32 process that often happens without observers’ awareness (Banaji and Hardin, 1996). When the
33
34 nature of disability is not disclosed, stereotypes attributed to the disability type are not readily
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36 available and therefore less likely to be evoked. In this paper, we argue that using ‘pending
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38 diagnosis’ – a common label used in medical documentation by healthcare practitioners to
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40 substantiate leaves of absence and return-to-work accommodation – serves as protection from
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42 negative stereotyping and, in turn, results in less negative evaluations of employees compared to
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44 psychiatric disabilities. It important to note that a pending diagnosis is different from not
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46 disclosing a disability. A pending diagnosis acknowledges that the employee has a disability
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48 (i.e., disability status) but does not specify the nature of the disability (i.e., disability type). The
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50 theoretical explanation provided above illustrates that in a hierarchy of disability types,
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3 psychiatric disability is the most stigmatized, whereas physical disability is the least likely
4 among disability types to evoke negative attitudes and it may even result in more positive
5 evaluations (see Colella and Stone, 2005). Pending diagnosis is likely to be in the proverbial
6 middle as it contains elements of uncertainty due to the undisclosed nature of the disability.
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12 In the return-to-work context, persons with disabilities have already secured employment.
13 Hence, we focus on managers' evaluations of employees' social performance (i.e., perceived
14 aggressiveness) and anticipated work attitudes (i.e., professional trustworthiness and
15 organizational commitment) as they return to work. Managers' evaluations of aggressiveness,
16 trustworthiness, and organizational commitment are particularly important as they may have
17 implications for interpersonal treatment of employees with disabilities, their career progression
18 and compensation.
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28 *Hypothesis 1: Disability condition will affect managers' perceptions of employee*
29 *aggressiveness, such that employees with a psychiatric disability will be*
30 *evaluated as the most aggressive among all disability types (H1a), and employees*
31 *with a physical disability will be evaluated as the least aggressive among all*
32 *disability types (H1b).*
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35 *Hypothesis 2: Disability condition will affect managers' perceptions of employee*
36 *professional trustworthiness, such that employees with a psychiatric disability*
37 *will be evaluated as the least trustworthy among all disability types (H2a), and*
38 *employees with a physical disability will be evaluated as the most trustworthy*
39 *among all disability types (H2b).*
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42 *Hypothesis 3: Disability condition will affect managers' perceptions of employee*
43 *anticipated organizational commitment, such that employees with a psychiatric*
44 *disability will be evaluated as the least committed among all disability types*
45 *(H3a), and employees with a physical disability will be evaluated as the most*
46 *committed among all disability types (H3b).*
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49 Method

50 Procedure

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3 To assess the attitudes of managers to employee disability type, the medically-diagnosed
4 condition of a focal employee, Pat (a gender-neutral name), was experimentally manipulated in
5 the form of a brief vignette (see Appendix) and a realistic-looking medical note (see Figure 1)
6 from a health care provider requesting a graduated return-to-work schedule (see Figure 2). One
7 of the authors had considerable experience with accommodating employees with disabilities, and
8 the medical note was modelled after the real examples she and other managers encountered in
9 her organization. There were three possible categories of disability type: *psychiatric*, *physical*,
10 and *pending diagnosis*. The pending diagnosis condition served as an ecologically valid control
11 group, effectively holding a medical opinion constant as with the psychiatric and physical
12 conditions but not specifying what the nature of the disability was. A fourth condition served as a
13 control group; it was separate from those receiving psychiatric, physical, or pending diagnosis
14 conditions above, and contained no information or label about Pat's diagnosis. In all conditions,
15 the vignette began with a short description about Pat's company (Conexpro), Pat's job
16 characteristics, as well as Pat's work history prior to the medical leave. The full vignette is
17 presented in the Appendix. Each participant in the first sample was randomly assigned to one of
18 the three conditions, with participants in the second sample receiving the control condition only.

