

The Disclosure Conundrum: How People With Psychiatric Disabilities Navigate Employment

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The vocational rehabilitation and mental health literatures usually urge people with psychiatric disabilities to disclose their disability at work. Reasons for preferring disclosure include the opportunity to invoke rights conferred by the Americans with Disabilities Act of 1990, the risk of losing federal disability benefits when earning a higher income, and the belief—held by many professionals—that people with psychiatric disabilities will experience permanently debilitating symptoms. However, a newer model of recovery from psychiatric disability challenges these assumptions. A qualitative study of people with psychiatric disabilities explored these issues. The participants were current or former recipients of social security benefits provided to persons with significant disabilities. Participants described complex situations around employment and disclosure, which were more difficult to resolve than disclosure advocates have recognized.

Keywords: disability, employment, disclosure, mental illness, psychiatric disability

Usually when you start talking about yourself on the job, that tends to make them treat you different . . . I don't want to tell anybody, because people who aren't ill, they do have a tendency sometimes to treat you different. They'll start teasing you or they'll shy away from you. It's a strange thing about us, the mentally ill, we've got to disguise ourselves a lot, because people who aren't ill, when they know things about you, they tend to treat you different.

—Jeanine, a person living with schizophrenia (study participant)

Jeanine is one of many people with psychiatric disabilities currently in the workforce, 15 years after the passage of the Americans with Disabilities Act of 1990 (ADA). Although the intent of the ADA was to help people with physical as well as psychiatric disabilities find and maintain work, effective inclusion of individuals with psychiatric disabilities in the workforce has not yet been achieved fully (Cook & Razzano, 2000). Instead, “the invisible workforce” struggles for equality of employment opportunity (Anthes, 2000).

A longitudinal qualitative study explored the barriers to employment faced by 32 people recovering from significant symptoms of psychiatric disabilities. This article focuses on one set of decisions that the participants had to make in the process of finding jobs or reentering the workforce. These decisions centered on

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whether to disclose the disability at work and, if so, to whom, when, and the extent of the disclosure. The participants were people who had limited financial resources and had received federal social security benefits that are available to people with significant disabilities. Many participants were also receiving public mental health and vocational rehabilitation (VR) benefits.

As discussed below, many professionals in the public mental health and VR fields promote employment disclosure by their clients with psychiatric disabilities. In spite of this disclosure approach preferred by many professionals, many study participants grappled privately with disclosure decisions. Disclosure was not always their preferred choice. This article discusses the particular set of challenges that these participants faced in making their disclosure decisions.

The introductory section addresses the ADA and other laws and policies that have a significant impact on the employment experiences of some people with psychiatric disabilities. The role of the public mental health and VR systems in the employment experiences of the study participants is then explained. There are two competing perspectives among researchers and mental health professionals about the trajectory of psychiatric disability: the medical model and the recovery paradigm. The introduction also discusses how these conflicting approaches affected the employment experiences and disclosure decisions of the study participants.

Definitions

Psychiatric Disability

In this article, a person with a *psychiatric disability* refers to a person with severe mental illness or severe and persistent mental illness; these are some of the terms for people diagnosed with schizophrenia, bipolar disorder, depression, anxiety disorders, and other mental illnesses. We use the term psychiatric disability because it is the term generally preferred by people living with mental illness (International Association of Psychosocial Rehabilitation Services [IAPRS], 2003). We do not claim (nor is it necessary to demonstrate) that every person we refer to as being a person with a psychiatric disability would meet the very narrow definition of “person with a disability” that has been adopted by courts interpreting the ADA.

Consumers

A subgroup of people with psychiatric disabilities are sometimes referred to as *consumers* or *mental health consumers*. This term refers to people with psychiatric disabilities who use public mental health or VR services. This article does not use that term, because advocacy groups find it pejorative (IAPRS, 2003). In this article, we simply refer to “people with psychiatric disabilities.”

Stigma

Stigma is the “negative and inaccurate views of mental illness” held by many members of society (Wahl, 1999b, p. xvii), a term first brought into public discourse by Goffman (1963). Generally, stigma refers both to the negative views held by those without the disability as well as the internalized shame experienced

by someone with the disability (Allbright, 2003). Recently some propose that *discrimination* is a better term for referring to the negative views held by nondisabled persons (IAPSRs, 2003). Because the participants and much of the literature use the term stigma to refer to the negative views held by others, that convention is followed in this article.

Employment Decisions

What Employment Decisions?

Some people with psychiatric disabilities have periods of nonemployment because of their disability. At some point, or at various times, they decide to reenter the workforce. During that process they face a series of decisions, from how to look for a job, to what kind of job to seek, to how many hours to work, and what kind of information to disclose to employers. One particularly delicate issue is whether to invoke one's right to seek an accommodation at work for the disability, as authorized by the ADA. To do so, one must first disclose information about the disability to a potential or actual employer.

The Systems

Some people with psychiatric disabilities find themselves involved with the public mental health or VR systems after a period of hospitalization or other episode of severe symptomatology. The systems consist of federal- and state-sponsored mental health and VR services, which usually are provided at no cost to people with psychiatric disabilities who have limited financial means. Many people involved in the mental health or VR systems receive social security benefits for their psychiatric disability. The Rehabilitation Act of 1973 authorized a range of mental health and VR services for people with disabilities. In some states, mental health and VR services are provided in a unified setting, which is sometimes called a *clubhouse*. In the clubhouse, people recovering from psychiatric disability work with VR counselors, caseworkers, and other professionals. The Rehabilitation Act of 1973 (Title I) mandates that VR counselors help people with disabilities find employment. Although VR services are intended to serve all people with disabilities, people with psychiatric disabilities make up the largest single disability group in the VR system.

Not everyone with psychiatric disabilities and receiving public benefits due to their disability remains in the mental health or VR systems for long periods. Most people with psychiatric disabilities never receive public benefits because of financial resources and other supports (Stefan, 2001, 2002). This article discusses a subset of people with psychiatric disabilities. The subset consists of persons with limited financial resources, who have received social security disability benefits, and who may also have received publicly funded mental health or VR services.

Legal Framework

The ADA

The ADA, a federal law passed in 1990, prohibits discrimination against people with physical or mental disabilities. A descendant of the civil rights movements of the 1960s, it is imbued with the broad ideals of that era's legislation

and the goals of empowerment (Wodatch, 1990). The congressional findings were broad based. For example, one finding claimed that there had been a pervasive pattern of discrimination against people with disabilities in employment and other areas (ADA, Section 2). The congressional intent for the ADA was to address these conclusions and help people with disabilities achieve "equality of opportunity, full participation, independent living, and economic self-sufficiency" (Section 2).

The ADA prohibits discrimination in employment. It also allows persons with disabilities to obtain work accommodations under certain circumstances. The ADA's Title I, addressing employment, requires employers to make a reasonable accommodation to the known physical or mental limitations of a job applicant or employee, as long as the accommodation does not create an undue hardship on the employer (Section 102). The term *reasonable accommodation* is defined to include "job restructuring, part-time or modified work schedules, . . . and other similar accommodation" (Section 101(9)).

The accommodation provision is useful, but the ADA also contains a notice provision that authorizes accommodations only for known disabilities. An employee must disclose some aspect of his or her mental health condition to obtain a workplace accommodation. When a disability is more apparent, as in the case of mobility impairments, the employee's dilemma generally is when to disclose. For example, is it better to disclose in the letter of inquiry or wait until the job interview? The disclosure analysis is often more complicated, however, for people with psychiatric disabilities and other hidden disabilities. The question may then be whether to disclose at all and, if so, how much. A group of experts called the disclosure decision a "wrenching" one for people with psychiatric disabilities (Behney, Hall, & Keller, 1997).

Family and Medical Leave Act of 1993 (FMLA)

The FMLA also provides rights to people with disabilities. An eligible employee is entitled to take 12 weeks of unpaid leave per year under certain circumstances, one of which is a serious health condition that makes the employee unable to perform the functions of his or her position.

Other Federal Policies

In addition to the ADA and FMLA, other federal and state policies, such as the social security disability program, have an impact on employment options for people with psychiatric disabilities. These policies send conflicting messages to beneficiaries about employment, particularly on whether to seek full-time or mentally challenging work, as full-time or higher paid work may result in a recipient's losing disability benefits, health insurance, and related benefits (Burkhauser, 1997; Mashaw & Reno, 1996; National Council on Disability, 1997; O'Day & Killeen, 2002a).

Thus, the ADA and other federal laws and policies have a significant impact on the employment experiences of those people with psychiatric disabilities who have limited financial means and who may need accommodations to sustain employment.

Competing Professional Paradigms

Medical Model

One perspective regarding disability held by many VR and mental health professionals is based on the medical model of disease. It holds that psychiatric disabilities result in permanently debilitating conditions with recurrent symptoms. For example, Smith, Schwebel, Dunn, and McIver (1993) reflect this view when they state the following: “A diagnosis of schizophrenia implies chronicity, almost by definition, because of its generally poor prognosis” (p. 966).

Employment Implications of the Medical Model

Many VR professionals subscribe to the medical model, which then has an impact on the advice provided by VR counselors. Most place their clients with psychiatric disabilities in part-time, low-wage positions, regardless of clients’ past work experience. The preference for low-wage work is based on two important concerns. The first is that the stress of a more challenging job will exacerbate symptoms and cause a relapse; the second is that higher pay may result in the loss of federal benefits.

VR staff may view these low-paying jobs as fairly interchangeable, making it less important for the counselors to determine the best work environment or job fit for a particular client (Baron, 1995; Kirsh, 2000). The job that a VR counselor may find for a client with a psychiatric disability may or may not be suited to that person’s educational qualifications, employment interests, or work potential. It was recently found that vocational outcomes of people with psychiatric disabilities will improve if the VR counselor makes an effort to understand the “culture and climate of the workplace and the extent to which the values for persons and work environments fit with one another” (Kirsh, 2000, p. 19). Because research in the general employment field has consistently concluded that people will be more successful in jobs compatible with their values and preferences, this finding in the VR field highlights that the VR emphasis is more on finding a job than finding a good fit.

