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Social workers with mental illness : coming out in the workplace

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ABSTRACT

The purpose of this study was to explore the experience of disclosure in the workplace among social workers with mental health issues with a particular focus on the catalysts of coming out, whether stigma inhibits disclosure, and the perceived social and emotional benefits and costs of coming out. Due to the sensitive nature of the research topic, an anonymous online survey was used. Participants completed a demographic questionnaire, mental health questionnaire, and a researcher-designed Outness Inventory. Thirty-six clinical social workers with Diagnostic and Statistical Manual diagnoses participated in the study, 21 of whom reported being out to someone at work about some aspect of their mental health. Of the participants who were out, 75% or more endorsed feeling supported by coworkers, feeling closer personally to coworkers, and being better able to perform as a clinician. Stigma of mental illness appeared to be the largest barrier to disclosure of mental illness in the work place. Given the benefits of being out for the clinician, client, and community, it is imperative that the social work profession be committed to decreasing the stigma of mental illness. Social contact theory suggests that one way to do so would be to increase the visibility of social workers with mental health diagnoses within the work setting.

Key words: Mental Illness, Mental Health, Social Workers, Stigma

SOCIAL WORKERS WITH MENTAL ILLNESS:

COMING OUT IN THE WORKPLACE

A project based upon an independent investigation
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work

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Chapter I: Introduction

The purpose of this study was to explore whether social workers with mental health issues disclose these issues to their coworkers and whether stigma inhibits disclosure. In addition, the study investigated precipitants and consequences of disclosure. There is an abundance of research on the stigmatization of mental illness and the effects of this stigma (e.g. Bos, Kanner, Muris, Janssen, & Mayer, 2009; Corrigan, Kerr, & Knudsen, 2005; Corrigan et al., 2010; Ellison, Russinova, Lyass, & Rogers, 2008; Livingston & Boyd, 2010). There is little research, however, on the degree to which such stigma exists towards and among clinicians who have mental illness. Because mental illness can often be concealed, clinicians with mental illness diagnoses (e.g. Major Depressive Disorder or Generalized Anxiety Disorder) must actively choose whether or not to be out to their colleagues regarding their mental illness. In this paper, I consider the implications of the findings regarding mental health disclosure on clinicians' work with clients and in the larger community.

There are well documented and widespread findings that mental illness is stigmatized and that stigma is harmful to targeted individuals (e.g. Bos et al., 2009; Corrigan, Kerr, & Knudsen, 2005; Corrigan et al., 2010; Livingston & Boyd, 2010). There is also a statistical reality that mental health professionals are not immune to mental illness. For example, as many as 1 in 10 adults will experience depression at one point in time (Center for Disease Control (CDC), 2012), and in any given year approximately 25% of adults in the United States are diagnosable with one or more disorders (National Institute of Mental Health (NIMH), 2012). Using survey-collected

data, researchers found that between 57% (Deutsch, 1985) and 61% (Pope & Tabachnick, 1994) of therapists reported at least one episode of clinical depression.

There is little research on the disclosure of mental health issues in the workplace among mental health professionals. Even in a study on professionals and managers with severe mental illness in which 20% of the sample were mental health professionals and that touched briefly on disclosure (Ellison, Russinova, Lyass, & Rogers, 2008), no analyses were conducted specifically on disclosure of mental illness among the subsample of mental health professionals. In this particular study, the majority of the participants endorsed "feeling I have to hide my psychiatric condition or that others might find out" as a stressful interpersonal experience.

Given the prevalence of mental illness, in addition to recognizing it and treating it, decreasing its stigmatization should be a priority for the clinical social work profession. Activists, researchers, and theorists have suggested that one way to decrease stigmatization is to increase visibility of and contact with the stigmatized population (Herek & Capitanio, 1996; Pettigrew & Tropp, 2006; Rees-Turyn, 2007). Furthermore, if being closeted negatively impacts the ability of clinicians to provide optimal care to their clients (e.g. is distracted in sessions due to daily fear of being found out), it is imperative to remove barriers to clinicians being out about their mental illness.

The goal of this research study was to explore the experience in the work place of clinicians with mental health issues, specifically in the realms of catalysts of coming out and the benefits of being out, and to promote increased outness among clinicians in the workplace based on the findings. Because of the lack of previous research on the topic of disclosure of mental illness among clinicians in the work place, this study was exploratory in nature.

Chapter II: Literature Review

Stigmatization of Mental Illness

The definition of mental illness has evolved over time. In this paper, the term "mental illness" will refer to a behavioral or emotional DSM diagnosis, unless otherwise noted. The term "mental health consumer" will refer to a person currently in treatment and the term "mental health provider" will refer to social workers, psychologists, and psychiatrists, as well as graduate level students of these fields.

As mentioned previously, the stigmatization of mental illness has been heavily researched. Stigma can be defined as endorsing stereotypes about those who belong or are perceived to belong to a particular social group (Goffman, 1963). In this paper I will focus on self-stigma, the belief in, anticipation of, and internalization of these stereotypes (Corrigan, Kerr, & Knudsen, 2005). "[I]n the context of mental illness, [stigma] can be described as a process whereby affected individuals endorse stereotypes about mental illness, anticipate social rejection, consider stereotypes to be self-relevant, and believe they are devalued members of society" (Livingston & Boyd, 2010, p. 2151). There is a strong relationship between self-stigma and decreased self esteem (Livingston & Boyd, 2010; Wahl, 1999), decreased life satisfaction (Markowitz, 1998), and increased psychiatric symptoms (Livingston & Boyd, 2010; Markowitz, 1998).

Markowitz (1998) looked at the relationships between stigma, psychological wellbeing, and life satisfaction among persons with mental illness (N=610). The study used longitudinal

data from individuals in self-help groups and outpatient treatment. Wahl (1999) used a nationwide survey to collect data from mental health consumers on their experience of stigma and discrimination (N=1,301). Livingston and Boyd (2010) conducted a meta-analysis of the expansive body of research investigating the experience and adverse consequences of internalized stigma in regards to mental illness. They systematically reviewed 127 empirical articles on topic and included 45 in their meta-analysis. The empirical studies reviewed above had large sample sizes and strong methods, and the results of the meta-analysis corroborate their findings.