39 **Samples**

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42 A total of 1,065 individuals pre-selected as employed managers received an electronic
43 survey through StudyResponse, a service offered through the University of Syracuse for
44 conducting electronic surveys (Stanton and Weiss, 2002); 240 responded and participated in the
45 study (22% response rate) ("Sample 1"). Of these respondents, 139 (58%) were female and 34%
46 indicated that they had been in a medical leave of absence (excluding parental leave). The
47 average age of the participants was 40 years ($SD = 10.11$, range = 20 to 70), had a mean
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DISCLOSURE AND PREJUDICE 12

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3 organizational tenure of approximately 10 years ($SD = 8.07$, range = 1 to 40), and worked in a
4 wide variety of countries: 135 (57%) worked in the United States (U.S.), 49 (21%) in Canada, 13
5 were from Australia (5%), and 40 (17%) worked in various other countries. Of the participants
6 completing the survey, 88 (37%) were randomly assigned to the psychiatric condition, 68 (29%)
7 to the physical condition, and 82 (34%) to the diagnosis pending condition.
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15 The second sample (“Sample 2”), also recruited through StudyResponse, consisted of 104
16 respondents. Of these respondents, 47 (45%) were female. The average age was 38 ($SD = 8.40$,
17 range = 24 to 69). Respondents had a mean organizational tenure of 10 years ($SD = 6.31$, range =
18 1 to 31), with the majority of participants from the U.S. (89%), and 38% indicated that they had
19 been on a medical leave of absence. All participants were presented with the same description
20 but received no information about the nature of Pat’s disability. Furthermore, to ensure that
21 respondents from the control group do not attribute a particular disability type to the described
22 control condition (e.g., Santuzzi et al., 2014) – which could evoke stereotypes associated with
23 the anticipated condition – we asked them to specify which type of condition was described in
24 the vignette. Of 104 respondents, 42 (40%) reported that there was “no condition indicated,” 54
25 (52%) attributed the described scenario to physical condition, five (5%) reported psychiatric
26 condition, and two (2%) suggested pending diagnosis. Only those respondents who indicated “no
27 condition” (i.e., $N = 42$) were included in the subsequent analysis as the control group.
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45 A comparison of the gender composition of the four experimental groups did not reveal
46 any differences ($\chi^2(3) = 3.31, p = .347$). Experience with being on a medical leave of absence
47 (excluding parental leave) did not differ across the conditions ($\chi^2(3) = 1.84, p = .605$). There
48 were also no significant differences in participants’ average organizational tenure [$F(3, 272) =$
49 $.68, p = .562$] or age [$F(3, 272) = 2.58, p = .054$] across the four groups. However, given that the
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control group had a higher percentage of participants from the U.S., there was a significant association between country and experimental group ($\chi^2(9) = 30.83, p < .001$).

Measures

Perceived aggressiveness. We measured perceived aggressiveness with four items developed for the current study, capturing the extent to which the respondent felt afraid of Pat's interpersonal behavior while at work (cf. Barling *et al.*, 2001). The items were "I am afraid that Pat will shout or swear while at work," "I am afraid that Pat will be violent at work," "I am afraid of how Pat will behave while at work," and "In general, I am afraid that Pat will display some form of aggression, violence, or threat of aggression or violence at work." The items were anchored on a 7-point scale (1 = strongly disagree to 7 = strongly agree) (Sample 1, $\alpha = .92$; Sample 2, $\alpha = .98$).

Perceived professional trustworthiness. To measure professional trustworthiness we adapted five items from McAllister's (1995) cognitive trust scale (1 = strongly disagree to 7 = strongly agree): "I feel that Pat will approach the job with professionalism and dedication," "Given Pat's track record, I see no reason to doubt Pat's competence and preparation for the job," "I will be able to rely on Pat not to make my job more difficult by careless work," "I feel that most people, even those who aren't close friends of Pat, trust and respect Pat as a coworker," and "Work associates who interact with Pat consider Pat to be trustworthy" (Sample 1, $\alpha = .89$; Sample 2, $\alpha = .93$).

Perceived organizational commitment. We adapted four positively worded items from Meyer and Allen's (1997) organizational affective commitment scale: "I believe that Pat would be very happy to spend the rest of a career with Conexpro," "I believe that Pat enjoys discussing Conexpro with people outside of the company," "I believe that Pat feels that a problem for

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3 Conexpro is a problem for Pat,” and “Conexpro has a great deal of personal meaning for Pat.”

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5 All items were measured on a 7-point scale from strongly disagree (1) to strongly agree (7)

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7 (Sample 1, $\alpha = .77$; Sample 2, $\alpha = .84$).