Jobs found by VR professionals, often called *supported employment*, generally involve explicit or implicit disclosure of the disability by the employee to the employer. Disclosure usually occurs by necessity, because VR counselors and staff arrange the jobs for their clients. Employers usually know that employees who use VR services have disabilities.

As a result, many VR and mental health professionals believe that people with psychiatric disabilities should disclose their disabilities to employers (Marrone & Golowka, 1999). Most VR research investigates supported employment settings that involve disclosure (Bond et al., 2001; Greig & Bell, 2000).

Recovery Paradigm

In recent years, some mental health and VR professionals and disability activists have argued that a “recovery” paradigm is a more accurate view of psychiatric disability (Frese & Walker Davis, 1997; Scheid, 1999). The recovery perspective postulates that most people with psychiatric disabilities recover from the most disabling experiences, and that recovery is a process of gradual improve-

ment in social and psychological functioning. Recent research supports this model. For example, several studies have shown the benefits to clients with psychiatric disabilities of a mental health rehabilitation perspective, which is an optimistic, multifocused approach to recovery (Corrigan, 1995; Harding & Keller, 1998). Research has found that most people with significant psychiatric disabilities, including schizophrenia spectrum disorder (often considered the most disabling disorder), can recover sufficiently to maintain successful employment, including competitive, nonsupported employment (Ruscinova, Wewiorski, Lyass, Rogers, & Massaro, 2002). People with psychiatric disabilities who have joined this discussion (e.g., Chamberlin, 1998; Deegan, 1996) strongly support the recovery paradigm.

In fact, it has been found that the course of a psychiatric disability is based more on sociocultural views of health, illness, and disability than on biologically based factors. For example, the World Health Organization has found that people diagnosed with schizophrenia recover more quickly in developing countries than in Europe and the United States, due in large part to different cultural views of whether recovery is possible (Basic Behavioral Science Task Force of the National Advisory Mental Health Council, 1996). Recovery research suggests that there are no clear patterns as to who recovers when; rather, recovery appears to be an individualized process (Hoffman & Kupper, 2002).

Those advancing the recovery perspective critique the VR approach in many ways. For example, some criticize the VR focus on finding supported employment rather than fully competitive employment. Marrone and Golowka (1999) argued that rehabilitation services should help people obtain jobs independently; that work is a right and an obligation; and that difficulties in maintaining competitive work are no worse than those from not working, such as poverty and social isolation. "Overprotectiveness in the name of public safety, or gratuitous concern and caring for those less fortunate, becomes a form of oppression and stigma in and of itself—preventing growth, independence, and opportunity for the individual most in need" (Marrone & Golowka, 1999, p. 191).

The effect of these differing paradigms is that those mental health and VR professionals who subscribe to the recovery model view community integration and satisfying work as possibilities for many of their clients with psychiatric disabilities; they actively support the efforts of their clients to achieve these goals. In contrast, those whose views are based on the medical model anticipate that their clients will experience a lifetime of recurring severe symptomatology, impaired functioning, and an unending sequence of short-term, low-wage jobs.

Research on Disclosure

Researchers who have studied disclosure issues among people with hidden disabilities have often found that disclosure poses significant challenges for people with hidden disabilities. For example, Harlan and Robert (1998), studying the difficulty that employees with disabilities had in obtaining reasonable accommodations, noted that for people with hidden disabilities the disclosure decision "entails substantial risk to their careers" (p. 411).

Research on disclosure by those in the VR field has mainly focused on supported employment. For example, Rollins, Mueser, Bond, and Becker (2002)

found that VR clients placed in supported environments tended to disclose more to employers and coworkers than those placed in more competitive employment. The increased disclosure to coworkers had a price, however. The people who disclosed had higher stress levels postdisclosure, although Rollins et al. did not seek to determine the reasons for the increased stress.

Two recent studies focused on employment disclosure experiences specifically of people with psychiatric disabilities (Ellison, Russinova, MacDonald-Wilson, & Lyass, 2003; Granger, 2000). Granger (2000) used focus groups to address this question. Participants included some people who used the VR system to find employment and some who did not. Most of this study's participants who worked with VR staff disclosed their disability, usually even before being hired. This group generally obtained ADA accommodations but understood little about their ADA rights. Of the participants, 43% did not use VR staff to find work; this group usually did not disclose. In fact, "[m]any were adamant about not disclosing their disability at all" (Granger, 2000, p. 218). Only 14% of Granger's participants were familiar with the ADA or even the concept of job accommodation.

Ellison et al. (2003) performed a quantitative study of disclosure experiences of 350 professionals and managers with psychiatric disabilities. Almost half (46.4%) of Ellison et al.'s study participants had graduate education, and over half (57.3%) were earning more than \$30,000 a year. The majority of their survey respondents (62.3%) worked as professionals or in technical occupations, and 28.3% worked as executives, managers, and administrative personnel.

In Ellison et al.'s (2003) study, a large majority (86.6%) of participants had disclosed their psychiatric disability at work. About half (50.5%) of the people who disclosed had at least one unfavorable circumstance leading to disclosure, and about one third (38.0%) disclosed only when they felt comfortable. About one third (37%) of the people who disclosed expressed regrets about disclosing. Those who were compelled to disclose generally felt more regrets about the disclosure than those who felt they had more choice about disclosing. Some of the people who did not disclose believed that people on the job suspected they had a psychiatric disability, even when the participants had not disclosed it. There was a high disclosure rate among Ellison et al.'s participants even for those working in technical, business, or educational settings (86.6%), or health and social services (81.3%). Some of the findings about disclosure from these two studies are inconsistent.

The ADA and other federal laws and policies, as well as the competing paradigms in the VR and mental health fields about the prospects for recovery, had an impact on the employment experiences of our participants. The conflicting findings from Granger's (2000) study and Ellison et al.'s (2003) study also suggested that further research is needed into disclosure experiences of people with psychiatric disabilities. We undertook a qualitative study of the work experiences of a small group of people with psychiatric disabilities to understand these issues better and to hear directly from people with psychiatric disabilities. The study was designed to explore the participants' perspectives on barriers to employment. What emerged from the study is that disclosure was a central issue in the employment decision-making experiences of the study participants.

Method of Inquiry

Qualitative Research

Qualitative researchers “stress the socially constructed nature of reality, the intimate relationship between the researcher and what is studied, and the situational constraints that shape inquiry” (Denzin & Lincoln, 2000, p. 8). The focus is more on the meanings people give to social situations than on measuring causal relationships between variables representing groups of people or frequency of behaviors. The underlying goal of qualitative research is to understand the complexity of participants’ lived experience, with its contradictions, imperfections, and unspoken understandings (Greenspan, 2002; Josselson, 2004; Rogers, Casey, Ekert, & Holland, 1999).

Qualitative researchers start by asking questions rather than presenting hypotheses. When they explore a new area of research, knowledge emerges from the data, a process known as *grounded theory* (Charmaz, 2000; Glaser & Strauss, 1967). The data are the spoken words of the participants. Accordingly, much of the discussion of findings, below, consists of participants’ actual comments.

Some have argued that qualitative studies are particularly appropriate for research on people with disabilities. For example, Honey (2000) urges VR researchers to conduct qualitative rather than quantitative research, in which the voice of people with psychiatric disabilities, which is rarely heard, will be emphasized. She even argues that qualitative research is more “compatible with the philosophy of empowerment” sought by people with disabilities, in contrast to quantitative studies, which, she believes, tend to maintain the power in the researcher (Honey, 2000, p. 275). Qualitative research is appropriate for studying disability issues: it seeks to understand issues not previously studied; its results can provide the blueprint of issues for future research; it allows for a deep exploration of issues that are complex and multilayered; it can tease out the interactions among sociopolitical factors and internal dynamics; and it maintains a focus on the disability experience (O’Day & Killeen, 2002b).

Participants

The study consisted of in-depth interviews of 32 people in the year 1999, with follow-up interviews, 18–24 months later, of 28 of the initial 32 people. The initial 32 participants were drawn from three separate urban areas of a mid-Atlantic state. Participants were recruited from several different sources, including the state’s department of VR, local psychosocial rehabilitation centers or social clubhouses, organizations of people with psychiatric disabilities, Internet electronic mailing lists, and word of mouth. We recruited an equal number of participants employed and unemployed at the time of the first interview and an equal number of men and women, and recruitment continued until the numeric goal of 32 was met. When it was determined that most participants were involved in the public mental health system or the VR system, recruitment was enlarged to include some people not involved in these systems.

In the study, we intended to examine people who have experienced significant symptoms of psychiatric disabilities. Thus, one recruitment criterion was that a participant be a current or former recipient of social security disability benefits for

a psychiatric disability, because social security benefits are geared toward people with the most severe disabilities (LaPlante, 2002). However, by choosing people who had received social security benefits, the recruitment process excluded a larger group of people who have experienced significant symptoms of their disability but who have never received social security, public mental health, or VR benefits.

The original 32 participants were ethnically diverse, with 19 Caucasians, 11 African Americans, 1 Asian American, and 1 Native American; they were also from different socioeconomic backgrounds. Of the participants, 5 were married, and 8 had children. At the time of the first interview, participants ranged in age from 27 to 64 years ($M = 41$ years). There were no significant differences between the employed and nonemployed participants in terms of ethnic identity, marital status, whether they had children, and level of education, with the exception that the employed group contained 2 individuals with graduate degrees. At the time of the first interview, 7 of the employed participants were no longer receiving social security benefits; they had worked their way out of the benefits system.

The participants self-identified their mental health disorders. The major disorders were included, with 44% of the participants having schizophrenia or schizoaffective disorder, which are the disorders generally considered the most severe. Of the 32 participants, 12 were diagnosed with schizophrenia, 2 with schizoaffective disorder, 7 with bipolar disorder, 4 with anxiety disorders, and 7 with other mental health disorders. These diagnoses were equally distributed between the employed and unemployed groups, with the exception of bipolar disorder. In the unemployed group, 5 people were diagnosed with bipolar disorder, whereas only 2 (12%) of the employed participants had received this diagnosis, so bipolar disorder was overly represented in the unemployed group.