There is sparse research on the prevalence of stigma towards mental illness among mental health providers. The first two studies conducted on this topic were conducted in the Swiss-German region of Switzerland (Lauber, Anthony, Ajdacic-Gross, & Rössler, 2004; Nordt, Rössler, & Lauber, 2006). The researchers did not find a significant difference in stigma towards mental illness among mental health professionals and the general population. The first study, compared psychiatrists (n=90) to the general population (n=786). The latter study, compared a broader range of mental health professionals (n=1073), including psychiatrists, psychologists, social workers, vocational workers, and nurses, with the general public (n=737).

Smith and Cashwell (2010) were the first US researchers to do empirical research on the topic. They found significantly less stigma among students and professionals of mental health than business students and professionals. It should be noted, however, that their sample size was relatively small (n=188) compared to those in the European studies. In addition, there were fewer business students and professionals (n=54) than students and professionals of mental health (n=134). The mental health field included social work, counseling, and psychology. The

demographics of the sample were as follows: 63% female and 37% male; 89% Caucasian, 4% African American, and 7% from other racial backgrounds; and individuals ranging in age 21-65.

Additional studies based in the US with larger sample sizes would be beneficial for determining whether or not there is less stigma towards mental illness among mental health professionals than among the general population. Evidence that there is less stigma among mental health professionals might increase the likelihood that mental health professionals would disclose mental illness to coworkers and supervisors.

Social Contact Theory

Social contact theory suggests that increasing contact between majority populations and stigmatized populations decreases stigma (Herek & Capitanio, 1996). Much of the research on social contact theory has focused on visible stigma (Herek & Capitanio, 1996). Herek and Capitaninio (1996) found that heterosexuals who had experienced contact with gay and lesbian individuals expressed significantly more favorable attitudes towards gay and lesbian individuals than those without contact (n=538, Wave 1; n=382, Wave 2). Having more contact with gay and lesbian individuals increased this effect. In their meta-analysis of 713 samples from 515 studies, Pettigrew and Tropp (2006), found that intergroup contact generally reduces intergroup prejudice. They concluded that becuase of its generalizability, social contact theory can be used beyond the racial and ethinc populations for which it was initially intended. This research supports activitsts who advocate that being out is form of activism for LGBTQ clinicians (e.g. Rees-Turyn, 2008).

Disclosing Mental Illness

In research with non-provider samples, researchers found that the decision whether or not to disclose one's mental illness was related to perceived stigma, perceived social support, and

self esteem (Bos et al., 2009). Bos and colleagues conducted a survey-based study of 500 outpatient mental health consumers in the Netherlands. They found that among those who disclose, people report that disclosing mental illness to family and friends was met with more support and less stigmatizing reactions than disclosing to acquaintances and colleagues. There is a major gap in the literature regarding additional factors that influence a person's decision to disclose mental illness. Presumably, similar to with those disclosing sexual orientation, other factors include a person's social environment (Legate, Ryan, & Weinstein, 2011) and perceived risks of disclosure.

Indeed, researchers have noted a potential parallel between the experiences of individuals with mental illness and GLBTQ-identified individuals with regards to stigma (Corrigan et al., 2010; Herek & Capitanio, 1996). These researchers have used the terms "concealed stigma" and "hidden stigma" to connote the idea that identifying as GLBTQ or having a mental illness can both often be concealed. As a result, the individual is faced with the decision of disclosure (Bos et al., 2009)**.** Researchers have theorized that like those with a visible stigmatized identity, those with concealed conditions experience a considerable amount of stress (Corrigan et al., 2010; Pachankis, 2007). Potential stressors include: the decision whether or not to disclose, the anxiety of being 'found out,' being isolated from others with the shared stigmatized condition, and being detached from one's 'true self' (Pachankis, 2007). Because both identities are concealed stigmas, the literature on coming out as GLBTQ can be used to inform an understanding of the experience of disclosing mental illness.

Much research has been conducted on the pros and cons of coming out as GLBTQ. Individual (or personal) benefits of coming out as GLBTQ include: enhanced psychological well-being, such as increased self esteem and decreased stress (Corrigan & Matthews, 2003;

Morris, Waldo, & Rothblum, 2001), improved interpersonal relationships (Corrigan & Matthews, 2003), and enhanced relatedness to institutions, such as work (Corrigan & Matthews, 2003; Day & Schoenrade, 1997; Ragins & Cornwell, 2001). It is likely that these are applicable to those who come out regarding having a mental illness (Corrigan & Matthews, 2003). Negative consequences of coming out as GLBTQ include increased self-consciousness, social avoidance by others, job and housing discrimination, and physical harm in the form of hate crimes (Corrigan & Matthews, 2003). It should be noted that while most of these may be applicable to disclosing mental illness, the degree of physical harm associated with coming out as GLBTQ, probably occurs less frequently in response to disclosure of mental illness; however, individuals with mental illness may be subject to a higher incidence of mandated or coercive treatments (Corrigan & Matthews, 2003).

Some researchers have suggested that the social and emotional benefits and costs of coming out are context specific (Legate, Ryan, &, Weinstein, 2011). In their sample of 161 participants recruited through several online mechanisms, Legate, Ryan, and Weinstein (2011) found that social contexts characterized by interpersonal acceptance and support for authentic self expression were more likely to foster positive coming out experiences (e.g. lower depression and higher self esteem). There is a significant relationship between perceived work place discrimination and the degree of disclosure of coming out, such that the more discrimination perceived, the lower the level of disclosure (Ragins & Cornwell, 2001). Gay and lesbian employees perceived less discrimination when their supervisors were gay or lesbian, when there was a higher proportion of gay and lesbians among employees, in the presence of supportive agency policies and practices, and in organizations governed by protective legislation. These conditions, therefore, facilitated increased disclosure. This is of particular note, because

researchers have found that employees who are out about being GLBTQ report higher job satisfaction than those who are closeted (Day & Schoenrade, 1997; Ragins & Cornwell, 2001).

Day and Schoenrade (1997) analyzed surveys of 900 individuals recruited from a city-based gay and lesbian activist group. Ragins and Cornwell (2001) analyzed surveys of 534 individuals and actively recruited a racially diverse sample by recruiting from a national gay Latino-Latina organization and a national gay African American organiziation in addition to one of the nation's largest gay civil rights groups. The sample was 67.6% White, 15.2% Black, and 12.2% Latino or Hispanic. Day and Schoenrade did not report the racial or ethnic breakdown of their sample. While both studies had large sample sizes, a notable limitation is that because samples were recruited from advocacy groups, the findings may not be generalizable to the rest of the GLBTQ population. In addition, in the former study, because of their tendency towards activism, closeted workers may have exaggerated the hardships of being in the closet and workers who are out may have exaggerated the benefits of being out (Day & Schoenrade, 1997).