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10 **Marker variable.** To assess the presence of common method variance (CMV), we used a
11 marker variable in the form of a 7-item measure of empathy (Davis, 1980) (1 = does not describe
12 me well, 5 = describes me very well). A sample item is “I am often quite touched by things that I
13 see happen.” (Sample 1, $\alpha = .79$; Sample 2 $\alpha = .80$)

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19 **Demographic variables.** We collected data about respondents’ gender, age, tenure, and
20 country of residence.

21 22 23 24 25 **Results**

26 To test the discriminant validity of the measures, we conducted a series of confirmatory
27 factor analyses in Mplus 7 (Muthén and Muthén, 2019). The three-factor model¹ (i.e., perceived
28 aggressiveness, perceived trustworthiness, and perceived commitment) demonstrated excellent
29 fit to the data, $\chi^2(61) = 160, p < .001$, comparative fit index (CFI) = .96, Tucker-Lewis index
30 (TLI) = .95, root mean square error of approximation (RMSEA) = .08, standardized residual
31 mean (SRMR) = .06. The three-factor model had significantly better fit than both a two-factor
32 model (i.e., commitment and trustworthiness combined) ($\Delta\chi^2(2) = 203, p < .001, \chi^2(63) = 363,$
33 $p < .001, CFI = .89, TLI = .86, RMSEA = .13, SRMR = .09$), and a one-factor model (i.e., all
34 items load onto a single construct) ($\Delta\chi^2(3) = 843, p < .001, \chi^2(64) = 1,003, p < .001, CFI = .64,$
35 $TLI = .56, RMSEA = .23, SRMR = .22$). Furthermore, we used a marker variable technique
36 (Lindell & Whitney, 2001) to assess the impact of CMV (Podsakoff *et al.*, 2003). After partialing
37 out the variance, all relationships remained significant, suggesting that CMV did not affect the
38 results.
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3 Descriptive statistics for the two samples appear in Table 1, and zero-order correlations
4 among the study variables and scale reliabilities appear in Table 2. To test our hypotheses in
5 Sample 1, we conducted three ANOVAs using diagnosis condition – physical, psychiatric, or
6 pending diagnosis – as our independent variable and perceived aggressiveness, perceived
7 professional trustworthiness, and perceived organizational commitment as each of the dependent
8 variables. To compare the three disability conditions, we also conducted post hoc pairwise
9 analyses with a Bonferroni correction. As Sample 2 (control group) was collected separately, we
10 then conducted independent sample *t* tests to identify significant differences between each of the
11 three conditions in Sample 1 with the control group in Sample 2.
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26 Insert Tables 1 and 2 about here
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31 Perceptions of Pat's aggressiveness varied by type of disability [$F(2, 235) = 3.57, p = .03,$
32 partial $\eta^2 = .03$]², with significantly higher perceptions of aggressiveness in psychiatric condition
33 ($M = 2.64, SD = 1.20$) than physical condition ($M = 2.18, SD = 1.06$), $t(154) = 2.52, p = .038, d$
34 $= .41$, but not pending diagnosis ($M = 2.30, SD = 1.13$), $t(168) = 1.95, p = .157$. These results
35 provided partial support for Hypothesis 1. Perceptions of professional trustworthiness did not
36 differ across disability conditions [$F(2, 235) = 1.88, p = .156$], failing to support Hypothesis 2.
37 Anticipation of Pat's organizational commitment varied by disability type [$F(2, 235) = 4.49, p =$
38 $.012$, partial $\eta^2 = .04$]³. Post hoc analysis indicated that psychiatric condition resulted in
39 significantly lower perceptions of Pat's commitment ($M = 4.26, SD = .88$) than physical
40 condition ($M = 4.70, SD = .92$), $t(154) = -2.97, p = .01, d = .49$, but not pending diagnosis ($M =$
41 $4.50, SD = .95$), $t(168) = -1.70, p = .271$, providing some support for Hypothesis 3.
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DISCLOSURE AND PREJUDICE 16

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3 Further, we examined whether the three conditions in Sample 1 differed from the control
4 group in Sample 2 on the three outcomes. When comparing psychiatric condition to the control
5 group, significant differences were found for all three dependent variables: perceptions of
6 aggressiveness [$t(128) = 2.33, p = .021, d = .43$], professional trustworthiness [$t(128) = -2.01, p$
7 = $.047, d = .37$], and organizational commitment [$t(128) = -2.55, p = .012, d = .45$]. There were
8 no significant differences between the control group and either the physical disability or pending
9 diagnosis conditions with respect to perceived aggressiveness, perceived professional
10 trustworthiness, or perceived organizational commitment.
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22 Discussion