In terms of annual income, at the time of the first interview, 6 people in the employed group earned less than \$11,000 per year, and 11 earned less than \$15,000. Those earning less than \$15,000 a year included 7 people who were receiving social security benefits and working part time. Most of the working participants still lived in poverty; almost half had incomes so low that they qualified for income benefits.

When participants were contacted for follow-up interviews 18–24 months after the first interviews, 2 of the initial participants could not be located, another declined to be interviewed, and another was incarcerated. Of these 4 participants, 3 were women—so the 28 follow-up participants consisted of 13 women and 15 men. Other than gender, the demographic characteristics of the 4 people not participating in the follow-up interviews were similar to those of the other participants.

The employment status of several participants changed between the first and second interviews. Of the 16 participants employed at the time of the first interview, 3 had lost their jobs by the second interview, and an equal number of unemployed participants had found jobs by the second interview. Four additional participants had found employment and worked for several months before again becoming unemployed.

Interview Procedure

The interviews were semistructured and audiotape recorded. The first interviews, between 2 and 3 hours long, took place in person at the participant's home or at the social clubhouse or psychosocial rehabilitation center that the participant attended (initial interview). The second interviews were conducted by telephone and lasted approximately 1 hr (follow-up interview). An interview guide was developed for each set of interviews, which consisted of open-ended questions (available on request). The initial interview explored participants' work history, the impact of their disability on work, their current employment status, their perspectives on barriers to employment, and their knowledge of and experience with the ADA. The follow-up interview addressed changes in participants' employment, disability symptoms, and benefits since the initial interview, participants' experiences with the ADA, and disclosure issues.

Procedure for Analyzing Data

After the interviews were transcribed, the data were first analyzed by preparing summaries of each interview. The researchers then met in biweekly project meetings to discuss each interview and the emerging themes. We sorted the data into categories using NVivo, a qualitative data analysis software package. In these meetings, we analyzed each category and identified common themes and experiences. After the follow-up interviews, we reviewed changes over time and other longitudinal issues. The final step was to analyze and interpret core themes from the data, grounding our understandings in the literature.

Data Discussed

During the initial interview, the researchers included some questions concerning disclosure and the ADA. On the basis of the responses, the follow-up interviews explored these issues in more depth. For this reason, this article addresses findings from the follow-up interviews except as noted.

To protect privacy, participants' names and identities have been changed, and any potentially identifying textual material has been modified.

Results

Interrelated Factors

Several interrelated factors had an impact on participants' employment decision making and experiences. A previous article discussed how the participants in the study could be categorized as being in four recovery phases, on the basis of factors such as their experiences of symptoms, ability to retain employment, and community integration (O'Day and Killeen, 2002a). Those findings are summarized here because they affect the participants' employment decisions.

The first factor involved the participants' phase in recovery. This had an impact on participants' decisions about how to search for employment. Participants' phase in recovery and search process in turn had an impact on their decisions about disclosure. Other factors influencing disclosure decisions included participants' knowledge of the ADA, their experiences with stigma and prejudice,

and their beliefs about their job abilities. This discussion of results addresses each factor.

Four Recovery Phases

After the initial interviews it became evident that the participants could be categorized into four recovery groups, each reflecting a different phase of recovery from severe symptomatology. The phases were based on participants' relationship to the labor market, experience of symptoms, recovery from psychiatric disability, and degree of community integration. These phases are described in detail in O'Day and Killeen (2002a) and are summarized here insofar as they impact on the participants' disclosure decisions. The four groups are as follows: Phase 1: currently unable to work; Phase 2: working in part-time, temporary, low-wage positions; Phase 3: holding low-wage positions long term; Phase 4: working or volunteering in competitive professional positions.

Participants' narratives indicate that few participants remained in any phase permanently, and they did not move through them in any particular order, so this is not necessarily a chronological framework. In fact, a number of participants changed phases during the study. This analysis is based on the status at the time of the initial interview.

Phase 1: Currently unable to work. The four participants in this phase struggled with debilitating symptoms and medication management. They often reported receiving help managing their medications. Side effects from their medications often made it difficult to function. They lived in group housing or with family members. They were generally not managing their own money and their social security checks were in someone else's name. They often reported difficulties maintaining a schedule, managing healthy eating and personal habits, sleeping, waking, socializing, and handling general life skills.

Phase 2: Working in part-time, temporary, low-wage positions. The 11 participants in this group held jobs such as dishwasher, laundry worker, office cleaner, cashier, and stock person. These participants could not hold a job for more than a few months, or they moved from job to job. They had developed some skills and strategies for managing their medications and symptoms, but they often still struggled with symptoms that could interfere with employment. They reported that their worst symptoms returned during times of stress. They were hospitalized on occasion for brief periods. At times, some reported feeling so well in their recovery that they stopped taking their medications entirely. As a result they would experience an increase in symptoms or a relapse. They reported trying to keep to a schedule and develop good eating and sleeping habits. People in this phase engaged in more social activities than those in Phase 1. These participants were still learning how to manage living with a psychiatric disability.

Phase 3: Holding low-wage positions long term. Eight participants fell into this group. They held the same types of jobs as those in Phase 2, but they had developed stability in their employment and social relationships. Some worked full time; some had begun to take on more responsibilities at work or had advanced in other ways. They could hold a part-time or full-time job for 1 year or longer. Some of these participants had been at the same job for as long as 5 years. They reported having developed their own unique skills and strategies for

managing their symptoms and medications. These people were living more independently and often had their own apartments. They also managed their own money. They valued peer and social support and had made it an integral part of their lives.

Phase 4: Working or volunteering in competitive professional positions. Nine participants belonged in this group. They had made the transition from low-wage work to competitive professional employment or professional-level volunteer work. They worked as peer counselors in the mental health system, social service workers, computer technicians, and in other professional occupations. They reported being integrated into the mainstream community and having rich and diverse social support networks that included people both with and without psychiatric disabilities. They had developed skills and strategies to manage their medications and their symptoms; they often reported having few symptoms that interfered with their work or personal lives. If they experienced an increase in symptoms, then they had developed a plan to deal with that situation. For example, they would elect to admit themselves into a hospital when they felt the need. They reported living rich and rewarding lives and being proud of their achievements.

Experience of Symptoms

Although the participants were in different phases of recovery, all participants reported in the follow-up interviews that they experienced symptoms of their psychiatric disability on at least one occasion during the 18–24 month period since the initial interview. The symptoms ranged from short periods of depression to psychotic episodes requiring hospitalization. Some, particularly those in Phases 2 and 3, reported having symptoms while working. Participants continued to use mental health treatment and medications. Yet, in spite of occasionally experiencing symptoms, most participants reported feeling better at the time of the follow-up interview than they felt at the initial one.

Decision Making on Method of Job Search

When deciding to look for employment, the first question is how to find work. For the study participants, most of whom had been involved with the public mental health and VR systems, the first decision in starting a job search was whether to use VR or mental health services to assist in the job search or to look independently (i.e., without using mental health or VR staff to find the job).

Using VR Services

Because the majority of participants were recruited through the VR system, most (20) of the 28 follow-up participants had found their current or a recent job with the help of VR or mental health staff. Of the 20 participants, 4 were in Phase 1 (essentially not able to work), 7 were in Phase 2 (in part-time, temporary, and low-wage jobs), 5 were in Phase 3 (holding long-term, low-wage work), and 4 were in Phase 4 (volunteering or working in competitive professional positions). However, all 4 people from Phase 4 and 1 of the people from Phase 3 were working in the mental health system; their work experiences differed in significant ways from those of other participants. No other participants from Phase 4 used VR

services. In other words, the people who used VR services to find employment fell into two categories: (a) those who were in earlier phases of recovery and (b) those in later phases of recovery who worked in the mental health field. Moreover, most of the participants used VR services when they were in Phases 1 or 2, even if they did not use those services during the time of the study.

Some participants appreciated VR services, even if they subsequently looked for work independently. According to Vernon:

[The VR counselor] has been helpful in the past. One time she helped me buy clothes for an interview. She helped me buy my glasses. She helped me go to driving school because my job required a little bit of driving . . . The [VR] job coach . . . is a guy that helps you with transportation and helps you go to the job site. Sometimes he can fill in for you if you're not enjoying your job at a certain period, or there are days you want off . . . The last time when I was looking for a job through [VR staff], I used him a lot. He helped me a whole lot. He helped me with transportation back and forth, helped take me to the place to take the drug test. He sat in with me through orientation with the different jobs I was hired for.

Complaints About VR Services

A common theme for many participants from all four phases was the feeling that the low-wage jobs found by VR staff were neither as challenging nor as interesting as jobs they could find on their own. The better educated participants and those with work histories in skilled employment often found working in low-wage jobs particularly stressful and difficult. For example, Tim, who was working as a parking attendant at the time of his first interview, found a job as a peer counselor by the follow-up interview. In his initial interview, he commented on this common frustration:

I think the problem that we have with the [VR] job program is that we have what is called blue-collar positions, and they probably don't have a means to place you in more difficult things . . . A lot of the employment that is available for special situations, a lot is designed for people who are retarded . . . When people get mentally ill they don't lose their intelligence. So there should be fields for mental illness that could use a higher IQ.

Tim stated that he believed people with psychiatric disabilities have tremendous difficulty with "anything that is tedious . . . If you are on an assembly line and you are depressed, there might be a problem."

In addition to wanting more challenging positions, several participants were troubled by what they felt were demeaning attitudes of some VR staff. Pauline (Phase 4), an articulate woman with several professional skills, expressed this concern. She remembered the job VR staff first found her. She experienced that job as "just beneath me, just stuffing envelopes" and indicated she would use their services again only . . .