Implications

Individuals who are closeted about having mental health issues may be fearful that participating in a survey on the topic may "out" them. It is important to use a data collection technique in which participants will feel safe to participate and feel comfortable sharing information that they may have not previously shared. Using confidential or anonymous surveys is one way to address this (e.g. Day & Schoenrade, 1997; Deutsch, 1985; Ragins & Cornwell, 2001).

Another consideration is semantics. There is not a singular definition of what it means to be out. The researcher must define whether he or she is talking about to whom one is out, about what one is out, etc. Mohr and Fassinger's (2000) Outness Inventory, which was designed to

measure "the degree to which respondents' sexual orientation was known by or openly talked about with people in different spheres of the respondents' lives" specifically addresses that outness is not a dichotomous state.

Given the strong relationship between the stigma of mental illness and decreased self-esteem, decreased life satisfaction, and increased psychiatric symptoms, there is a clear need to identify ways to reduce the stigma of mental illness. Furthermore, given that selective disclosure has been found to increase self esteem, decrease stress, improve interpersonal relationships, and enhance relatedness to organizations, it is imperative that we create more opportunities for positive disclosure experiences.

Chapter III: Methodology

Formulation

The purpose of this study was to explore the experience of social workers with mental health issues in regards to disclosure in the workplace.

Research Question 1

Do social workers who have a DSM-IV diagnosis disclose their mental illness to their co-workers and supervisors?

a. To whom do they disclose?
b. What do they disclose?
c. To what percentage of co-workers do they disclose?

Hypothesis 1

Most participants will have engaged in some degree of disclosure.

a. Participants will indicate that they disclose to co-workers who are "peers with whom they are close" more frequently than to any other category of co-workers (e.g. co-workers with whom they are not particularly close).
b. Participants will indicate that they disclose information about their symptoms more frequently than information about seeing a therapist, taking medication, missing days of work because of symptoms, or missing days of work because of treatment.
c. The majority of participants will be out to less than half of their coworkers

Research Question 2

Why do social workers come out about their mental health at work?

Hypothesis 2

In response to the prompt, "I am out at work about my mental health because..." participants will select "being in the closet was too stressful" more frequently than any of the following responses: I believed coming out would be cathartic, I prefer to be my authentic self with my colleagues, I wanted to improve my relationship with my colleagues, I wanted to educate my colleagues (e.g. around living with mental illness), or it's my responsibility as a social worker to decrease the stigma towards mental illness and being out at work is one way to do so.

Research Question 3

Why are social workers selective about their disclosure?

Hypothesis 3

In response to the prompt, "I am selective about my disclosure because..." participants will select "I worry others might view me less positively" more frequently than any of the following responses: I worry I might lose my job, be denied promotions, or denied increases in pay; none of my co-workers are out about mental health issues; none of my supervisors are out about mental health issues; or my agency discourages expressing personal information with one's colleagues.

Research Question 4

Do clinicians feel better about themselves in terms of their self esteem after they have come out?

Hypothesis 4

The majority of participants will indicate feeling better about themselves in terms of self esteem since coming out .

Research Question 5

Do clinicians feel less anxious after they have come out?

Hypothesis 5

The majority of participants will indicate feeling less anxious since coming out.

Research Question 6

Do clinicians feel more satisfied with their job after they have come out?

Hypothesis 6

The majority of participants will indicate feeling more satisfied with their job since coming out.

Research Question 7

Is there a positive correlation between talking openly to one's coworkers about one's mental health and the perceived benefits about being out?

Hypothesis 7

There will be a positive correlation between talking openly to one's co-workers about one's mental health and the perceived benefits of being out.

Research Method and Design

Due to the sensitive nature of the research topic, an anonymous online survey was used. It employed a mixed methods cross sectional design, using primarily categorical level questions and responses. Participants completed a demographic questionnaire, mental health questionnaire, and an Outness Inventory designed by the researcher specifically for this study.

Non-probability sampling was used due to the difficulty of locating mental health providers with mental health diagnoses. Participants were recruited both through a snowball method of e-mails sent to peers and colleagues, as well as postings to several social media sites such as Facebook and LinkedIn. Each potential participant received an electronic recruitment letter which included information related to the research topic, inclusion criteria, the nature of participation, and a hyperlink to the online questionnaire. No eligible participant was excluded due to race, ethnicity, gender, sexual orientation, or other demographic characteristics.

A research proposal was submitted to the Smith College Human Subjects Review board and the study was approved (see Appendix A). All participants completed an informed consent form (see Appendix B).

Demographic Questionnaire. The demographic questionnaire included questions on the following: age, gender, sexual orientation, race/ethnicity, social work degree, years in the field, and hours at current agency (see Appendix C). Participants were asked about their sexual orientation to explore the relationship between identifying as GLBTQ, being out as GLBTQ, and being out with a DSM-IV diagnosis. Analysis regarding this relationship was not conducted for this study, but may be conducted at a later date.

Mental Health Questionnaire. The mental health questionnaire included questions on the following: DSM-IV diagnoses, current use of therapy, current use of medication, and current severity of symptoms (see Appendix D). Participants were asked whether their diagnosis was from another professional, self diagnosed, or both. For participants with multiple diagnoses, participants were asked to indicate their most salient diagnosis.

Outness Inventory of Mental Health in the Workplace - The Outness Inventory of Mental Health in the Workplace is a researcher-designed scale that explores the degree to which

individuals are out in the work place (see Appendix E). More specifically, it looks at the types of co-workers to whom social workers are out at work and what they are out about (e.g. being on meds or seeing a therapist), as well as the perceived social and emotional costs and benefits of being out. The measure contained primarily categorical level questions and responses. In addition, it contained the following single open ended question, "Is there anything else you'd like to share with us about the topic of mental illness among mental health providers?" The content used throughout the measure was largely based on the literature about the coming out experience of GLBTQ-identified individuals. The questionnaire was also loosely based on Mohr and Fassinger's (2000) Outness Inventory, which was designed to measure "the degree to which respondents' sexual orientation was known by or openly talked about with people in different spheres of the respondents' lives." Due to limitations of time and resources this measure was not tested for reliability or validity prior to usage.