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24 In this paper, we examined the extent to which disability type contributed to differential
25 evaluations of employees by managers. Our findings indicate that employees with psychiatric
26 disabilities are negatively evaluated by managers. Employees with disclosed psychiatric
27 disabilities were evaluated as more aggressive, less trustworthy, and less committed to the
28 organization than employees without disabilities. Moreover, employees with disclosed
29 psychiatric disabilities returning to work were perceived by managers as less committed to the
30 organization than employees with physical disabilities. Further, we examined how disclosure of a
31 disability of an undiagnosed nature (“pending diagnosis”) would compare to the effects of a
32 disclosed psychiatric or disclosed physical disability across three outcomes. Compared with
33 employees with either disclosed psychiatric or physical disabilities, employees with pending
34 diagnosis were perceived by managers as no more aggressive towards other employees, no less
35 trustworthy, and no less committed to the organization. Compared to employees without
36 disabilities (control group), employees with physical disabilities or pending diagnoses were
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3 perceived as no more aggressive, no less trustworthy, and no less committed than employees
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5 without disabilities.
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7 **Theoretical and Practical Implications**

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10 Our findings have important implications for the disclosure decisions of employees with
11 disabilities and managers' reactions to the disclosure. Although labor legislation in some
12 countries prevents managers from accessing medical documents of an employee (e.g., Americans
13 with Disabilities Act), employees who are returning to work from a short- or long-term absence
14 might choose to disclose their disability to the manager and/or coworkers. Disability disclosure
15 takes place at different stages (e.g., during an interview, when returning to work, or while on the
16 job). Previous research indicates that the stage of disability disclosure and disability type have
17 implications for the outcomes (e.g., Bonaccio *et al.*, 2019; Stone and Colella, 2005), while the
18 amount of disclosed information does not (e.g., Spirito-Dalgin and Bellini, 2008). Given that an
19 employee may acquire a disability during their employment, understanding how managers react
20 to a disclosed disability in the return-to-work context has important practical implications.
21 Overall, our findings suggest employees with a pending diagnosis or where no diagnosis is
22 provided tend to experience better outcomes.
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40 Another important implication of the current research is the need to disclose a psychiatric
41 disability. While employment documentation required for organizational entry such as résumés
42 and job applications do not require disclosure of a disability, policies for organizational re-entry
43 such as return-to-work often require details of the disability to accommodate the employee
44 appropriately. The present research demonstrates that managers' perceptions of employees with
45 disclosed psychiatric disabilities are, at least in the case of anticipated organizational
46 commitment, different from employees with disclosed physical disabilities. These findings were
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3 robust and did not change when we included managers' gender and managers' personal
4 experiences with medical leave. Supervisors play an influential role in socializing employees
5 with disabilities (Kulkarni and Lengnick-Hall, 2011). Managerial perceptions of employee
6 commitment to the organization may seem innocuous, but have implications for how the
7 employee is treated (Shore *et al.*, 1995; Shore *et al.*, 2008). This includes the extent to which
8 managers perceive employees with psychiatric disabilities as having potential and being
9 promotable, which may threaten the longer-term interests of employees with psychiatric
10 disabilities by providing the shorter-term benefits of workplace accommodations after disability
11 disclosure. This is consistent with Ren *et al.*'s (2008) meta-analysis of experimental studies on
12 the effects of disability on managers' judgments: they found differences for psychiatric and
13 physical disabilities on managers' performance expectations of employees with disabilities, but
14 had no data on differences on perceived organizational commitment.
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31 In the context of return to work, Florey and Harrison (2000) explored the factors that
32 correlated with managers' compliance with requests for accommodation from employees with
33 disabilities. In their two studies, perceived obligation to provide accommodation and attitudes
34 towards perceived performance instrumentality (i.e., the extent to which managers felt
35 employees would be able to fulfill job responsibilities) played important roles, so judgments of
36 the potential of employees with disabilities has implications for even accommodating the
37 disability appropriately.
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47 While not disclosing a disability might seem a preferable option, research on disability
48 concealment demonstrates that concealment has negative consequences for employees' well-
49 being (Pachankis, 2007). In the current study, we explored the relative status of a pending
50 diagnosis label (i.e., disclosing disability status without specifying its nature); it seems
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3 employees with pending diagnoses get the proverbial benefit of the doubt, and are assessed no
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5 differently on the three outcomes compared to employees with disclosed disabilities. While
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7 absence of differences from a single study does not provide definitive evidence, these results
8
9 suggest that disclosing a disability but not being specific about its nature may be an appropriate
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11 way forward. Pending diagnoses in medical documentation to substantiate gradual return to work
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13 was commonly encountered by one of the authors of the current study in her practice as a human
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15 resource professional dealing with return to work accommodation. While accommodating many
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17 types of disabilities may be required of managers, there seems to be a stigma attached to
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19 psychiatric disability that does not exist for most managerial evaluations of employees with
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21 physical disabilities or those with pending diagnoses. Using the pending diagnosis label may
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23 therefore be appropriate when there is concern that disclosing a psychiatric disability could
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25 engender prejudice from stigma but also meeting requirements for return-to-work
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27 accommodation.
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33 Finally, we did not find any differences between disclosed physical disability and the
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35 control condition suggesting that employees with disclosed physical disability are not evaluated
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37 differently in terms of aggressiveness, professional trustworthiness, or organizational
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39 commitment. This finding is consistent with research conducted in the hiring context (e.g.,
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41 Spirito-Dalgin and Bellini, 2008; Tagalakis *et al.*, 1988). When making decisions about disability
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43 disclosure, it would be helpful for employees and practitioners to understand implications of
44
45 disclosing different types of disabilities.
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49 **Limitations and Directions for Future Research**