. . . as a last resort. To be honest with you, my [VR caseworker] told me, "Just face facts, you'll never do as well as everybody else because of your mental illness. Why even try?" I couldn't believe she was saying that kind of stuff. She's got this stigma against mental illness.

Others commented that the job the VR counselor found for them was not well suited to their personality or disability. For example, Christie, who is a person with schizophrenia, described the job that the VR counselor had found for her at a local health club.

I was folding towels, drying towels, washing towels, bringing them up for the people to use . . . It was a good job, but I was downstairs by myself a lot. I had time to think on my own and it gave me problems. It gave me too much time by myself . . . I started concentrating, and when you start concentrating and start thinking, then your mind starts getting cluttered, and it gave me problems.

Christie reported that she knew that work involving social interaction would be easier for her than work in isolation, but the VR counselor never asked her about her preferences. In contrast, some other participants, who felt they worked better alone, had difficulty in the socially interactive jobs found for them by the VR counselor.

Searching Independently of VR

Of the 28 follow-up participants, 8 sought jobs independently. Most of the independent job seekers were from Phase 4 (working in competitive professional positions). They gave several reasons for choosing an independent search strategy, the most common being prior negative experiences with VR services and the desire for more challenging work. For example, Bob (Phase 4) described why he chose not to use VR staff for his job search: "I thought they would only get me a menial job and I was interested in a professional job . . . I've never heard of them getting a professional job for anybody else."

Working in the Mental Health System

Five follow-up participants worked as peer counselors or in other positions for the mental health center or clubhouse. They were in the later stages of recovery; 4 were in Phase 4, and 1 was in Phase 3. Their work was satisfying, as they generally felt recognized and appreciated. These participants were exempt from many of the painful decisions faced by other participants.

These results suggest participants' recovery status had some impact on their job search strategy: Those earlier in recovery (Phases 1 and 2) generally used VR staff to find employment, even though some had criticisms of VR services. Those more stabilized in their recovery (Phases 3 and 4) tended to search for work independently, except for those choosing to work in the mental health system.

Disclosure Choices

Participants had a range of perspectives on employment disclosure. It was difficult to determine whether 5 people disclosed at work, so they are excluded from the following analysis. About 60% (14) of the 23 remaining follow-up participants disclosed their psychiatric disabilities at work. These included the 5 people working in the mental health system. Of the 9 other people who disclosed, 1 was in Phase 1 (generally unable to work), 5 were in Phase 2 (working in part-time, temporary, low-wage positions), 2 were in Phase 3 (holding low-wage

positions long term), and 1 was in Phase 4 (working in a competitive professional position). The participant in Phase 4 emphatically explained that she disclosed only in a particular mental health setting, but she would definitely not disclose in any other setting. Of the 9 people who disclosed, 7 used the VR system to seek work.

Of the 23 follow-up participants, 9 chose not to disclose their disability at work. Phases 2, 3, and 4 each had 3 people who did not disclose. Of these 9, 4 found their jobs through the VR staff, and 5 found their jobs independently. Viewed another way, of 16 participants using VR staff for a job search, 12 disclosed (of which 5 worked in the mental health field), and 4 did not. Of those seeking work independently, 3 disclosed, and 5 did not disclose.

Those participants using the VR system to find work tended to disclose more often than those seeking work independently. Conversely, those seeking work independently generally preferred nondisclosure. The data suggest that participants' decisions regarding disclosure were somewhat related both to their phase of recovery as well as their search method (VR system or independent search). Nondisclosure was a considered option for those who were (a) further along in their recovery (Phases 3 and 4), (b) seeking work independently, or (c) working outside of the mental health field. Their disclosure experiences are now described in more detail.

Disclosure. Some felt disclosure was beneficial. For example, Julie (Phase 2) felt that with disclosure, "they treat me like anybody else . . . I'm happy about it." Some thought disclosure was required. For example, Pam (Phase 2), a person with schizophrenia, said "You have to tell them because if you don't tell them they could easily fire you because they could say you lied to them, so I just tell them."

However, not all people who disclosed were satisfied with the results. Some believed that supervisors make people with psychiatric disabilities work harder than their fellow employees without disabilities. Tyrone (Phase 2), who has schizoaffective disorder, felt that he was given more work than his coworkers without disabilities and then was fired because of his disability:

Once you're labeled mentally ill, they automatically assume there's a big difference . . . To a certain extent, I've noticed that normal people, even though they might not work as well, they're tolerated more on a regular job than mentally ill people are . . . I've also noticed that if you don't watch, the boss will put more on a mentally ill person to do, especially if that mentally ill person doesn't complain.

Stacey (Phase 2, diagnosis of schizophrenia), shared this view. Because of her negative experiences, Stacey indicated she might not disclose her disability to an employer in the future: "I'm not sure [whether I would disclose] because sometimes it plays a role in the long run. They seem to try to detect it, or overwork you, or have you doing extra work and extra days."

For purposes of this article, it is not necessary to determine whether these views of participants are true or shared by their employers. What is important is that people had these perspectives, which may affect their future decision making with regard to employment and disclosure. Accordingly, disclosure had mixed results for a number of these participants.

Nondisclosure. Tracy (Phase 4, independent search) was typical of those participants in later phases of recovery who chose not to disclose. When first interviewed, Tracy was working for the mental health clubhouse as a clerk, but she subsequently sought employment independently. She chose not to disclose her disability in her current job. She feared that disclosing her bipolar condition, even though it is currently under control with medication, would preclude her from seeking advancement within the company and would jeopardize her ability to remain there until retirement: "I'd like to continue with this company, if all goes well, and go through other jobs, but I definitely feel that I would not get the other jobs if it was known that I had a mental illness."

Many people who did not disclose and whose symptoms are generally hidden (Phases 3 or 4) preferred to "pass" as "normal" (Blantz, 2003). Jane, for example, said:

Something that my boss did on this job, she asked me about my kids . . . I don't want people on the job to know that my mother has custody of my son . . . I find myself telling them a little lie about that sometimes, that I'm raising my son.

Cynthia, who is living with agoraphobia (an anxiety disorder involving a fear of travel), disclosed her diagnosis only for a mental health job. She did not intend to disclose it to others. She similarly explained:

I don't go out and advertise myself as having a disability. I like being able to keep it hidden when I choose. I do run into problems, from time to time, when I then hear people talk about their true feelings about people with mental illness, and they don't know that I've got one . . . I find that I'm happier when I can just blend into society and not always have my disability be the topic of a conversation, to defend or give my opinion on.

Only nondisclosure gave participants the option to "blend in."

It is not surprising that the five people who sought work independently and did not disclose were from Phases 3 and 4 (2 from Phase 3 and 3 from Phase 4). These were people well on their way to recovery. What is surprising, however, is that 3 of the 4 people who did not disclose and who found work through the VR staff were from Phase 2 (the 4th person was from Phase 3). These 3 people continued to experience significant symptoms of their disability.

For example, Vernon (Phase 2) had a negative experience with disclosure in the past:

One time I did [disclose] and the woman didn't hire me. I told her about it, and I think she did not hire me because of that . . . I told her I was schizophrenic. I believe that's the reason why she wouldn't hire me.

As a result of that experience, Vernon now chooses a nondisclosure approach:

I don't plan on telling them about it. Some people are prejudiced against that. A lot of people are. They probably think you're going to do something at the job or start acting up or quit on them all the time.

Nondisclosure provided some participants with the opportunity for full-time work and benefits, which they may not have had otherwise. For example, Sandra said:

A lot of disabled people, when they work, don't have insurance or benefits . . . I had insurance, I had benefits, I had vacation leave, I had sick leave, I had a 401k . . . I had more than I would have, because a lot of those jobs where you disclose, where you go in as a disabled worker, they do not offer you the normal benefits.

However, people who did not disclose also faced challenges. One, illustrated by Neil (Phase 3), who has schizophrenia, is the difficulty in explaining a checkered work history to potential employers.

Some of them laugh at me. Last week I applied for a job as a photo technician in a computerized shop. They looked at me and saw a guy who is 51 years old and he's applying for an apprentice job.

There are also psychological difficulties for those who choose not to disclose, in the employment situation and elsewhere. A person may have to create complicated stories to avoid disclosure, like Jane's decision to hide that she is not raising her son. For example, Cynthia (with agoraphobia, Phase 4) reported in her initial interview the lengths to which she has gone to avoid having to travel farther than was comfortable. Once at college, her grade depended on traveling and she "faked" an ankle injury: "I even went to the trouble of going down to the drugstore and getting a bandage for my ankle and crutches. I felt really ashamed" (initial interview).

Cynthia noted in her follow-up interview that she still sometimes has to fabricate stories to avoid disclosing her disability:

What bothers me about this whole scenario is that it makes me depressed if I have to invent a lie to get out of doing something. I think to myself, you are ashamed of this, or you're worried about what people will think of you, because you have to invent this thing. Inventing it creates stress and it is using your mind to concoct all these things when it would be so much better to say, "You know what? I cannot do this because I have agoraphobia . . ."

I have less of a problem saying that now . . . Most people deal with it pretty well. But the downside [of disclosure] is that I can't be invisible . . . I'm thinking that I'm in this pretty bad situation where I want to blend in anonymously . . . [If I feel forced to disclose,] I'll be angry that I had to reveal the most intimate part of myself to people I would not want to do that with.

Inadvertent disclosure. Some people who did not disclose came later to believe that employers knew of their disability and then discriminated against them anyway. One prong of the ADA definition of disability prohibits discrimination against people "regarded as" disabled. If employers believed these people were disabled, then the participants were protected under the ADA. Some of the most poignant stories were from participants in this situation. For example, Jack (Phase 3), who has bipolar disorder, explained how his disability affected his work:

I'm a manic-depressive, so my manic state would go higher up and I'd be working constantly . . . It brought in a lot of stress . . . When they fired me, they knew . . . They knew all along because I was hyper. They knew that they were going to let me go.