Sample Selection Criteria

Individuals were eligible for this study if they were licensed clinical social workers with DSM-IV diagnoses who at the time of the data collection were practicing at least 20 hours a week in an agency setting in the United States. Participants did not need to report their specific diagnosis, but were asked to note the DSM-IV category into which their diagnosis fell. These categories included: substance-related disorders, schizophrenia and other psychotic disorders, mood disorders, anxiety disorders, eating disorders, personality disorders, and adjustment disorders. Potential participants were informed that it was okay if they were uncertain whether or not they met the *exact* DSM-IV diagnostic criteria, as long as they perceived that they had the diagnosis. It should be noted that for this study, the diagnoses of learning disabilities was excluded.

Data Analysis

After the data collection period, the raw data were downloaded from SurveyMonkey into Excel and then analyzed in SPSS with the support of a data analyst. The primary method of analysis was descriptive statistics. Only Research Question 7 required additional statistical analysis in the form of correlation statistics to look at the relationship between variables.

Chapter IV: Findings

Demographic Questionnaire

The study assessed a sample of 36 (*N*=36) clinical social workers with an average age of 35.97 years (*SD*=11.84; range, 25-68) and average years practicing as a clinical social worker 7.37 years (*SD*=9.15; range, 0-40) (see Table 1). The highest degree held was most commonly a Master of Social Work (88.9%), followed by Bachelor of Social Work (5.6%), followed by a Doctorate of Social Work (2.8%). In this sample, 69.4% of the clinicians reported working full time (40+ hours per week) and 27.8 reported working part time (20-39 hour per week).

The largest self-reported racial/ethnic group in this study was Caucasian (86.1%). This group was followed by Black or African American (5.6%), Asian (2.8%), and Bi- or Multi-Racial (2.8%). In terms of gender, 88.9% of the sample self identified as female, 5.6% as male, and 2.8% as transgender. In terms of sexual orientation, 66.7% as straight, 11.1% as lesbian, 11.1% as bisexual, and 8.3% as queer.

Mental Health Questionnaire

The following diagnoses were reported: depressive disorder (n=13), bipolar disorder (n=3), other mood disorder (n=1), post traumatic stress disorder (n=5), generalized anxiety disorder (n=3), panic disorder (n=2), other anxiety disorder (n=3), eating disorder (n=2), alcohol related disorder (n=1), other disorder (n=1). The "other" disorder was specified as attention deficit disorder. Mood disorders making up 47.2% of reported diagnoses and anxiety disorders

making up 36.1%. In terms of origin of diagnosis, 11.1% of participants were self-diagnosed and 89.9% were diagnosed by a health or mental health professional.

Table 1

Demographics

Age	**Frequency**
25-29	12
30-34	10
35-39	3
40-44	1
45-49	2
50-54	1
55-59	2
60-64	0
65-70	2
Race/Ethnicity	**Frequency**
American Indian or Alaska Native	0
Asian	1
Black or African American	2
Hispanic or Latino	0
Native Hawaiian or Other Pacific Islander	0
White	31
Bi- or Multi-Racial	1
Sex	**Frequency**
Female	32
Male	2
Trans	1
Sexual Orientation	**Frequency**
Gay	0
Lesbian	4
Bisexual	4
Queer	3
Questioning	0
Other Non-Heterosexual Identity	0
Straight	24

In this sample, 38.9% of participants were engaged in psychotherapy to manage their diagnosis and 50% were taking medication to manage their diagnosis. A majority of 55.6% of the participants reported the current severity of their symptoms as mild, 38.9% as moderate, and 0% participants reported the current severity of their symptoms as severe. Five point five participants did not respond to this question.

Hypothesis 1

As predicted by Hypothesis 1, the majority of participants reported having engaged in some degree of disclosure. In response to the questions, "Are you out to anyone at work in anyway about your mental health?" 58.3% of participants answered "Yes."

Hypothesis 1a, was not supported by the data. Participants did not indicate that they disclose to coworkers who are "peers with whom they are friends" more frequently than to other categories of coworkers or supervisors. Only one participant reported being out to a colleague (peer) whom they consider friends. Being out to at least one agency supervisor received the greatest number of responses (n=7), followed by being out to at least one senior agency colleague with whom they are close (n=6), being out to at least one senior agency colleague with whom they are not particularly close (n=1), and being out to at least one agency colleague (peer) to whom they are not particularly close (n=1).

Hypothesis 1b was supported by the data. Participants reported disclosing information about their symptoms (n=17) more frequently than about seeing a therapist (n=12), taking medication (n=11), their specific diagnosis (12), missing work because of symptoms (n=5), or missing work because of treatment (n=5).

Hypothesis 1c, that participants would be out to less than half of their coworkers, was supported by the data. This hypothesis was assessed in the domains of being out about some

aspects, most aspects, and talking openly about one's mental health. Of the 19 participants who responded to the question, 17 reported being out about "some aspects" to less than half of their coworkers (and, more specifically, to 30% or less). Three of these participants were not out to any of their coworkers about some aspect of their mental health. Of the 19 participants, 17 reported being out about "most aspects" of their mental health to less than 50% of their coworkers (and, more specifically, to 20% or less.) Five of these participants were not out to any of their coworkers about most aspects of their mental health. Lastly, 18 of the 19 participants reported talking openly about their mental health with less than 50% of their coworkers (and, more specifically, to 20% or less.) Four of these participants do not talk openly with any of their coworkers.

Hypothesis 2

The data did not support Hypothesis 2, the assertion that in response to the prompt, "I am out at work about my mental health because..." participants would select "being in the closet was too stressful" more frequently than any other choice (see Table 2). The most frequently endorsed statement was "I prefer to be my authentic self with my colleagues," which was selected by 12 of the 16 participants who completed this question. The second most frequent statement was "It's my responsibility as a social worker to decrease the stigma towards mental illness and being out at work is one way to do so," which was endorsed by 10 of the 16 participants. Being out because "Being in the closest was too stressful" was the third most frequent response with 7 of the 16 endorsing the statement.