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51 The current research provided an analysis of how the stereotypes associated with the
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53 nature of the disability affect managerial evaluations. We used three general categorizations –
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3 psychiatric disability, physical disability, and pending diagnosis – in medical documentation
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5 accompanying a gradual return to work request. What is less clear is how disclosing different
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7 types of psychiatric (e.g., autism; Johnson and Joshi, 2016; depression; Martin, 2010) or physical
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9 conditions (e.g., cancer; Martinez *et al.*, 2016; Robinson *et al.*, 2015), disability severity, or co-
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11 morbid disabilities (Dwertmann, 2016) may affect the pattern of results. Future research should
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13 consider exploring the implications of these situations in field-based studies. Further, how
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15 disclosure of a disability may change the behavior of employees in response to cues of
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17 managerial discrimination (e.g., the belief that Pat will be less committed to his/her organization)
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19 or self-created barriers to performance once back to work is also unclear (Kulkarni and
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21 Lengnick-Hall, 2014). Finally, the focus of this study was specifically on managerial prejudice to
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23 employees with disabilities in the context of return-to-work. What is less clear is how disclosing
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25 medical information in general affects managerial prejudice. For example, employees who are
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27 returning from medical leave but do not have a disability (e.g., returning from a surgery) might
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29 be evaluated differently based on the medical information they provide.
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35 There are also several methodological limitations and implications for future research.
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37 First, this was an analogue study (Aguinis and Bradley, 2014) in which results were derived from
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39 a context in which managers had no stake (i.e., Pat was a ‘paper person’ in an on-line
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41 experiment) or the ability to ask follow-up questions. Future research needs to be able to
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43 examine such judgments in real-life situations in which social desirability may not be as strong
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45 (Colella and Stone, 2005; Dwertmann, 2016) and overall positive global attitudes to employees
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47 with disabilities, concerns about impression management, and sympathy effects are less salient
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49 (Kulkarni and Lengnick-Hall, 2014).
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3 Second, respondents provided perceptions of Pat after learning about the type of
4 disability in the context of documentation for gradual return-to-work. While this feature of the
5 vignette was consistent across all three conditions, we cannot determine whether managers were
6 responding differentially to Pat's disability, the gradual return-to-work, or both. Nevertheless,
7 research often compares attitudes towards employees with disabilities with employees without
8 disabilities in realistic job contexts, and thus the current research provides further understanding
9 of how being able to label the nature of the disability makes a difference.