Similarly, Pauline (Phase 4) did not disclose her schizoaffective disorder diagnosis to her current employer in county government and was then looking for another county job. She has had repeated difficulty finding a new job and believed that potential county employers found out about her psychiatric disability:

Because every time I go for a promotional interview, I'm always passed up. It's happened about 30 times by now . . . There's some kind of inherent risk involved. "We don't want to promote her—too much time off" . . . I think they know who I am, that I'm a client of a mental health center, that I take medication, and I have a medical condition that's easily stigmatized.

Whether the employers actually knew about the participants' psychiatric disabilities is not as important as the fact that the participants believed they did. Someone believing that inadvertent disclosure has occurred loses the ability to make a deliberate choice of whether, when, what, and how to disclose.

Selective disclosure. For a few participants, the best approach was selective disclosure, which allowed them to invoke ADA protections and seek accommodations, but also protected their privacy. Al, for example, disclosed the more socially acceptable part of his disability: "I told my employer I get anxious. She didn't know anything about it and wanted to know whether I took medicines for it. I said 'Yeah' . . . I didn't say I had schizophrenia."

In a new job, Pauline disclosed only that she takes medications: "I just told [the employer] that I take medication and left it at that. I didn't specify anything."

Participants who had physical as well as mental disabilities sometimes chose to disclose only the physical one. Philip, who has both epilepsy and schizophrenia, noted the little he believed his employer knew: "They know that I have psychomotor epilepsy, and they know that you can do bizarre things under that . . . They still do not know that I have [a] mental illness."

These partial disclosures had not resulted in further employer inquiry, which is permitted by the ADA. For this group of people, selective disclosure seemed to result in successfully obtaining accommodations while also protecting privacy. It appears that these participants arrived at the selective disclosure option by themselves; no one indicated a VR or mental health professional had advised of this option.

It is unclear whether other participants considered selective disclosure as an option, because this approach emerged in the process of conducting follow-up interviews. It appears that most participants thought disclosure meant full disclosure, and they had not been advised otherwise.

Disclosure for work in the mental health system. Certain jobs in the mental health system, such as peer counselor, were reserved for people with psychiatric disabilities, so disclosure provided the means for such a job. Participants who took these jobs felt free to disclose and request accommodations. For example, Todd, diagnosed with a depressive disorder, noted the following:

Because my job was made for someone who is a mental health consumer, I really appreciate how they accommodate any problems I have. One week last December, a friend of mine died and I was upset and took too many pills and had to go to the hospital to get my blood checked out. The next day I went to work, but I was told that if I wanted to take the day off, that was fine because of what happened. So they

are very accommodating, and it does help to have a job where people know that you have a limitation.

These were among the group of participants most fully integrated into the community; 4 were in Phase 4, and 1 was in Phase 3. Their jobs carried significant responsibility and these participants enjoyed their jobs. Disclosure benefited this group and resulted in few negative repercussions. Yet, most in this group indicated they would be less likely to disclose if they looked for employment independently. Tim (Phase 4) said the following:

I don't have a problem with being mentally ill, if anybody asks me, because I can use it as education for people. But it would depend on what type of job it was . . . My degree is in business, and if somebody wanted to hire someone who was disabled, not any particular disability, for a business position, I wouldn't mind saying that I have a disability or chronic illness. If I sensed that they were prejudiced against anybody who was different, I might wait until later on—until I had proved myself—before saying that I am.

Thus, these participants recognized that disclosure may be a benefit to them now but might result in difficulties in competitive employment later.

Strategically timed disclosure. Tim's comment suggests another possible solution to the disclosure conundrum: a strategically timed disclosure made after working in a position long enough to develop mutual trust with staff and coworkers. The ADA permits disclosure to be made at the last possible minute. For example, someone could wait to disclose until a time came that he or she needed an accommodation for the disability. Participants were not asked whether they considered making a strategically timed disclosure, so it is unclear whether others considered this option.

ADA

Limited knowledge of the ADA. Although the ADA has an impact on the work experience of people with psychiatric disabilities, few participants knew about it, and none understood it well. Even though both interviews inquired about participants' knowledge of the ADA, 15 follow-up participants said they did not even know what the ADA was. The other 13 were somewhat familiar with it. Some of these participants were optimistic about the ADA's importance and effectiveness. Julie, for example, with a depression diagnosis (Phase 2), felt the ADA has . . .

. . . helped a lot of people get jobs that [they] wouldn't have gotten . . . otherwise . . . The ADA is probably the reason I have my job now . . . They can't discriminate. Whether or not you have a physical or mental problem, they have to deal with you as an individual.

Tim, who also has a diagnosis of depression, hoped the ADA would stop discrimination, because "if an employer can accommodate your disability and know what your limitations are and what your abilities are, that can be an asset to the company." The ADA protections were particularly important to Tim, as he believes he had experienced blatant discrimination earlier:

I tried to get a job at a company once, and they asked a lot of questions that I answered truthfully. When I called them about my application, I heard someone in the background say, "He's the one who isn't balanced," and I did not get that job. If I could have taped that and the ADA was in place at the time, I probably could have done something. (initial interview)

Wilson, who has schizophrenia, thought he would use the ADA when disclosing his disability to a potential employer:

I'd probably mention the Americans with Disabilities Act, and tell them that I'm qualified, that I have a disability, and that I have to be on medicine that sometimes makes it hard to get up in the morning . . . I might bring up that, according to federal law, please do not discriminate against me because I have a mental illness . . . The overall spirit of the ADA is to level the playing field for people who have disabilities and making sure that as long as the reasonable accommodation isn't too overbearing, that the employer should hire the person who has a disability.

Most of the other participants who knew about the ADA were more cautious. Some, like Annette, feared the ADA would be unable to stop discrimination:

The ADA is kind of like [racial] integration. You can pass a lot of laws, but you have to change people's attitudes before things really take hold. It is a step in the right direction. How helpful or how powerful it is, I don't know.

Similarly, Todd, who has a diagnosis of depression, made the following comment: "Sometimes I think employers still find other reasons for getting rid of people. They may not say they're slow or whatever, but employers may use another excuse to fire them."

Philip, who has a diagnosis of schizophrenia, believed the ADA has had a negative impact on employment options:

Because employers are fearing legal problems. Consumers can't use the ADA because they can't get a lawyer, but an employer may fear that litigation will be brought against him, so they don't want to get in the situation to begin with. So it's working against the consumer in both ways. (initial interview)

Participants' feelings of disempowerment and their fear of discrimination appears inconsistent with the ADA's stated goal of empowerment.

The 15 follow-up participants who indicated they knew virtually nothing about the ADA were in earlier recovery phases (3 from Phase 1, 8 from Phase 2, and 3 from Phase 3). Some knew they could ask for accommodations at work, but they did not use the term "accommodation," and they did not know that accommodations are mandated by the ADA. The reaction of Vernon, who has schizophrenia (Phase 2), when asked about the ADA in the follow-up interview, provided a response typical of many participants' responses: "I think I've heard of it before, but I haven't heard any details of it. I've heard the name before."

Todd (Phase 4), who lived with depression and was then working as a peer counselor for others with psychiatric disabilities, tried to explain why so many participants seemed ignorant about the ADA. He thought people with psychiatric disabilities generally knew about the ADA, but did not mention it at work because they were afraid its use would be harmful:

I'm not sure if they've reported any troubles that they've had. They may feel like they don't want to start anything in some areas of working . . . For instance, if there's a problem on the job where somebody is being bossy and the person can't stand up to them, maybe they don't want to bring anybody else in to interfere because of fear of one thing and another not working out for them. They just put up with things as they are.

The views of those participants who knew about the ADA ranged from optimistic to skeptical about its ability to assist and protect people with psychiatric disabilities. Most of the participants, however, were uninformed about the ADA.

Requests for ADA accommodations. Only 1 participant used the term employment "accommodation." However, many relied on accommodations in their workplaces. The accommodations desired by most participants were for part-time work or a flexible work schedule. Even though almost all of the participants who disclosed obtained these accommodations, they did so without understanding the ADA's role in these achievements.

Because an accommodation could be requested only after disclosure, the people who did not disclose did not have the option of seeking accommodations. This was a recurring challenge for them. For example, Vernon (Phase 2) found it difficult to explain his request for part-time work:

The lady at one employer called me and she was asking me. I put in for part-time hours, and I find it's hard to get people to hire you to put in the hours you want to work, if you want to work part-time. She was asking me, "When are you going to do those hours?" She was asking me that, so she probably won't call me back . . . I figure she was saying, "You probably don't want to work."

For Vernon, this problem is especially complex, as he fears multiple prejudices:

My doctor told me it's best to work because of me being a Black male in this society. They go on prejudice against you because they probably ask why you're out of work all this time . . . If you're a Black male, they think you're probably doing drugs.

Thus, the ADA's requirement that notice must precede any request for accommodation directly conflicted with the preference of some participants not to disclose.

Difficult Decisions

As these narratives illustrate, each employment decision made by the participants resulted in both professional and psychological ramifications. Participants faced difficult and challenging choices, including whether they used VR staff or looked for work independently and whether they disclosed. For example, Pauline, who has schizoaffective disorder (Phase 4), discussed the risks on both sides:

I had the case where I was working for an employer and I didn't disclose my disability. Then I started having medication reactions at work, and the supervisor was about to put me out in the street and tell me to go to detox. It was like I was overdosing or something. But I found out it would be to my benefit to disclose, so they wouldn't jump to conclusions and think I've been doing drugs or something. In my case, it would be to my benefit. But at the same time . . . they can hold that

against you too. "We don't trust you with that detailed kind of work because we know who you are."

Because only a few participants understood their ADA rights well, it seems the participants made these difficult decisions in a vacuum, without fully grasping the legal and personal implications of each choice.

Prejudice and Discrimination

The fact that some participants chose not to disclose, notwithstanding the difficulties nondisclosure can present, can perhaps be understood in the context of the experience of stigma and discrimination, which 17 participants discussed in the follow-up interviews.