Table 2

Factors Influencing Decision to Come Out

"I am out because..."	Number of participants who endorsed statement by selecting agree or strongly agree	Of the participants who responded to the question, percentage who endorsed the statement
I believed coming out would be cathartic	4	25
Being in the closet regarding my mental health diagnosis was too stressful	7	43.8
I prefer to be my authentic self with my colleagues	12	75
I wanted to improve my relationship with my colleagues	6	37.6
I wanted to educate my colleagues (e.g. around living with mental illness)	5	31.3
It's my responsibility as a social worker to decrease the stigma towards mental illness and being out at work is one way to do so	10	62.6

Hypothesis 3

The data supported Hypothesis 3, the assertion that in response to the prompt, "I am selective about my disclosure because..." participants would select "I worry that others might view me less positively" more frequently than any other choice (see Table 3). Of the 30 participants who responded to this question, 21 participants endorsed the aforementioned statement, 58% of the entire sample.

Table 3

Factors Influencing Decision to Disclose Selectively

"I am selective about my disclosure because..."	Number of participants who endorsed statement by selecting agree or strongly agree	Of the participants who responded to the question, percentage who endorsed the statement
I worry others might view me less positively	21	70
I worry I might lose my job, be denied promotions, or denied increases in pay	13	43.3
None of my co-workers are out about mental health issues	13	43.3
None of my supervisors are out about mental health issues	18	62.1
My agency discourages expressing personal information with one's colleagues	11	37.9

Hypothesis 4

The data did not support Hypothesis 4, the assertion that the majority of participants will indicate feeling better about themselves in terms of self esteem since coming out (see Table 4). Of the 16 participants that responded to this question only 5 endorsed this statement. Of the 5 who endorsed it, 5 "agreed" with the statement, and 0 "strongly agreed."

Hypothesis 5

The data did not support Hypothesis 5, the assertion that the majority of participants will indicate feeling less anxious since coming out (see Table 4). Of the 16 participants that responded to this question 8 endorsed this statement and 8 disagreed with the statement. Of the eight who endorsed it, 7 "agreed" with the statement, and 1 "strongly agreed."

Hypothesis 6

The data supported Hypothesis 6, the assertion that the majority of participants will indicate feeling more satisfied with their job since coming out (see Table 4). Of the 16 participants that responded to this question, 11 endorsed this statement. Of the 11 who endorsed it, 9 "agreed" with the statement, and 2 "strongly agreed."

Table 4

Positive and Negative Consequences of Coming Out

"Since coming out about my mental health diagnosis at work..."	Number of participants who endorsed statement by selecting agree or strongly agree	Of the participants who responded to the question, percentage who endorsed the statement
I have felt supported by my colleagues	14	87.5
I have felt supported by my supervisor(s)	10	62.5
I have felt self conscious about being "different" than my peers	5	31.3
I have felt better about myself in terms of my self esteem	5	31.3
My colleagues have avoided me in social situations (e.g. eating lunch)	0	0
I have lost a friend(s) at work due to coming out	1	6.3
I have lost my job and believe that it was related to my disclosure	0	0
I have been passed over for raises and/or promotions and believe it was related to my disclosure	1	6.3
My co-workers have compared me to a client(s)	3	18.8
A client overheard, asked me about it, and terminated services	0	0
A client overheard, asked me about it, but did not terminate	0	0

services		
A client overheard, asked me about it, and it led to a therapeutic conversation for the client	0	0
I have felt less anxious	8	50.1
I have felt closer personally to my co-workers	13	81.3
I have felt closer professionally to my co-workers	9	56.3
I am better able to perform to my full potential as a clinician	13	81.3
I am overall more satisfied with my job	11	68.8
I have connected with at least one co-worker with whom I have a shared experience of being a clinician with mental health issues	13	81.3

Hypothesis 7

Spearman correlations were run to determine if there was a relationship between talking openly to one's coworkers about one's mental health and the perceived benefits of being out. As predicted by the hypothesis, two significant positive correlations were present (out of nine possible correlations). There was a significant positive strong correlation between talking openly and feeling supported by one's supervisor(s) (rho=.651, p=.006, two-tailed) and a significant positive moderate correlation between talking openly and feeling less anxious (rho=.584, p=.017, two-tailed).

Qualitative Findings

Thirteen of the 36 participants responded to the final survey question, "Is there anything else you'd like to share with us about the topic of mental illness among mental health providers?" Several themes emerged including: the profession's absence of discussion about mental health

providers with mental health issues and the importance of this topic (n=3), not resonating with a need or desire to disclose (n=3), the absence of a supportive work environment (n=2), comments on in-patient hospitalization and its place as a mental health experience (n=2). In addition, various individuals commented on the following: that coming out created a more positive work environment, that decisions to come out may vary depending on one's position in one's agency, and that some symptoms may be stigmatized more than others.

Chapter V: Discussion

Disclosure: Patterns, Benefits, and Barriers

The findings of this exploratory study are informative about the benefits of mental health providers being out in the workplace in regards to their own mental illness and about the barriers to coming out. The high endorsement of benefits and low endorsement of costs of coming out is encouraging. In contrast, cautiousness regarding coming out, suggests that much work must be done to increase awareness among social workers so that there can be reduced stigma towards social workers with mental illness.

In terms of the nature of disclosure in the workplace, the majority of participants reported being largely guarded in whom they are out to and how much they disclose. This finding is consistent with previous research suggesting that the nature of disclosure is generally context specific and dependent on factors such as social environmental and perceived risks of disclosure (Bos et al., 2009; Legate, Ryan, & Weinstein, 2011). Participants most frequently reported disclosing to supervisors and senior agency staff. Disclosing primarily to supervisors suggests that the worries associated with being out may be negated by the confidential and supportive atmosphere supervision seeks to create.

In terms of what clinicians disclose, clinicians most frequently disclosed information about their symptoms. There are several possible explanations for this. Talking about the fatigue associated with depression or anxiety, for example, is not only something to which most clinicians without mental illness can relate, but it is also not a symptom that is likely to be

stigmatized. By talking about symptoms rather than illness, one can be selective about how much one discloses. Further research might explore what kind of symptoms clinicians disclose. In other words, do clinicians disclose purging, binging, cutting, nightmares, passive suicidal ideation? While clinicians can talk about these symptoms in their own therapy, what is the impact of having symptoms in common with one's clients without being able to discuss this in supervision?