10
11 In workplaces with employees returning to work following leave from a disability,
12 employees' pre-leave performance would probably influence managers' subsequent evaluations.
13 There are also a number of contextual and dispositional factors that could affect how managers
14 react to disclosed disability. For example, some companies might have training programs or
15 internal regulations around return-to-work for employees from medical leave. In both samples,
16 the majority of participants were employed in the U.S., with a relatively small number of
17 respondents from other countries (e.g., Canada, Australia). We suggest future research examines
18 cultural context, including possible differences in labor laws, as managers' reactions to disclosed
19 disability might differ across jurisdictions. Finally, the control group had a higher percentage of
20 participants from the U.S. compared to other experimental groups. Dwertmann (2016)
21 highlighted that work values vary across cultures and countries. Hence, we suggest future
22 research examine reactions to persons with disabilities in the return-to-work context in more
23 culturally homogenous samples.

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Conclusion

In conclusion, the current research illustrated how types of disability affected managers' evaluations of employees in the context of gradual return to work. The results suggest that, apart

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3 from managers' evaluations of organizational commitment of employees with psychiatric
4 disabilities, perceptions of employee trustworthiness and aggressive behavior toward co-workers
5 do not differ by disability type. This emphasizes the potential importance of a pending diagnosis
6 categorization in jurisdictions in which specification of a reason for work absence is required,
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8 but disclosure of the nature of the disability is not mandated.
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Personnel Review

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Footnotes

¹ We allowed error terms for two items from professional trustworthiness scale to covary (“I feel that Pat will approach the job with professionalism and dedication” and “Given Pat’s track record, I see no reason to doubt Pat’s competence and preparation for the job”). To ensure robustness of ANOVA results and *t*-test comparisons we ran the analyses with different combinations of professional trustworthiness items comprising the observed professional trustworthiness variable (i.e., removing one of the items and both items). The pattern and significance of the results remained the same.

² After controlling for respondents’ gender and having personal experience with medical leave, the pattern of the results remained the same, $F(2, 235) = 3.61, p = .028$.

³ Including respondents’ gender and personal experience with medical leave did not change the pattern of the results, $F(2, 235) = 4.55, p = .012$.

Table 1

Managerial attitudes towards employee as a function of disability type

Managerial Attitudes	Psychiatric <i>n</i> = 88		Physical <i>n</i> = 68		Pending Diagnosis <i>n</i> = 82		Control Group <i>n</i> = 42	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Organizational commitment	4.26	.88	4.70	.92	4.50	.95	4.73	1.17
Perceived professional trustworthiness	5.14	1.00	5.44	1.01	5.33	.95	5.52	1.05
Perceived aggressiveness	2.64	1.20	2.18	1.06	2.30	1.13	2.10	1.35

Personnel Review

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Table 2*Scale reliabilities and zero-order intercorrelations of study variables for Samples 1 and 2*

Variables	α	α	1	2	3
	Sample 1	Sample 2			
1. Organizational commitment	.77	.84		.77**	-.40*
2. Perceived trustworthiness	.89	.93	.36**		-.64**
3. Perceived aggressiveness	.92	.98	-.10	-.34**	

Note. Sample 1 correlations appear below the diagonal ($N = 238$). Sample 2 correlations appears above the diagonal ($N = 42$). Means and standard deviations for both samples appear in Table 1.

α = Cronbach's alpha.

* $p < .01$, ** $p < .001$.

Appendix

The structure of the vignette's experimental manipulations

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

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

Shortly after Pat's colleagues noticed these symptoms, a medical certificate signed by a specialist physician arrived at the Human Resources department, stating that Pat was unable to work for an indefinite period due to a *[psychiatric, physical, an undiagnosed condition]*.

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

Queen Elizabeth Health Center
 Medical Specialists Clinic
 Tel. (123) 456-7890

Surname: _____
 First Name: Pat

R

Unable to work for
 indefinite period of time due
 to psychiatric condition

Repeat: -1- -2- -3- -4- -5- NR

Dr. 

License No.: Q2746-13

Figure 1. Example of a medical note specifying reasons for work leave (in this case, psychiatric condition)

Queen Elizabeth Health Center
 Medical Specialists Clinic
 Tel. (123) 456-7890

Surname: _____
 First Name: Pat

R

Gradual return to work
 over 6 week period:

2 days x 2 weeks

3 days x 2 weeks

4 days x 2 weeks

Repeat: -1- -2- -3- -4- -5- NR

Dr. [Signature]

License No.: Q 2746-13

Figure 2. Example of a medical note specifying schedule for gradual return-to-work (appeared in all three conditions and control group)