Stigma. Many of these 17 people discussed the negative stereotypes they believed are held toward people with psychiatric disabilities. Wilson (Phase 4), currently working in a mental health center, said the following:

I just like having a job where I can say, "Yeah, I'm a computer programmer." . . . I don't have to talk about mental illness or anything like that . . . It just keeps me from opening a can of worms about what I do for a living, if somebody ever asks . . . If it's somebody that I don't know, or somebody that I've just met, I'm very hesitant to talk about my mental illness problems . . . If I've just met a pretty girl and start talking about being hospitalized or being schizophrenic—when I used to do it—it generally turns people off. I'm not blaming anybody for it, but that's the attitude.

Todd (Phase 4) emphasized how important public education is to remove the stigma:

What I would like to change most is getting people to understand that people that are sick or mentally ill can live in the community and be valuable community members. They just may need a little assistance, a little help once in a while understanding things . . . They have so many programs on TV now that show the bad side of schizophrenia, and somebody is always attacking somebody and killing somebody, but that isn't always the truth.

Many of these participants feared that the public, including employers, have negative views toward people with psychiatric disabilities. The most serious one is that mentally ill people are violent and may "go postal." Participants were also afraid that their employers might have other stereotypes, such as that people with psychiatric disabilities are irresponsible at work, erratic in work attendance, behave strangely, and fight with their coworkers.

Tracy's statements captured the feelings of many participants. She was recovering from both bipolar disorder and alcoholism. She admitted publicly that she was a member of Alcoholics Anonymous, but was less comfortable disclosing her bipolar disorder diagnosis:

I went into AA in 1980 . . . I'll say, there is a hell of a stigma to mental illness . . . For me, with the dual diagnosis, I know I am more frightening to somebody as a bipolar than as a recovering alcoholic.

Stacey, who has schizophrenia (Phase 2), was unemployed at the time of the

follow-up interview. She also expressed concern about stigma. She did not want to go back to her job as a janitor after a period of illness; she believed her employer had learned about her condition, and she was afraid of being stigmatized if she returned:

I had seen my foreman . . . She asked me to come back there, but I told her I didn't want to take that job. When I was working down there, I had gotten sick during the time I was working. I was dealing with my medication, with my mental illness. People were responding to that.

And Jeff (Phase 2) touched on the humiliation of being stigmatized:

I want to work, and I want to fit in, and I want to be normal. I don't want people staring at me like I'm a zombie or something from the zoo. I don't want to be stared at like I'm different just because I have bipolar. (initial interview)

Discrimination. Many among this group of 17 believed that stigma is associated with workplace discrimination, and many believed that they had experienced discrimination by supervisors or fellow employees. They described circumstances when coworkers avoided them or supervisors treated them differently, fired them, or never hired them in the first place. For example, Christie, who has schizophrenia (Phase 2), believed that if people know a person has a psychiatric disability, they treat the person "worse . . . They treat you different . . . They look at you different, they talk to you different, and they act different towards you because they think something's wrong with you." In short, the discomfort some participants felt about disclosure seemed related to the situations in which they believed they had experienced discrimination or stigma.

Beliefs About Capabilities

Another factor in the participants' employment decisions was how the participants, and counselors and family, felt about their ability to maintain employment over a period of time. Those who felt most supported by family, counselors, or other people were more willing to seek full-time or higher paid work, even though they would run the risk of losing their federal disability benefits. For example, Cynthia (Group 4), when discussing an organization of people with psychiatric disabilities, said the following:

It's really important to have that kind of support, to have that sort of family environment to succeed. We're all such social creatures, and the more personable and the more invested each person is in that concept, the more successful the outcomes are.

This factor is described in more detail in Killeen and O'Day (2004).

These findings indicate the interrelationship of several factors in the participants' employment searches, including the restrictions placed by federal laws and policies, participants' status in recovery, their decision about method of job search, their disclosure choices, their knowledge of the ADA, their beliefs about stigma and discrimination, and the faith of professionals and family members in the ability of people with psychiatric disabilities to succeed at work.

Discussion

The in-depth nature of this qualitative study was intended to provide a rich understanding of aspects of employment experiences of this group of participants, who were people recovering from psychiatric disabilities, involved in the public benefits systems, and trying to work. All of the participants had been receiving social security disability benefits, and most were receiving public mental health or VR services. Accordingly, their perspectives are likely to be typical only of other people with psychiatric disabilities who receive social security, public mental health, or VR services. The participants' experiences around systemic supports and barriers are probably not shared by those people with psychiatric disabilities who do not receive those public benefits.

The essence of the findings of this study centers around the interrelationship among contextual issues, such as legal and policy constraints and the views of professional advisors on recovery, with other factors—such as people's phases in recovery, their methods of job search, and whether they believe they have experienced stigma or discrimination.

Recovery

In recent years, there has been an emerging recognition that people with psychiatric disabilities represent an extremely heterogeneous group, with individuals at all stages of managing their disabilities. In the last decade, among both researchers and mental health providers, there has begun a shift in perspective in the understanding of psychiatric disability from a medical model to a recovery model. Approaching psychiatric disability from a purely medical perspective tended to ignore the individual's own agency in the management of his or her illness and tended to depict all individuals with psychiatric disability as progressively deteriorating, persistently impaired, and in need of lifelong care (Harding, Zubin, & Strauss, 1992). The recovery model of psychiatric disability has been found to reflect more fully the findings of longitudinal research in the last 15 years on this population. Specifically, the majority of people with severe mental illness have been found to either recover or to improve significantly across major life domains over time (Harding, 2003). The recovery perspective includes the recognition that many individuals with psychiatric disabilities rebuild their lives through the development of strengths and skills, engagement in meaningful activities, and rediscovering a strong sense of self (Rusinova, 1999).

The findings of this study support this perspective. They also support the findings of those researchers who are developing stage models of recovery (Spaniol, Wewiorski, Gagne, & Anthony, 2002). The participants in the study could be categorized as being in four different phases with regard to the management of their psychiatric disabilities and of their working lives. Those in the later phases of recovery reported that in previous years they had experienced the more severe symptoms and conditions of early recovery. The majority of participants stated that their lives had improved during the period between the study's two interviews.

All of the participants, including those in Phase 4 and those who did not disclose, reported experiencing some symptoms of their psychiatric condition during the course of the study. This suggests that people recovering from psy-

chiatric disability and still experiencing its symptoms are capable of finding and maintaining employment, even when the employer does not know of the disability.

VR Versus Independent Job Search

The participants who expressed satisfaction with VR services were those for whom part-time, unskilled positions were a good fit at the time. However, others expressed dissatisfaction with VR services or the job placements made by VR counselors. Most who sought work independently had previously used VR staff for a job search and were familiar with the VR system.

Disclosure Decisions

The disclosure dilemma requires a strategic analysis of a range of issues, but few participants engaged in a careful approach. Many, particularly those earlier in recovery, using the VR staff for their job search, or working in the mental health system, assumed disclosure. Although disclosure provided the opportunity to seek ADA accommodations and invoke other legal rights, some people who disclosed indicated that disclosure had adverse consequences for them. Some reported experiencing harsher treatment by supervisors; others felt stigmatized by coworkers or supervisors; some reported receiving uncomfortable attention from others. Nondisclosure offered protection from these problems; it allowed a person to participate in the larger community without fear of prejudice or discrimination. The nondisclosure option was particularly useful for participants in later phases of recovery. However, nondisclosure posed its own challenges, such as the difficulties in explaining an uneven employment history, obtaining work accommodations, and keeping the diagnosis confidential.

Two possible solutions to the disclosure issue emerged from the interviews: selective disclosure and strategically timed disclosure. Both are feasible under the ADA. Selective disclosure may result in further inquiry, but the ADA limits the extent of permissible employer inquiry. Strategically timed disclosure would be very effective under the ADA. Employees could wait to disclose until they believed their work was appreciated and they were liked and respected by staff and supervisors. They could choose to disclose only when they needed to take advantage of the ADA, when, for example, their symptoms were increasing. Only 1 participant seemed to have considered this option.

Most VR and mental health professionals have not recognized that their clients need to grapple with disclosure issues, because the VR literature generally promotes disclosure as the only option. VR professionals tend to advise disclosure, mainly in the hope of protecting their clients from the potential loss of social security benefits and to avoid the psychological challenges in nondisclosure, such as maintaining the diagnosis as a secret (Bell & Lysaker, 1997; Smart & Wegner, 1999). Scott (1996) documented the ways that an occupational therapist can work with a client to prepare the client for disclosure. Scott acknowledged disclosure difficulties: stigma, the impracticality of receiving requested accommodations, and postdisclosure repercussions. Still, Scott favored disclosure, largely because of the benefit of ADA protections. The findings about the problems encountered by the people who did not disclose support Scott's argument. Yet, the VR

literature often pays less attention to the reverse problem that emerged from these data: the difficulties posed by disclosure.

The results of this study enlarge on the prior research on disclosure of psychiatric disabilities by taking an in-depth look at the experiences of people, usually low-income earners, who currently or previously received public benefits such as social security, public mental health, or VR services. Our qualitative findings are generally consistent with those of Granger (2000), but are somewhat inconsistent with those of Ellison et al. (2003). However, Ellison et al.'s study focused on professionals and managers with psychiatric disabilities, which is a very different population than that of this study. Most of Ellison et al.'s respondents (66%) had never received federal disability benefits. They were also on average a much better educated and better paid group than the participants in this study. It may also be a group with less disabling conditions. About three quarters of Ellison et al.'s respondents (73.4%) had diagnoses of mood disorders, but only 11.2% had a diagnosis of schizophrenia, often considered the most disabling psychiatric condition.

In Ellison et al.'s (2003) study, a large majority (86.6%) of participants had disclosed their psychiatric disability at work. This high disclosure rate is inconsistent with the findings from our study and Granger's (2000) study (the disclosure rate in our study was 71%). The high rate of disclosure may be due to the higher proportion of participants in Ellison et al.'s study who worked in the field of mental health (40%) and for whom disclosure may have been a necessity. Nonetheless, for many of Ellison et al.'s respondents, disclosure was not a planned choice. About half (50.5%) of the people who disclosed had at least one unfavorable circumstance leading to disclosure, and about one third (38.0%) disclosed only when they felt comfortable doing so. Furthermore, about one third (37%) of the people who disclosed expressed regrets about disclosing. Thus, although many of Ellison et al.'s respondents disclosed their diagnosis, some had mixed feelings about the process and the decision. This ambivalence is consistent with our findings.