Many participants also disclosed seeing a therapist, taking medication, and their diagnosis. Clinicians may not be as selective about what they disclose, but rather about to whom they are disclosing. The fact that the percentage of people to whom clinicians disclose some aspects versus most aspects versus all aspects of their mental health is relatively consistent supports this suggestions.

Of those participants who were out, the majority endorsed having positive experiences. In addition, there was a significant relationship between talking openly about one's mental health issues and some of these benefits. One participant wrote, "As I came out to my co-workers, they too came out with their own struggles with mental illness. It created a more open work environment." As predicted, the findings were consistent with previously researched benefits of coming out as GLBTQ, including improved interpersonal relationships, enhanced relatedness to institutions such as work, and improved psychological well-being (Corrigan & Matthews, 2003; Day & Schoenrade, 1997; Morris, Waldo, & Rothblum, 2001; Ragins & Cornwell, 2001) and thus in support of Corrigan and Matthews' (2003) suggestion that the benefits of being out for GLBTQ identified individuals may be applicable to those with mental illness.

The findings of this study suggest that the stigma of mental illness may be the largest barrier to disclosure of mental illness in the work place among mental health professionals. The

majority of participants reported being selective of about disclosure because of worrying that others might view them less positively. As stated by one of the participants, "We talk about reducing stigma about our clients who struggle with a mental health diagnosis but the majority of my colleagues talk bad about other staff members if they suspect they have a diagnosis. Its hurtful!"

It appears that stigma affects clinicians similarly to the way it affects the general population. As stated previously, "[I]n the context of mental illness, [stigma] can be described as a process whereby affected individuals endorse stereotypes about mental illness, anticipate social rejection, consider stereotypes to be self-relevant, and believe they are devalued members of society" (Livingston & Boyd, 2010, p. 2151). It is possible that clinicians do not endorse the stereotypes or consider them to be self relevant, but rather anticipate that their co-workers endorse these stereotypes and, therefore, they anticipate social rejection. However, among this sample, respondents heard colleagues speaking in stereotyped and negative ways. Further research should investigate whether or not clinicians with mental illness internalize stereotypes about those with mental illness.

Methodological Strengths and Weaknesses

The anonymity of the online survey allowed for the inclusion of participants who may have otherwise been concerned about their confidentiality, especially participants who are not out and participants who may have known me. In addition, it may have allowed participants to be more honest than they might have been in an interview format. The use of a snowball sampling technique allowed me to reach as many participants as possible given the invisibility of the sample I was recruiting and my limited financial resources which inhibited the purchase of the National Association of Social Workers mailing lists.

The greatest limitation of this study was the small sample size. There are several possible explanation for this. Recruitment for this study involved reaching out to the broader category of social workers and asking them to pass along the invitation for participation to their social networks in hopes that it would catch the attention of social workers who self identify as social workers with mental health issues. I was unable to identify preexisting groups of clinicians with mental health issues that I could target directly.

It is possible that many social workers with mental health issues do not resonate with the idea of their mental health issues as playing a role in their social work identity. If social workers are taught that one's mental health issues are to be dealt with outside of work and only outside of work, early in their careers clinicians may decide to "separate" their own mental health issues from their identity as a social worker. I would argue, however, that this is a false dichotomy and that their experience with mental health issues and as a consumer of mental health services has impacted their clinical practice. In her book *Addressing Cultural Complexities in Practice* (2007), Hays outlines the ways in which age, race, ethnicity, socioeconomic status, gender, sexual orientation, religion/spirituality, disability, etc affect who we are, how we perceive the world, and how others perceive us. She argues that as a result, these components of the clinician's and the client's identities are brought into the therapeutic relationship. While she does not address mental illness, I would argue that mental illness is a formative part of one's identity and, therefore, plays a role in one's social work identity, even if that role is implicit.

Another factor that may have contributed to the small sample was the focus on clinicians with DSM diagnoses rather than with mental health issues. Some mental health professionals hold the belief that DSM is pathologizing in nature and, may for example, refrain from using it with the exception of for billing purposes. One participant wrote, " You seem very focused on

the diagnosis which for me is more irrelevant compared to my general mental health narrative and personal struggles." Other social workers with similar feelings may have been deterred from participating in the study due to the use of the DSM in the study's eligibility criteria. In addition, some mental health professionals are concerned about the stigma associated with DSM diagnoses. Corrigan (2007) explains, "First, the label provided by a diagnosis may act as a cue that signals stereotypes. Second, the criteria that define a diagnosis may augment the stereotypes that describe mental illness" (p.34).

Another limitation of this study if that the reliability and validity of the Outness Inventory of Mental Health in the Workplace was not conducted. Retrospectively, there are several things I would change about the measure. Primarily, some of the Likert scales probably would have been more appropriate as forced choice "yes" or "no" questions. To address this, in my analysis I collapsed "strongly agree" and "agree" into one response and "strongly disagree" and "disagree" into another. However, using "yes" or "no," instead may have improved the clarity of the questions being asked.

Lastly, there is a certain topic that was unintentionally excluded from this measure. Several participants highlighted that I did not ask about disclosing information about in-patient hospitalizations, and the associated stigma with this experience. One of the participants poignantly wrote,

> In my three years of employment at my current agency, I have not felt as supported as I thought I would specifically after being hospitalized for mental illness. Upon returning to work, I felt colleagues and staff were tip-toeing around me, too afraid to ask questions. I also felt confused because I didn't know what they were told in my absence. I think this topic is rarely talked about, yet one of the most important themes among social workers due to the high percentage of "wounded healers" as they say, or workers who are in the field because of a personal experience with mental illness.

Implications

The findings of this study indicate that stigma impacts mental health professionals with mental illness. It deters them from being out in the work place, which in turn prevents them from experiencing the benefits of being out, including being able to perform to their highest potential as a clinician. As such, it is imperative that the social work profession address the culture of perceived stigma towards mental illness in the workplace. In light of the high endorsement of the benefits of being out and low endorsement of negative consequences, the social work profession should consider ways to increase awareness of the prevalence of social workers with mental illness and the benefits of being out.

The role of the supervisor emerged as being of particular importance. Given that social workers were most likely to disclose to their supervisor, those in supervisory roles may need additional professional development in addressing this type of disclosure. The absence of supervisors who are out about mental health issues was endorsed as one of the largest barriers to disclosure. Consequently, supervisors with mental illness have the opportunity to make the work environment safer for others by coming out. In a study on supervisor self-disclosure in supervision, researchers found a strong link between supervisor self-disclosure and their working alliance with social work students (Davidson, 2011).

There is a definitive need for further research on this topic. The necessity of this research was made clear, not only by the survey outcomes, but by feedback provided by several of the participants and via the social media sites through which the survey was advertised. From thanking me for conducting the study to offering to share their personal narratives, social work students and professionals repeatedly stated the high need for activism in regards to changing the experience for mental health professionals with mental health issues.

Conclusion

This study opened the door to beginning to understand how mental health professionals with mental health issues experience their diagnosis in their workplace. It explored whether social workers with mental health issues disclose these issues to their coworkers and whether stigma inhibits disclosure, as well as the precipitants and consequences of disclosure. It appears that clinicians disclose selectively and infrequently. The findings, however, suggest that the social and emotional benefits of being out exceed the costs of coming out. The social work professionals should continue to explore ways to decrease stigma towards clinicians with mental health and create environments in which coming out is not only acceptable but normative.

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Appendix A

Human Subjects Review Letter of Approval

School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

February 22, 2013

Dear Alix Zamansky,

Thank you for making all the requested changes to your Human Subjects Review application. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

Marsha Kline Pruett, M.S., Ph.D., M.S.L.
Acting Chair, Human Subjects Review Committee

CC: Joanne Corbin, Research Advisor

Appendix B

Informed Consent Form

Dear Participant,

I am Alix Zamansky from Smith College School for Social Work in Northampton, MA. I am conducting my Masters thesis, which explores the experiences in the work place of clinicians with DSM-IV diagnoses, and their decision whether or not to "come out" about their diagnoses to their co-workers and supervisors. I am focusing on literature-based factors that may influence disclosure and the perceived consequences of, or lack of, disclosure. The data will be used for a for a Master's thesis, possible publication, and presentations. Dr. Burton, a faculty member at the School for Social Work, will continue the research after I have completed my thesis.

To participate in this study you must be a licensed clinical social worker and currently practicing in an agency setting in the United States for at least 20 hours a week (you may also practice in another place as well). In addition, you must have a DSM-IV diagnosis. This can be from either another professional or self diagnosed. It is okay if you are uncertain whether or not you meet the *exact* DSM-IV diagnostic criteria, as long as you perceive that you have the diagnosis. It should be noted that for this study I am excluding diagnoses of learning disabilities.

This study will be conducted using an internet survey. You will first be asked several questions about who you are and your practice followed, by a brief questionnaire on your DSM-IV diagnosis. The remainder of the survey which focuses on topics such as "outness" at work, self-esteem, and depression. The entire process should take 20-30 minutes.

Because the survey will include reflections on your own experiences with having a DSM-IV diagnosis or self-diagnosis and being closeted or being out in the work place, there is a risk that participation in the study could cause negative emotions to arise. I strongly encourage you to take advantage of your social support network or seek treatment. Possible benefits from participating in the study include having an opportunity to reflect upon your own experiences in a manner in which you might have not have done previously and knowing that your responses could be contributing to the development of knowledge about supporting clinicians with DSM-IV diagnoses in the workplace.

This survey is anonymous. Also, in the interest of anonymity, you are asked not provide any identifying information about the agencies at which you work. Any identifying information you include about yourself, co-workers, or clients will be treated confidentially and then deleted.

All data from the questionnaire will be kept in a secure location for a period of three years, as required by Federal guidelines, and data stored electronically will be fully protected. If the material is needed beyond a three year period, it will continue to be kept in a secure location and will be destroyed when it is no longer needed.

Your participation in this survey is totally voluntary. You have the right to refuse to answer any question on the survey. You may also withdraw from the study at any time by

navigating away from the webpage on your browser. If you do this, any answers you provided on previous questions will be immediately deleted. However, once you complete and submit your answers to the full questionnaire, it will not be possible to withdraw, because you will not be able to be identified.

If you have any additional questions about the study, please feel free to contact me directly at XXXX. Should have any concerns about your rights I encourage you to contact the Co-Chair of the Smith College School for Social Work Human Subjects Review Committee at XXXX.

BY CHECKING THE BOX BELOW THAT SAYS "I AGREE," YOU ARE INDICATING THAT YOU HAVE READ THE INFORMATION ABOVE AND HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS; AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Please print a copy of this page for your records.

_____ I disagree _____ I agree

Appendix C

Demographic Questionnaire

1. How old are you? _____

2. What do you identify as your race/and or ethnicity? Please choose one.
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Bi- or Multi-Racial
- ☐ White
- ☐ Other

3. What is your sex
- ☐ Female
- ☐ Male
- ☐ Neither/Other
- ☐ Trans

4. What is your sexual orientation
- ☐ Gay
- ☐ Lesbian
- ☐ Bisexual
- ☐ Queer
- ☐ Questioning
- ☐ Other non-heterosexual identity
- ☐ Straight

5. What is the highest level of social work degree you hold?
- ☐ BSW
- ☐ MSW
- ☐ PhD

6. How many years have you practiced as a Clinical Social Worker [please count since obtaining your licensure] _____

7. How many hours do you currently work per week in an agency setting?
- ☐ Part Time (20-39)
- ☐ Full Time (40+)

Appendix D

Mental Health Questionnaire

1. Please indicate your primary DSM-IV diagnosis. If you have multiple diagnoses, please choose the one which is most salient in your day to day life.