Ellison et al.'s (2003) respondents were quite well educated and trained. Their general willingness to disclose suggests that better educated and professional people with psychiatric disabilities, in a later phase of recovery, may not be particularly fearful of experiencing stigma and prejudice and may not need ADA accommodations.

The data from our study suggest that disclosure is a benefit for people with psychiatric disabilities who work in the mental health field. Our participants working in the mental health system were among the highest functioning participants; they were exempt from the disclosure conundrum. Ellison et al.'s (2003) results support these qualitative findings. Of Ellison et al.'s respondents, 40% worked in the mental health field; of those respondents, 95% disclosed at work.

Some of our participants chose not to disclose but felt that their disability was evident to coworkers or supervisors, a process we called *inadvertent disclosure*. Ellison et al.'s (2003) data support those preliminary findings. Some of the respondents from Ellison et al.'s study chose not to disclose but believed their employers knew without being told by the respondent. It has been suggested that people with psychiatric disabilities may reveal their disability by "nonverbal and verbal behaviors that are readily observable," even when most symptoms are

minimal (Holmes & Rivers, 1998; Scott, 1996, p. 58). Others suggest that a gap in an employment record or medical information may provide an unintended disclosure (Hall, 1997). Whatever the source of an inadvertent disclosure, or even whether the employer does not know, a person's belief that such a disclosure has occurred appears to reduce the employee's experience of choice and empowerment.

The findings from Ellison et al.'s (2003) study support the claims by some, including Stefan (2001, 2002), that there are two worlds in American society of people with psychiatric disabilities; a "first" world of people whose lives are not defined by disability, and a "second" world with people whose lives are so defined. Stefan contends that the difference is not necessarily based on severity of symptoms but on other issues, such as family support and financial wherewithal. People in the first world may see private practitioners for therapy or medication, but they generally do not receive social security benefits. She suggests that those in the first world probably prefer not to disclose their disability and may be highly successful at work. Ellison et al.'s study data support the assertion that there are many people with psychiatric disabilities who never enter the public VR or mental health systems. Ellison et al.'s data differ from Stefan's hypothesis, however, with their findings of a high level of disclosure by this group.

Ellison et al.'s (2003) study data represent a more complicated analysis of disclosure and employment than that maintained by those who use the medical model. The fact that Ellison et al.'s group participants were professionals and managers, by itself, challenges the medical model view that all people with psychiatric disabilities face debilitating symptoms, chronicity, and a poor prognosis and therefore should only work in part-time, low-skilled jobs.

Taken together, these three studies (Ellison et al., 2003; Granger, 2000; and the current study discussed in this article) reinforce the idea that many people with psychiatric disabilities are capable of recovery and of sustained and successful work. They also suggest that people may not always disclose and that some who disclose may have mixed feelings about disclosure.

ADA

Our participants were inadequately educated about their ADA rights and how to find employment that used their unique skills and education. More than half knew virtually nothing about the ADA. The others understood something about the ADA's protections or the notion of employment accommodations, but they rarely used that knowledge. A few discovered independently the selective disclosure approach, but this was not a clearly delineated option known by participants. Only 1 participant considered a strategically timed disclosure.

As a result, participants' evaluation of whether, when, and what to disclose appeared to be ad hoc. Their disclosure decisions tended to be a byproduct of how they sought work (through VR or independently) and their beliefs about discrimination and stigma, not on carefully reasoned ADA analyses. Thus, it appears that both the people who disclosed and those who did not disclose had difficulty fully benefiting from the ADA, but for different reasons. People who disclosed usually obtained ADA accommodations, but they often did not attain the psychological empowerment or integration into society intended by the ADA's drafters. Because

they generally assumed disclosure would occur, they missed the opportunity to view disclosure as a choice for consideration and reflection. They also usually assumed the need for part-time hours, but did not know that the right to request them was one conferred by the ADA.

In contrast, the people who did not disclose were generally more successful at community integration—an important accomplishment. However, the cost was often high. They had to maintain the disability as a secret and even fabricate stories to hide evidence of it. Moreover, people who did not disclose forfeited their right to request and negotiate accommodations, a crucial (and, for many, necessary) ADA right. A particularly difficult repercussion of nondisclosure occurred for those who chose not to disclose but believed they did so inadvertently. These participants lost the empowerment that is gained from having the choice of when and how to disclose, or whether to disclose at all.

Those drafting the ADA did not intend this cluster of results. However, there is no clear culprit and no one program that can remedy the problems. Although participants would have benefited from better education from VR professionals about disclosure options, this is only one piece of a complex puzzle. Positive intentions of VR staff are constrained by conflicting federal and state policies that penalize people with disabilities who seek full-time or higher paid jobs. Working with limited funding and large caseloads, VR counselors often do their best to find jobs for their clients and protect them from the feared loss of disability benefits, a loss that could be devastating to someone in an early phase of recovery. Similarly, the ADA has not proven to be as protective as its advocates had hoped, but there are complex reasons why its goals have not yet been fully achieved.

Stigma, Prejudice, and Discrimination

Many of our participants believed that their employers, fellow employees, or others were prejudiced against them or other people with psychiatric disabilities. Some felt that prejudice would lead to covert acts of discrimination prohibited by the ADA. They also recognized that there is a distinction between experiencing and proving discrimination and most felt they would be unable to prove that discrimination had occurred. They seemed to perceive prejudice and discrimination as subtle and insidious rather than overt. It is possible that these concerns are only evidence of paranoia, a symptom some of our participants experienced. Yet most of the participants held these attitudes, even those whose symptoms did not include any paranoid thinking.

These findings are consistent with other research on the stigma of psychiatric disability (Stefan, 2002; Wahl, 1999b). For example, Holmes and Rivers (1998) found that psychiatric disability carries the same stigma as convicted criminal status or drug abuse. However, the participants in Holmes and Rivers's study who had higher education or professional skills pre-disability, and fewer ongoing symptoms, seemed less affected by prejudice and discrimination than those whose disability started before they obtained education, training, or work experience. Other researchers have also found that people whose disabilities develop early in life are less likely to obtain professional skills later and more likely to experience workplace discrimination (Baldwin, 1999).

The participants' beliefs about prejudice and discrimination appeared to

influence their disclosure and other employment decisions. This consequence is also consistent with other research. For example, Wahl (1999a; 1999b) and Prince and Prince (2002) have studied the beliefs of people with psychiatric disabilities about stigma. Many of Wahl's participants gave the fear of stigma as the reason for not disclosing at work. Furthermore, some of Wahl's participants who disclosed felt regret afterward about the disclosure. Wahl concluded that both direct and indirect stigma have long-term psychological impacts on people with psychiatric disabilities, including anger, isolation, discouragement, and sadness. Prince and Prince (2002) found experiences of stigma by people with psychiatric disabilities affected their self-esteem, ability to integrate into the community, and fears of disclosure. Another recent survey supports the findings that many people with psychiatric disabilities feel they have experienced stigma or employment discrimination (Stefan, 2002). The report of the President's New Freedom Commission on Mental Health (2003) supports these findings and strongly recommends significant changes in the public mental health system to reduce stigma and improve services for people with psychiatric disabilities.

The finding that our participants and others with psychiatric disabilities believe there is prejudice against people with psychiatric disabilities is supported by research on attitudes in the general populace toward psychiatric and other disabilities. For example, Dixon, Krouse, and Van Horn (2003) found that some employers continue to have apprehensions about hiring workers with any kind of disability. Barriers for those employers included unfamiliarity with people with disabilities (about 10% of employers surveyed) or fear of the cost of accommodation (another 10%; Dixon et al., 2003). Researchers have found that employers are even more concerned about hiring people with psychiatric disabilities because of fears that people with psychiatric disabilities may be dangerous, peculiar, or unstable (Starnes, 1999). Both employers and employees fear violence by people with psychiatric disabilities (Scheid, 1999), and the degree of fear has seemed to increase since the implementation of the ADA (see research cited in the following studies: Laden & Schwartz, 2000; Stein, 2000, Footnote 87). In a recent U.S. Equal Employment Opportunity Commission case settled by the parties, an employer had terminated the plaintiff's employment while she was hospitalized for her psychiatric disability (Disability Compliance Bulletin, 2003). An article discussing the case explained the reason for termination as follows:

[The U.S. Equal Employment Opportunity Commission] claimed that the termination was motivated by stereotypes relating to mental illness. Management was aware that Malone had previously been hospitalized due to her mental disability, the agency said, and the upper level manager who made the decision to fire her did so based on a "gut feeling" that she would "go postal." (Disability Compliance Bulletin, 2003, p. 6)

Research on public attitudes indicates that negative feelings toward people with psychiatric disabilities are often derived from the fear that people with psychiatric disabilities are dangerous (Borinstein, 1992). In a large-scale study of public perception of psychiatric disability and likelihood of violence, Link, Phelan, Bresnahan, Stueve, and Pescosolido (1999) found that many people perceive a strong correlation between psychiatric disabilities (particularly schizophrenia, alcohol use, and cocaine use) and a propensity for violence. They also

found a significant correlation between a person's concerns about the dangerousness of people with psychiatric disabilities and that person's desire to keep a distance from people identified as having such disabilities. "This suggests that at least some part of people's reluctance to engage in interaction is an exaggerated fear that symptoms lead to violence" (Link et al., 1999, p. 1332). As Behney et al. (1997) noted, "if any one stereotype of mental illness is most prevalent and damaging, it is that of the homicidal maniac" (p. 7).