- ☐ Alcohol-Related Disorder
- ☐ Other Substance-Related Disorder
- ☐ Schizophrenia
- ☐ Other Psychotic Disorder
- ☐ Depressive Disorder
- ☐ Bipolar Disorder
- ☐ Other Mood Disorder
- ☐ Obsessive Compulsive Disorder
- ☐ Post Traumatic Stress Disorder
- ☐ Generalized Anxiety Disorder
- ☐ Panic Disorder
- ☐ Phobia(s)
- ☐ Other Anxiety Disorder
- ☐ Anorexia Nervosa
- ☐ Bulimia
- ☐ Other Eating Disorder
- ☐ Borderline Personality Disorder
- ☐ Other Personality Disorder
- ☐ Adjustment Disorder
- ☐ Other Disorder _____

2. Are you (check all that apply):
- ☐ Self Diagnosed
- ☐ Diagnosed by a health or mental health practitioner

3. Are you currently engaged in psychotherapy to manage your diagnosis?
- ☐ Yes
- ☐ No

4. Do you currently take medication to manage your diagnosis?
- ☐ Yes
- ☐ No

5. What is the currently severity of your symptoms?
- ☐ Mild
- ☐ Moderate
- ☐ Severe

Appendix E

Outness Inventory of Mental Health in the Workplace

15. Are you out to anyone at work in anyway about your mental health? YES NO

If "no," the respondent will be sent directly, by Survey Monkey to go to Question #32

Please choose response that most closely matches your own experience:			
	No	Yes	NA
16. I am out to at least one of my agency colleagues (peers) whom I consider friends	*1*	2	6
17. I am out to at least one of my agency colleagues (peers) with whom I am not particularly close	*1*	2	6
18. I am out to at least one of my senior agency colleagues with whom I am close	*1*	2	6
19. I am out to at least one of my senior agency colleagues with whom I am not particularly close	*1*	2	6
20. I am out to at least one of my agency supervisor(s)	*1*	2	6
I am out at work (my agency) to at least one person about:			
	No	Yes	NA
21. Symptoms related to my DSM-IV diagnosis (e.g. difficulty sleeping)	1	2	6
22. Seeing a therapist related to my DSM-IV diagnosis	1	2	6
23. Taking medication related to my DSM-IV diagnosis	1	2	6
24. My specific mental health diagnosis/condition (e.g. that I have OCD)	1	2	6
25. Missing days because of symptoms related to my mental health	1	2	6
26. Missing days because of treatment related to my mental health	1	2	6

Please choose the percentage that most closely matches your own experience:

27. What percentage of agency co-workers are you out to about <u>some</u> aspects of your mental health?	0	10	20	30	40	50	60	70	80	90	100
28. What percentage of agency co-workers are you out to about <u>most</u> aspects of your mental health?	0	10	20	30	40	50	60	70	80	90	100
29. With what percentage of agency co-workers do you talk openly about your mental health?	0	10	20	30	40	50	60	70	80	90	100

Question #30

I am out at work about my mental health because:

	Strongly Disagree	*Disagree*	*Agree*	*Strongly Agree*
a) I believed coming out would be cathartic	1	2	3	4
b) Being in the closet regarding my mental health diagnosis was too stressful	1	2	3	4
c) I prefer to be my authentic self with my colleagues	1	2	3	4
d) I wanted to improve my relationship with my colleagues	1	2	3	4
e) I wanted to educate my colleagues (e.g. around living with mental illness)	1	2	3	4
f) It's my responsibility as a social worker to decrease the stigma towards mental illness and being out at work is one way to do so	1	2	3	q

Question #31 Since coming out about my mental health diagnosis at work...				
	Strongly Disagree	*Disagree*	*Agree*	*Strongly Agree*
a) …I have felt supported by my colleagues	1	2	3	4
b) …I have felt supported by my supervisor(s)	1	2	3	4
c) …I have felt self conscious about being "different" than my peers	1	2	3	4
d) …I have felt better about myself in terms of my self-esteem	1	2	3	4
e) …my colleagues have avoided me in social situations (e.g. eating lunch)	1	2	3	4
f) …I have lost a friend or friends at work due to coming out	1	2	3	4
g) …I have lost my job and believe that it was related to my disclosure	1	2	3	4
h) …I have been passed over for raises and/or promotions and believe that it was related to my disclosure	1	2	3	4
i) …my co-workers have compared me to a client(s)	1	2	3	4
j) …a client overheard and asked me about it, and terminated services	1	2	3	4
k) …a client overheard and asked me about it, but did not terminate services	1	2	3	4
l) …a client overheard and asked me about it, and it led to a therapeutic conversation for the client	1	2	3	4
m) ... I have felt less anxious	1	2	3	4
n) … I have felt closer personally to my co-workers	1	2	3	4
0) … I have felt closer professionally to my co-workers	1	2	3	4
p) … I am better able to perform to my full potential as a clinician	1	2	3	4
q) … I am overall more satisfied with my job	1	2	3	4
r) ...I have connected with at least one co-worker with whom I have a shared experience of being a clinician with mental health issues	1	2	3	4

Question #32 I am selective about my disclosure because:				
	Strongly Disagree	*Disagree*	*Agree*	*Strongly Agree*
a) I worry others might view me less positively	1	2	3	4
b) I worry I might lose my job, be denied promotions, or denied increases in pay	1	2	3	4
c) None of my co-workers are out about mental health issues	1	2	3	4
d) None of my supervisors are out about mental health issues	1	2	3	4
e) My agency discourages expressing personal information with one's colleagues	1	2	3	4
Question #33 Past or current stresses of being closeted at work include:				
	Strongly Disagree	*Disagree*	*Agree*	*Strongly Agree*
a) Thoughts and feelings about whether or not to disclose my diagnosis	1	2	3	4
b) The fear of being "found out" regarding my diagnosis	1	2	3	4
c) The fear of losing my of job	1	2	3	4
d) The fear of how others might react	1	2	3	4
e) The fear of being seen by my colleagues as they see our clients	1	2	3	4
f) Being isolated from others who might share my experience	1	2	3	4
g) Being detached from my "true self"	1	2	3	4
h) Knowing that these stresses prevent me from being able to perform to my full potential as clinician	1	2	3	4

Question #34 The Agency I Work At:				
	Strongly Disagree	*Disagree*	*Agree*	*Strongly Agree*
a) In general, is accepting of individuals with stigmatized identities	1	2	3	4
b) Has policies in place to protect individuals with stigmatized identities	1	2	3	4
c) Treats individuals with disabilities	1	2	3	4
d) Has therapy or support groups for individuals with disabilities	1	2	3	4
e) Asks specifically about disabilities in their assessment	1	2	3	4

	No	Yes
35. Do you have a concealable stigmatized identity not yet addressed in this survey (e.g. sexual orientation, learning disability, etc.)?	*1*	2

For those who answer "Yes" above...

36. How many additional concealable stigmas do you have? _____

37. To what extent do you agree with the following statement?

	Strongly Disagree	*Disagree*	*Agree*	*Strongly Agree*
My co-workers are aware of this (or these) stigmatized identity(ies)	1	2	3	4

38. Is there anything else you'd like to share with us about the topic of mental illness among mental health providers?