The belief that people with psychiatric disabilities are dangerous is more prevalent today than in the past, even though research suggests the actual likelihood of violence in this population is low (Pescosolido, Monahan, Link, Stueve, & Kikuzawa, 1999). Sensational media reports may exacerbate these concerns (Wahl, 1995; Wahl & Lefkowitz, 1989), but positive media depictions of people with psychiatric disabilities, such as the movie *A Beautiful Mind*, may help to reduce the negative stereotypes (Grazer & Howard, 2002). Recent research suggests that media depictions of people with psychiatric disabilities are improving, but negative articles continue to dominate the news, often emphasizing issues of dangerousness (Phelan, Link, Stueve, & Pescosolido, 2000; Wahl, Wood, & Richards, 2002). The participants' apprehensions about stigma do not appear to be unfounded.

Positive Support

The finding that participants had more success in recovery when they received positive support from family and professionals is consistent with other research on the importance of positive attitudes toward clients with psychiatric disabilities by VR and health care professionals and family members (Ruscinova, 1999).

Implications and Recommendations

Although these findings are preliminary, they suggest the need for additional education of people with psychiatric disabilities, mental health and VR professionals, employers, and the general public. The results of this study also suggest the need for public policy changes.

People with psychiatric disabilities. The study results suggest that those people with psychiatric disabilities who are using or have previously used public mental health or VR services would benefit from education concerning the ADA, the FMLA, and other applicable law and policies (Stefan, 2002). They would benefit from knowing their rights under these laws, the meaning of accommodations, the negotiation process intended by the ADA, and the extent that employer inquiry is permitted. In addition, they would benefit from knowing the differences between the ADA and FMLA and when to invoke each option. For example, when an employee with a disability seeks medical leave, the FMLA seems to permit less intrusive employer inquiry about the health issue than the ADA (Stefan, 2002), so it may be preferable for an employee to identify a leave as an FMLA leave rather than an ADA accommodation. With such education, people with psychiatric disabilities could become empowered to request appropriate accommodations and to know when to accept negotiated compromises. Many of the participants in the study stated that they needed accommodations, usually involving a different work schedule or fewer work hours. For some, particularly

those in the early stages of recovery, accommodations may include help from a personal assistant, such as a job coach, extra or modified training or supervision, or modified job duties (MacDonald-Wilson, Rogers, & Massaro, 2003). Moreover, this group of people would benefit from education concerning disclosure options, such as selective disclosure and strategically timed disclosure.

Not all people with psychiatric disabilities need accommodations. Some may choose to forego an accommodation to obtain the anonymity available with nondisclosure. Employees with psychiatric disabilities who choose nondisclosure may need support in handling psychological and other stresses associated with hiding this part of their lives. In short, people with psychiatric disabilities should have the information and resources necessary to evaluate effectively the risks and benefits of their disclosure and other employment options to make the decisions that are most suitable for their needs at any particular time.

VR and mental health professionals. To work effectively with people with psychiatric disabilities on employment issues, VR, occupational, mental health, and other professionals must be educated about the same legal issues as people with psychiatric disabilities. Professionals would benefit from an understanding of the complexities of applicable statutes and the implications of both disclosure and nondisclosure. Mental health and VR professionals would benefit from a familiarity with the recovery paradigm, the research on recovery, and the importance of providing hope to clients with psychiatric disabilities. Moreover, it has been argued that when more people with psychiatric disabilities are working, integrated into the larger community, and identified as workers, there will be less need for intensive case management and multiple service providers (Marrone & Golowka, 1999).

These findings are consistent with other research that suggests a one-size-fits-all approach to employment for those with psychiatric disabilities does not meet the needs of people in different phases of recovery (Holmes & Rivers, 1998). VR services have been found to be generally unsuccessful in helping people with psychiatric disabilities obtain competitive employment (Lehman, 1995; Lehman et al., 2002), but some in later phases of recovery may prefer competitive work. For those people, VR professionals should be able to provide assistance in weighing the risks of disclosure versus nondisclosure and developing decision-making strategies. For example, one strategy suggested by Holmes and Rivers (1998) is disclosure to a peer group but not to the employer.

The VR and mental health fields are in the midst of broad and significant changes in attitudes and services to people with psychiatric disabilities, primarily because of the emerging recovery paradigm. Moreover, the public mental health systems are in a serious state of crisis. These conclusions have recently been supported by findings of two federal commissions studying mental health care in this country (National Council on Disability, 2002; President's New Freedom Commission on Mental Health, 2003). The President's New Freedom Commission on Mental Health (2003) expressly noted the failure of the public mental health system to focus on "the single most important goal of the people it serves—the hope of recovery" (Executive Summary, p. 4). We join with others who have urged better education and training of VR and mental health professionals to include this important area of research into professional training (Spaniol, 2001).

Employers. These results do not include data on employers' perspectives, such as their familiarity with the ADA or psychiatric disability. Employers must know how to work with the ADA. For example, employers should understand the ADA-mandated processes of negotiation and accommodation, and the standards for weighing the reasonableness of an employee's accommodation request compared with its cost to the employer. Additionally, employers should know that some people with psychiatric disabilities do not need significant accommodations, as these data suggest flexible schedules, part-time hours, and occasional short breaks are often sufficient accommodations. Employer knowledge of the ADA is important, because research has shown that employers familiar with the ADA are much more likely to hire people with psychiatric disabilities than those with less familiarity (Scheid, 1999).

Society. One concern, as with other antidiscrimination legislation, is that discrimination continues post-implementation albeit in more subtle and sophisticated ways. Along those lines, some caution that discrimination against people with psychiatric disabilities will not diminish, even with the ADA's coercive provisions in place (Baldwin, 1997).

Research suggests that stigma, stereotypes, and prejudice are very difficult to eliminate (Duckitt, 1992; Harper, 1999). Coercive legislation does not necessarily accomplish the goal of reducing such negative perception (Corrigan & Penn, 1999). The contact theory hypothesizes that contact with a member of a stigmatized minority will reduce prejudice and stereotyping (Desforges et al., 1991; Gaertner, Mann, Dovidio, Bachman, & Anastasio, 1996). This theory suggests that the stigma of psychiatric disability will be reduced with greater contact (Corrigan & Penn, 1999). Thus, the ADA has the potential to reduce stigma, by giving people with psychiatric disabilities an opportunity to enter the workforce and interact with others.

Although in theory the ADA may help reduce stigma by increasing contact, in practice it may not work as effectively. The contact theory simply will not work if people with psychiatric disabilities choose nondisclosure (Pinel, 1999). In fact, it is likely that many American workers already interact with people with psychiatric disabilities but never know this because the coworkers with psychiatric disabilities have not disclosed. For people to know that they have coworkers with disabilities requires those with disabilities to be willing to risk disclosure. Research suggests that some may not be willing to take that risk until stigma and discrimination are reduced. However, the results of the study by Ellison et al. (2003) suggest that some people in professional and managerial settings are now willing to risk disclosure. This might be an indication that stigma and discrimination are starting to dissipate in certain settings.

Policy. These findings suggest that a major employment barrier for people with psychiatric disabilities and the professionals working with them involves federal and state policies that make it difficult for people receiving social security disability or other benefits to move into full-time or higher paid work without losing benefits, health care, and other supports. A promising development was the passage of a recent amendment to the Social Security Act (Ticket to Work and Work Incentives Improvement Act of 1999), which provides more work options for people receiving disability benefits. Until financial protections allow people recovering from psychiatric disability to move into the work world at their own

pace, it is likely that people with psychiatric disabilities and their VR counselors may be unwilling to consider employment options that may result in the loss of benefits.

Limitations of the Study and Future Research

This qualitative study explored in depth the employment experiences of a small group of people with psychiatric disabilities, most of whom used public mental health and VR services. The data from this study should not be generalized to all people with psychiatric disabilities without further research. We felt it important to share our participants' perspectives in their own voices, especially because the professional mental health and VR literature often omits the voices of people with psychiatric disabilities. Because the focus of this study was on our participants' lived experiences, no effort was made to determine whether participants' employers shared their perspectives about what happened or about discrimination and stigma.

These findings therefore provide preliminary data about many areas that need further research in studies, small and large scale, qualitative and quantitative. Future research should ascertain whether these findings generalize to other people with psychiatric disabilities, such as people who are in different phases of recovery, who never received social security benefits for a mental health disability, who never received public mental health or VR services, or who are in Stefan's (2001, 2002) "first world." The differences between these findings and those of Ellison et al. (2003) should also be further explored. Another important area for further study involves the experiences of employers or potential employers of people with psychiatric disabilities. More research is also needed on ADA issues, such as the cost of accommodations, employers' views on inadvertent disclosure, and employees' success with selective disclosure and strategically timed disclosure. Finally, further exploration should be undertaken about both employer and employee knowledge about the ADA (Goodman-Delahunty, 2000).

Conclusion

Like the civil rights laws that have assisted other stigmatized groups, the ADA and FMLA will be effective in improving the workplace lives of people with psychiatric disabilities. However, this study suggests that achieving the civil rights goals of the ADA may require further efforts that involve, among other changes, education of people with psychiatric disabilities about their ADA rights, education of VR and mental health professionals about the ADA and recovery research, and education of potential employers and the public about psychiatric disability and phases of recovery.

This study provided a perspective on work and disclosure of some people recovering from psychiatric disabilities. The findings suggest that legal and policy factors—like the ADA and limitations on social security disability payments—and other factors (like an employee's phase in recovery and knowledge of the ADA) have an impact on disclosure and other employment decisions of some people with psychiatric disabilities. Professionals working with people with psychiatric disabilities need to understand fully this complex set of issues to help

people with psychiatric disabilities navigate the various employment decisions they face.

Perhaps the most important implication of these data is that there may be no one correct approach to these employment dilemmas. Complete or selective disclosure may work for some, whereas nondisclosure may be best for others, and this may change as an individual moves through phases of recovery. These findings suggest that for these participants, and perhaps for others as well, a key goal of the ADA has not yet been achieved: the sense of empowerment and choice. Once people with psychiatric and other hidden disabilities understand their ADA rights and choices, it is hoped that they will be able to make deliberate and thoughtful decisions, without negative consequences.

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